FOLLOWING UP WITH INDIVIDUALS AT HIGH RISK FOR SUICIDE:

DEVELOPING A MODEL FOR CRISIS HOTLINE AND EMERGENCY DEPARTMENT COLLABORATION

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In the United States, more than 33,000 people die each year by suicide (Centers for Disease Control and Prevention (CDC), 2009). Many of these are people that were previously seen in the emergency room setting. While it is difficult to predict with certainty whether an individual who has attempted suicide will make future suicide attempts, what we do know is that the likelihood is high and improving the management of those recently discharged from an ED setting should be an important component of any suicide prevention effort (Litts, Radke, & Silverman, 2008).

Crisis call centers have operated throughout the United States for over 50 years and provide a unique and accessible resource to the community in general and to individuals at risk of suicide in particular. The purpose of this paper is to promote the development of relationships between crisis call centers and their local emergency departments in an effort to reduce suicide risk in the community. This paper seeks to provide information on available research that underscores the significant risk that exists following discharge for those who attempt suicide, the need and benefit of following up with this group, and the role that local crisis call centers can play, in collaboration with their local emergency departments, in reducing this risk. The benefits and challenges that exist in the establishment of a clear working relationship will be addressed and a framework for the development of crisis center/ED partnerships in working with those recently discharged will be reviewed.

Emergency Departments and Attempt Survivors

In 2008, 1.1 million adults attempted suicide. Of these, 678,000 reported receiving medical attention for their suicide attempt, and 500,000 stayed overnight or longer in a hospital (Substance Abuse and Mental Health Services Administration, 2009). All those admitted to a hospital are initially evaluated in an emergency room setting.

EDs face significant overcrowding. Providing special attention to attempt survivors in an ED is challenged by the demands of overcrowding. Across the United States, from 1992 – 2001 an estimated 974 million visits were made to emergency department settings: 52.8 million (5.4%) of these visits were mental health related – an increase of 28% (from 17.1 to 23.6 per 1000). Suicide attempts accounted for seven percent of all mental health related visits and, as a fraction of ED visits increased by 47% over the course of the decade (Larkin, Smith, & Beautrais, 2008). As the number of overall emergency department visits has increased, the number of emergency departments nationwide has decreased by roughly 15% (Larkin, Claassen, Emond, Pelletier, & Camargo, 2005) leaving a high percentage of EDs operating above capacity (Institute of Medicine, 2007; The Lewin Group, 2002).

Greater numbers of attempt survivors are discharged to the community. While the causes of ED overcrowding are complex and multifaceted (Derlet & Richards, 2000), one of the most important contributors to ED overcrowding is the limited inpatient capacity in many facilities (Cowan & Trzeciak, 2005; Richardson, Asplin, & Lowe, 2002). The number of general hospitals providing psychiatric services has declined over the years from 1,707

in 1988 to 1,285 in 2002 (Liptzin, Gottlieb, & Summergrad, 2007) and the proportion of suicide attempt patients admitted after ED stabilization has similarly declined (from 49.6% to 32%) over the course of the decade (Larkin et al., 2008).

Many of those returned to the community make repeated ED visits at significant emotional and financial cost. Data collected from the South Carolina Violent Death Reporting System established that over half of suicide deaths in South Carolina (2003-2004) were linked to hospital discharge and emergency room records. From January 2003 through December 2004, 282 individuals logged a total of 865 visits to a hospital or emergency room with ED visits accounting for 573 of these visits by 223 people (Weis, Bradberry, Carter, Ferguson, & Kozareva, 2006). Beautrais and Gibb (2004) identified that 45% of incurred costs for hospitalization were a result of repeat visits to the ED – an issue that may take on increased significance in the months/years ahead. According to a recent article published in The Washington Post, the Obama administration, in an effort to address health care costs, have identified hospital readmissions as an unnecessary expense and a sign of poor overall care. In pursuing a new approach, the possibility of the establishment of a flat fee for a first hospitalization and 30 day follow up period has been raised – [an approach] that could result in clinics and EDs with high readmission rates being paid less (Connolly, 2009).

Despite being the first point of entry for many into the mental health system, EDs are not always adequately equipped to deal with the high numbers of suicidal patients. Baraff, Janowicz and Asarnow (2006) surveyed the medical directors of 346 Emergency Departments in the state of California in an effort to determine available resources and current practices in the treatment of patients who presented with suicidal ideation or attempts. Findings indicated limited mental health services for suicidal patients. In only 10% of EDs were psychiatrists involved in the assessment of suicide with this role primarily being carried out by mobile teams or social workers called to the ED to assist. Twenty-three percent of ED directors reported at times discharging patients with suicidal ideation without a psychiatric evaluation taking place at all. Seventy one percent reported needing improved access to mental health staff for evaluation of suicidal patients and 61% reported needing greater access to mental health personnel for assistance with disposition. In many cases, there are few alternative options for obtaining care - Seventy six percent of ED directors reported limited availability of community based mental health referrals for discharged patients.

Suicide Risk Post Discharge

Those discharged rarely link to services. Despite the fact that most serious suicide attempts are assessed in an emergency department setting there has been no established best practice in terms of discharge planning to reduce further risk. Individuals are discharged to a system that is fragmented, fraught with service gaps and significantly underfunded; a system that lacks the care coordination that is critical in the period following admission to an ED or inpatient setting. Many of those discharged from emergency room or inpatient settings never follow up with clinic referrals. As many as 70%

of suicide attempters never attend their first appointment or maintain treatment for more than a few sessions (Appleby et al., 1999; Boyer, McAlpine, Pottick, & Olfson, 2000; Jauregui, Martínez, Rubio, & Santo-Domingo, 1999; Litt, Cuskey, & Rudd, 1983; O'Brien, Holton, Hurren, Watt, & Hassanyeh, 1987; Spirito, Lewander, Fritz, Levy, & Kurkjian, 1994; Tondo, Albert, & Baldessarini, 2006).

Suicide risk is highest following discharge from psychiatric inpatient or ED settings. Limitations in continuity of care impact significantly on those already at risk for suicide. Individuals with a history of suicide attempts or deliberate self harm are at an increased risk of future suicide (Hawton, Zahl, & Weatherall, 2003), regardless of their age (Beautrais, 2003), and many studies have shown that suicide risk is particularly high following discharge from psychiatric inpatient or ED settings (Appleby et al., 1999; Cooper et al., 2005; Crandall, Fullerton-Gleason, Aguero, & LaValley, 2006; Gairin, House, & Owens, 2003; Goldacre, Seagroatt, & Hawton, 1993; Ho, 2003; Hunt et al., 2009; E. A. King et al., 2001; Qin & Nordentoft, 2005; Valenstein et al., 2009; Weis et al., 2006; Yim et al., 2004). A national study (in the UK) of 238 psychiatric patients who died by suicide within three months of discharge from the hospital found that 43% of these suicides occurred within one month of discharge – with 47% of this group dying before their first clinic appointment. The first week and first day after discharge were noted as particular high risk periods (Hunt, 2009). Similarly, Appleby et al. (1999) noted that 24% of the suicides they studied occurred within three months of discharge and peaked in the first week with by far the greatest number occurring within one day of discharge. Indeed, among the Joint Commissions reviewable sentinel events is the suicide of any individual receiving care in a facility that is staffed around the clock or within 72 hours of discharge from such a facility. In a recent report, analyzing the years 2002 - 2008, post discharge suicides had significantly outnumbered in-hospital suicides and accounted for over half of the sentinel event suicides each year (except for 2002). In the years 2005 – 2008, these suicides represented 81% of the total study suicides versus 56% in the earlier years (New York State Office of Mental Health, 2009)

The need to establish a formal "chain of care" and system for follow up of those at greatest risk is evident. In a recent study, conducted in Finland, the benefits of enhanced and flexible community services are highlighted. This study evaluated the relation between suicide risk and varying means of arranging mental health care services. Findings showed that suicide risk was significantly reduced when three characteristics of care were present: mental health services were multifaceted (i.e., there were a variety of outpatient service types); the ratio of outpatient to inpatient services types was higher; and 24-hour emergency services were available. The authors suggest that flexible, multifaceted community-based services that can be more responsive to the needs of the community are associated with lower suicide rates than are services that are focused on inpatient treatment (Pirkola, Sund, Sailas, & Wahlbeck, 2009).

Follow Up with Attempt Survivors

Efficient transition from the ED to community based support services is critical in suicide prevention efforts. Studies have shown that general follow up after discharge from an inpatient or ED setting can assist in improving treatment adherence and provide much needed social support, which can ultimately impact suicide risk. While several studies have highlighted the benefits of brief follow up post discharge, much of the available literature focuses on characteristics of those who fail to follow up with clinic appointments and characteristics of those who go on to repeatedly self harm; specific studies detailing the mechanisms that support positive outcomes post discharge from an ED setting are limited.

In 2000, the World Health Organization (WHO) undertook a multisite study that evaluated the use of brief interventions and long term follow up contact with individuals who had been discharged following a suicide attempt (Fleischman et al., 2008). Participating sites in five countries applied the same protocol to 1867 suicide attempters. Those assigned to the treatment group received (in addition to treatment as usual) a one hour information session that included information on risk factors for suicide, alternative coping strategies and referral options. This session was conducted immediately on discharge. In addition to this, participants received nine follow up contacts (phone call or visit) over the following 18 months. Findings indicated a significant difference between the groups – a significantly higher number of those in the 'treatment as usual' group had died by suicide at the 18 month follow up. [It should be noted, however, that the sample of countries included in this study were unique in that they were all "developing" countries with little/no mental health protocols incorporated into the "treatment as usual" in the ED.]

Other studies have shown similar benefits of follow up: Motto and Bostrom (2001) evaluated whether the maintenance of long-term contact by professionals with people at risk of suicide could exert a protective effect. A total of 843 individuals who had refused ongoing care following discharge from inpatient treatment for depression or suicidality were randomly assigned to either receive treatment as usual or to receive repeated contacts (letters) at least four times a year over the next five years. The letters sent simply expressed concern for the individuals well being and did not attempt to actively recruit individuals into treatment. Those who received repeated contacts had a lower suicide rate in all five years of the study and a significantly lower suicide rate during the first two years. Using a similar study design, Carter, Clover, Whyte, Dawson and D'Este (2005) tested the efficacy of a postcard intervention following discharge from a hospital based toxicology unit following a suicide attempt. Individuals received postcards eight times during the 12 months post discharge – findings indicated that the simple postcard intervention nearly halved the number of repeat episodes of self harm and significantly reduced the number of hospital days. When further analyzed, data revealed this intervention was effective primarily for the women that participated in the study.

Additional studies have shown that general telephone contact can improve an individuals overall well being (Winter & Gitlin, 2007) and ultimately reduce suicide risk (De Leo, Buono, & Dwyer, 2002) – particularly in an elderly population. De Leo et al. compared a

random sample of 299 TeleHelp – TeleCheck users with 275 persons either on a waiting list or newly connected to the service. Those using the service for at least 6 months showed statistically significant reductions in requests for home visits by GPs, hospital readmissions and depression scores. Likely again it is the decreased sense of isolation and social connectedness that results from brief contact that positively impacts outcomes and benefits overall psychosocial functioning. Additional studies have evaluated the use of telephone contact as a general outreach method to increase attendance at outpatient clinic appointments (R. King, Nurcombe, Bickman, Hides, & Reid, 2003; Ritchie, Jenkins, & Cameron, 2000; Zanjani, Miller, Turiano, Ross, & Oslin, 2008). Ritchie et al., for example, found that a telephone call to patients within three days of ED discharge improved attendance at appointment referrals from 54 to 71%.

One of the few studies that explicitly evaluated the use of telephone contact alone in relation to suicide prevention was conducted by Vaiva et al. (2006). This study sought to evaluate the effects of contacting patients by telephone one to three months after being discharged from an emergency department following a suicide attempt. A total of 605 individuals were randomly assigned to receive telephone contact at one month or three months or to receive treatment as usual. Follow up calls were conducted by psychiatrists who would review the treatment plan and provide support in terms of empathy, reassurance, explanation and suggestion. Crisis intervention was provided when needed. Follow up was conducted on all participants at 13 months. Findings indicated that for those contacted at one month the number who reattempted suicide was significantly lower than that of controls (12% vs. 22%); a difference that was sustained over the first six months after telephone contact. For those contacted at three months, the number was not significantly lower than that of controls (17% vs. 22%). It is important to note that of those contacted at one month post discharge, 22 calls required crisis intervention and 13 calls detected individuals at high risk for suicide who were sent back to the emergency room – eight of these were admitted and only one reattempted six months later.

Further suicide prevention efforts undertaken within the emergency department setting include the provision of crisis hotline information to individuals upon discharge. The provision of crisis cards, however, has been shown to have limited benefit when offered alone (J. Evans, Evans, Morgan, Hayward, & Gunnell, 2005; M. O. Evans, Morgan, Hayward, & Gunnell, 1999). The details of distribution in these studies, however, are unclear. Additional data is needed on whether adequate information is given to the patient regarding the crisis line services, whether ED staff themselves fully understand the service provision, whether patients keep the cards or if they in fact ever use them. In addition, the provision of crisis cards upon discharge is an intervention that relies on individual motivation and in essence provides no additional concrete support that may encourage the patient to seek help.

Potential Value of Crisis Lines in ED-Discharge Patient Follow Up

While follow up with those at risk would appear beneficial, no specific mechanism for effective follow up has been established. Even within the literature cited in this paper, follow up work has largely been provided to small manageable groups – at times by dedicated psychiatric staff (e.g. emergency room MDs) - making generalizeability somewhat limited. Outside of a formalized study setting, ED psychiatrists would unlikely have the time to conduct repeat follow up calls to patients and engage in potentially lengthy discussions or assessment. It is also likely that any perceived risk on follow up would be less tolerated by emergency room staff than by trained staff at a hotline dedicated to suicide assessment and prevention. But are crisis lines really equipped to respond to the challenge?

Crisis hotlines provide a unique and accessible resource to the community in general and to individuals at risk of suicide in particular. Often underutilized by the mental health community, crisis hotlines can provide low cost access to trained professionals and/or paraprofessional volunteers that are specifically trained in suicide assessment and intervention. Available 24 hours a day, crisis center staff can take the time to thoroughly evaluate a callers suicidal ideation, provide support and guidance, offer referral information, develop a safe plan with the caller, and if needed dispatch emergency intervention to the scene. Many centers connect directly with their local mobile crisis teams and emergency services to provide pertinent and timely information on the callers risk for suicide. They can avert unnecessary emergency room visits and ensure emergency room visits when needed. They can intervene when a caller is not able or willing to ensure their own safety. Some centers have established relationships with local law enforcement.

Crisis centers have operated throughout the US for over 50 years. Despite this, the literature addressing effectiveness, while positive, is still limited. One evaluation method that has been utilized has been the silent monitoring of calls to a crisis hotline. Mishara and Daigle (1997) monitored 617 calls from suicidal callers to two crisis centers in Canada. A reduction in depressive mood and suicidality were noted and linked to a specific intervention style. In another SAMHSA funded evaluation, Mishara et al. (2007b) silently monitored 1,431 calls to 14 crisis centers. Findings indicated that when emotional changes did occur during the course of a call that they were positive. Over half the callers were rated as more decided and less confused by the end of the call and 40% were more hopeful. Similarly, R. King et al. (2003) in evaluating 100 calls made to a crisis line in Australia found "significant decreases in suicidality and significant improvements in the mental state of youth" over the course of the call.

Further analysis of the value of crisis hotlines has demonstrated significant benefits. Gould, Kalafat, Munfakh and Kleinman (2007) studied 1,085 suicidal and 1,617 non-suicidal crisis callers to eight crisis hotlines. The hotlines had agreed to use standardized, evidence-based suicide risk assessments and measures of crisis states, assessed near the start and at the end of their calls and, for those who consented, at a follow-up call approximately 3 weeks after the original call. Significant reductions in crisis and suicide status occurred during the

calls continued to the follow-up. Callers reported a reduction in their intent to die, hopelessness and psychological pain. Notably, in response to an open-ended question at follow-up as to what was helpful about the call, 11.6% (n = 44) of suicidal callers said that the call prevented them from killing or harming themselves.

Despite increased evidence of the effectiveness of crisis hotlines, the quality of services provided has been shown to vary across settings (Mishara et al., 2007a). While crisis centers can differ significantly in the quality and type of service provided, those centers that are members of the National Suicide Prevention Lifeline ('Lifeline') network adhere to policies, guidelines and standards related to "best practices" in suicide prevention. The Lifeline (800-273-TALK) is a network of over 140 crisis centers nationwide that answer almost 60,000 calls a month. All participating Lifeline centers are required to have accreditation or licensure from an external body with the authority to audit their practices. While the Lifeline network accepts accreditations from several organizations, over 85% of the network have been certified by the American Association of Suicidology (AAS). The Lifeline continuously works to establish standards of practice across the network. In 2005, The Lifeline's Standards, Training and Practices Subcommittee (STPS) undertook extensive review of available research in the area of suicide risk assessment and developed standards of assessment that have been adopted across the network. In implementing these standards each center has agreed to ensure that every caller is asked about current suicidality and, when a positive response is given, complete a full risk assessment (for further information on these standards see Joiner et al. (2007)).

The Lifeline network wholly supports crisis center collaboration with local emergency resources and follow up for those at risk. These issues have been viewed as a priority for the Lifeline and are reflected in recent initiatives. In September 2008, the Lifeline Communications Team completed development of a Crisis Center-Emergency Department (ED) Toolkit that was disseminated to the entire network. This kit was developed to provide crisis centers with the tools and resources needed to begin to pursue collaborative relationships with their local EDs. In 2009, the Lifeline began implementing newly established Policies and Guidelines for Helping Callers at Imminent Risk of Suicide. These policies and guidelines, based on research and a consensus of expert opinion in the field of suicide prevention, were disseminated throughout the network and focus on ensuring that centers take all action necessary to ensure the safety of callers and initiate efforts on the development of collaborative community relationships.

In addition to the Lifeline focus on collaboration and follow up, there is a growing federal and national interest in follow up by crisis centers as noted below:

NASMHPD recommends collaborating with crisis hotlines. In its recent report on suicide prevention (Litts et al., 2008), the National Association of State Mental Health Program Directors (NASMHPD) made the following recommendations:

- Recommendation 3: *The public mental health system should support and collaborate with crisis hotlines to ensure individuals at risk for suicide, including those who have made a suicide attempt, can readily access high quality crisis support services.* [The authors note the unique capacity that crisis hotlines have to intervene at various points along the path to self harm and also note the specific benefit of crisis hotlines in rural areas with limited access to mental health services.]

- Recommendation 5: *The SMHA, in collaboration with the SHA, should initiate policies and practices that promote improved continuity of care for individuals at heightened risk for suicide following discharge from emergency departments for suicide attempts and inpatient hospitalization.*[The authors note that the lapses in continuity of care, especially following discharge from an ED or inpatient setting, contribute to significant suicide risk and also note the role that crisis hotlines can play in filling the gaps through telephonic follow up post discharge.]

SAMHSA grants to support crisis center follow up with suicidal callers. In March 2009, SAMHSA awarded six grants totaling more than $1 million over three years to help Lifeline crisis centers develop follow-up services for people at high risk of dying by suicide. The Lifeline crisis centers selected for these grants are developing or expanding systems to follow up with callers determined to be at high risk for suicide and will work to ensure they get the help they need. All of the grantee follow-up models are being evaluated by researchers from Columbia's Research Foundation for Mental Health, and all models include ongoing risk assessments, and enhanced safety planning, as well as a process for providing information for facilitating treatment linkages.

In August 2009, SAMHSA announced a supplemental grant to be awarded to the Lifeline to directly support up to 20 Lifeline centers in their suicide prevention work with those affected by the economic downturn. SAMHSA provided more than $1 million to help expand the ability of theses crisis centers to address the increased demand for services during a time of financial hardship, and to provide outreach and/or follow up to those in their communities most at risk. One identified means by which follow up could be provided is through a centers work with those recently discharged from an emergency room setting.

Joint Commission (JC) encourages use of crisis hotlines in discharge planning. The Joint Commission's 2007 Patient Safety Goals on Suicide require that the hospital "provides information such as a crisis hotline to individuals and their family members for crisis situations" (NPSG.15.01.01) and particularly suggests the provision of the Lifeline service, 1-800-273-TALK.

VA focuses on follow up with Veterans that call the Lifeline. In August 2007, the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) founded a national suicide prevention hotline to ensure veterans in emotional crisis had free, 24/7 access to trained counselors. To operate the Veterans Hotline, the VA partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National

Suicide Prevention Lifeline. Veterans can call the Lifeline number, 1-800-273-TALK (8255), and press "1" to be routed to the Veterans Suicide Prevention Hotline.

All callers to the VA hotline receive follow up. The Veterans Suicide Prevention Hotline in Canandaigua, NY (linked to the Lifeline) and the crisis centers in the Lifeline network refer veterans to a Suicide Prevention Coordinator (SPC) who is a specialized case manager that can provide follow up calls and continuing care to Veterans that are at risk for suicide. The VA has placed an SPC at every VA Medical Center across the nation and all callers are assigned to this service. Contact by an SPC typically occurs within 24 hours of their initial call to the hotline and can be continued weekly while they are connected to the services they need.

Barriers to Establishing Relationships

Despite the practical and theoretical appeal of establishing clear working relationships between emergency departments and local crisis centers, it has proved difficult for crisis centers to successfully achieve such a direct partnership in the care of suicidal patients.

Many centers within the Lifeline network have established *informal relationships* with local emergency departments that involve information sharing on the part of the crisis center but little reciprocity on the part of the ED. A major barrier to equal information exchange about suicidal individuals has been concerns related to privacy. While for the crisis center, protecting information and preserving confidentiality for the individuals they help is integral to maintaining the integrity of their service to the community, when a caller is assessed to be at imminent risk and to require the intervention of emergency services, virtually all crisis centers require that their staff break that confidentiality for the benefit of the caller's safety. For some centers, such as LifeNet in NYC, the information sharing extends beyond informing emergency services of the details of the crisis. As is standard protocol for this center, LifeNet staff will contact the receiving ED, fax a written report of their assessment of the caller (which includes a complete assessment of suicidality), and will follow up to ensure that the caller was evaluated. Should a caller leave the ED prior to a full assessment taking place, LifeNet will dispatch a mobile crisis team to complete the evaluation. The goal of this protocol is to ensure that a mental health professional fully assesses the caller in person.

In the development of *formal relationships,* with collaborative information sharing that extends beyond the immediate crisis, no real progress has been made. Several centers within the Lifeline network have proposed models of care which upon presentation have been met with overwhelming approval from hospital administration (see samples provided) – the practical administration of a collaborative program however has proved more difficult. The benefits of undertaking such a relationship are supported in the research - the literature cited in this paper highlights the fact that the post discharge period is the time of highest risk - so why then is this not standard practice?

Attitudinal Barriers

In addition to the practical barriers that exist in the development of collaborative crisis center/ED working relationships, there is also the issue of the [often ignored] attitudinal barriers that need to be overcome. Individuals with mental illness frequently experience discrimination and face negative attitudes not only from the community at large but also, perhaps surprisingly, from health care professionals themselves (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; Anderson, 1997; Cerel, Currier, & Conwell, 2006; McAllister, Creedy, Moyle, & Farrugia, 2002; Sidley & Renton, 1996; Souminen, Soukas, & Lonnqvist, 2007). Cerel et al. in a web based survey of the emergency room experiences of attempt survivors and their family members found that of 465 consumers, 31.2% felt that the injury was not taken seriously by ED staff and fewer than 40% felt that staff listened to them. In addition, 54% reported that staff made them feel punished or stigmatized due to the attempt. Frequent visits to the ED, a lack of training in some EDs on mental health issues, and a perceived "choice" to self injure may all contribute to a potentially negative experience.

The presence of a negative attitude within an ED setting can not only influence the care an individual receives (Horrocks, Price, House, & Owens, 2003) but can also impact the ease with which opportunities to address the needs of this high risk group are developed and sustained. For the crisis center, initial efforts to establish a working relationship may require a greater focus on providing the ED staff with educational opportunities that can address suicide issues such as the high risk following discharge, the value of follow up, and the scope of services offered by the crisis center. An overall focus should be placed on addressing any existing negative attitudes and providing practical strategies to inform practice.

From June 2008 to February 2009, the Contra Costa Crisis Center in California conducted a pilot program in partnership with a local behavioral health center to provide follow up call services to individuals recently discharged following a suicide attempt (for the full report see appendix). Following the programs early termination by the health center, the Lifeline contacted Contra Costa Crisis Center to discuss some of the challenges faced in the execution of the pilot program itself and to identify areas of focus for future collaborations. The issue of the education and involvement of health center/ED staff (or ED staff) was raised. According to the project director,

Much of the negotiations regarding the initiation of the pilot program and much of the operational details were worked out with management and supervisory staff; these were not the staff that would ultimately be carrying out the evaluation and referral to the crisis center itself. A meeting should have been held with all direct care staff to inform them of the crisis center, the background, what the crisis center could offer and the need for follow up. Without this information, the direct line staff do not have the same degree of buy in as they would with feeling they were participating in a potentially life saving program. It is also possible that some follow up reporting being made available to these staff would be beneficial and reinforcing (J. Hampshire, personal communication, July 9, 2009).

Limited Resources

For the local crisis center to fully participate in follow up calls to those discharged from the ED, additional resources would be needed. Follow up calls can be time consuming both in the multiple calls likely needed to locate the individual and the ongoing assessment required during each subsequent call.

In the Contra Costa pilot program, it was reported that one of the greatest difficulties encountered at the crisis center site was the degree of time required to carry out the follow up calls:
Additional staff were needed who could focus on follow up alone. Participants were often difficult to locate and the calls themselves were often lengthy. In addition to the time required for direct line staff, the logistics involved in coordinating call back times to suit the participant required significant administrative oversight (J. Hampshire, personal communication, July 9, 2009).

In addressing some of the time issues, the center reported that in any future project they would require more information be transferred in the original follow up request. At the time of planning, the center only requested basic information: name, age and phone number. Additional information such as the individual's general location, a back up contact, and details on the nature of the risk would, they believed, have saved a tremendous amount of time for the crisis center staff. Even with this in place, however, the center stressed the need for dedicated and experienced staff involved with follow up.

Significant policies and guidelines for staff would be required to ensure the efficient and effective management of any follow up program. Exact resources are difficult to predict and are dependent on local ED discharge volume. Many local crisis centers operate with limited funding. In addition to staffing requirements, crisis centers may need to identify additional phone lines for ED staff to access the follow up team and invest in the development of software to track follow up activity. While costs will vary by program, the sample proposal from LifeNet in NYC (included in this paper) provides one example of potential costs. LifeNet requested almost $49,000 in funding from the New York State Office of Mental Health to undertake a six month pilot follow up program with a local ED. They were awarded $35,000 for a three month pilot. In addition, the Contra Costa program in California received $20,000 in funding from the associated health care center to carry out the follow up on the patients they discharged (see example 2).

Liability Concerns

Information Exchange: For both parties, conversations about whether or not to exchange information become problematic when one or the other participating entity invokes questions or concerns related to the Health Information Portability and Accountability Act (HIPAA). In reviewing the regulations and related legal interpretations, HIPAA appears in

no way to be an impediment to exchanging information that could, in effect, better ensure an individual's personal safety. HIPAA Standard 164.512(j) states that:

A covered entity may, consistent with applicable law and ethical codes of conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat; or (ii) Is necessary for law enforcement authorities to identify or apprehend an individual….(OCR/HIPAA Privacy/Security Enforcement Regulation Text, 45 CFR 164.512(j))

It is important to note that follow up services to those at risk would follow a formal consent procedure with the individual served providing written permission to the ED and crisis center to share certain basic information that would be necessary to establish contact. The program would be voluntary further nullifying the reference to HIPAA as a barrier to service provision.

Added Responsibility*:* Concerns abound for both the ED and the crisis center regarding the ultimate responsibility for the welfare of the recently discharged patient. It is important to note that the inclusion of a crisis center in an ED discharge plan is not intended to replace any element within what should be a standard plan of care. Follow up on the part of the crisis center should be ***in addition*** to any discharge services that would be provided and so the question must be whether the addition of preventive services (such as the crisis center) could in any way *increase* risk.

Whenever a new element is entered into the "chain of care" the issue of exposing that element to litigation is raised. Who is ultimately responsible if something happens to the patient? Is it the hospital for discharging the patient or the crisis center that has assumed responsibility?

A critical issue in any litigation proceeding that occurs following a suicide is that the clinician has a duty to prevent suicide if they can reasonably anticipate the danger; could the treatment team have reasonably predicted that the patient was likely to exhibit suicidal behavior and did they do enough to protect them (Bongar, 2002; VandeCreek, Knapp, & Herzog, 1987)? In malpractice litigation, negligence is the predominant theory of liability (Packman, O'Connor Pennuto, Bongar, & Orthwien, 2002) and a negligent act on the part of the clinician includes not only that actions that were taken (act of commission) but also those actions that *should* have been undertaken (act of omission) (Simon, 2004). The literature presented in this paper indicates extensively that the risk for suicide is significantly heightened post discharge, that there is a predictable lack of follow up with referrals provided in the ED, and that follow up can impact treatment adherence and ultimately reduce risk. So if all this is known then surely it should be the standard of care to pay attention to the known facts when developing the discharge plan for those seen in the ED following a suicide attempt. While it is understood that there is no formal means for a clinician to predict a persons suicide, courts focus on whether there was sufficient evidence

for an identifiable risk of harm, and whether sufficient action was taken (VandeCreek et al., 1987). The addition of crisis center follow up to the "chain of care" would almost certainly contribute to the [perception] that all available services were accessed in the protection of the individual and would likely significantly reduce the possibility of the ED being sued (S. Simpson, personal communication, March 12, 2009). Follow up could, in fact, be protective against liability for the ED/hospital in any court setting.

For the crisis center, taking on the additional risk of following up with ED discharges can be managed in a number of ways:

1. The development of clear and consistent protocols and guidelines for program eligibility, emergency response and information exchange should be a key element in the development of any collaborative working relationship. The construction of a Memorandum of Understanding (MOU) will allow both the crisis center and ED to come to a mutual agreement on the guidelines for practice and should lay out clear practical guidance for staff to follow that include reference to (at a minimum) the following elements:
    a. A clear definition of program eligibility (e.g. age, risk level)
    b. Consent form for the disclosure of relevant information (details on information that will be disclosed – e.g. name, contact number)
    c. Protocols and procedures for secure transmission of protected information (secure fax lines, dedicated phone lines, etc.) between the facilities
    d. Scope of follow up services (details on the number of initial attempts to contact, point at which outreach will stop if no contact, point at which follow up calls will stop once engaged - e.g. linked to treatment, refusing treatment but low risk)

2. Both parties should agree to clearly inform the client of
    a. scope of service, and
    b. actions that will be taken if increased risk, and
    c. point at which the follow up calls will stop

3. Crisis center protocols and guidelines for follow up should reflect common practice in the field. As is evident from the literature cited in this paper, no clear "standard of care" exists in the provision of follow up services. In 2008/2009, the Lifeline convened a "follow up workgroup" of researchers and crisis center directors with expertise in general follow up practices. Based on a survey of expert opinion, this workgroup produced a paper that reviews current research and practice related to follow up, provides a framework for crisis center follow-up models, and offers samples of models consistent with this framework. The follow up workgroup made the following recommendations regarding the general use of follow up within a crisis call center context (see Appendix 1 for greater detail)

a. Anyone who has suicidal ideation or is considered by the crisis worker to be otherwise "at risk" or is "unsafe" and who is not assessed to be an imminent risk for suicide is a candidate for follow-up.
b. There should be a consistent approach to suicide risk assessment from the initial caller contact with the center through the follow-up calls. The follow-up should be an integral part of crisis center service delivery.
c. All follow-up protocols should include a structure for the caller's "safety planning", which is begun at the point of the initial caller contact with the center and continues through subsequent contacts with caller.
d. The center should structure consistent parameters and protocols for following up with callers that address:
    i. Which staff should be trained and available to conduct follow-up
    ii. How the caller consent for follow-up is obtained and subsequent contact with the caller arranged
    iii. Issues of confidentiality
    iv. Documentation guidelines for recording all exchanges between helper and caller over the course of follow-up
    v. Length of follow-up with callers
    vi. Trainings and supervision that address all of the items above

4. Finally, in addition to a well developed, consistent, and transparent follow up protocol, crisis center resources must be sufficient to effectively and efficiently carry out the proposed follow up. Adequate supervision, staffing and training must be available to fulfill expectations.

Benefits of ED/Crisis Center Model

How do the crisis center and ED benefit from the development of this collaboration? What is the incentive for them to pursue this working relationship?

For the crisis center:

- ***Integration into the formal mental health care system.*** For the crisis center, the development of an official relationship with an established emergency health care service in the community could facilitate the crisis center becoming an essential part of the hospital discharge plan and, in turn, facilitate integration into the formal mental health care system.
- ***Increased funding opportunities.*** Such a partnership could assist the crisis center in increasing visibility and credibility in the community - an important benefit in both sustaining and securing much needed funding.

For the ED:

- ***Reduced liability.*** For the hospital, the inclusion of additional resources in the care of those discharged and the establishment of a systematic follow up plan for suicidal patients could lead to the development of best practices in discharging high risk patients. While there are no measures that can completely eliminate liability, the inclusion of the crisis call center, when used in addition to existing routine ED discharge plans, would enhance the care of those at risk after discharge and has the potential to reduce opportunities for liability (G. L. Larkin, personal communication, September 21, 2009).
- ***Financial benefits.*** Providing special attention to attempt survivors in an ED is challenged by the demands of overcrowding. The potential for crisis centers to avert unnecessary ED visits could yield substantive benefits in terms of timely and effective interventions that ensure ED staff time is well spent and hospital costs are reduced.

For both crisis center and ED:

- ***Increased information sharing.*** A developed collaborative working relationship between the crisis center and ED would greatly enhance the management of at risk patients and contribute to a more coordinated less fragmented system of care. Open lines of communication would allow the crisis center and ED to assess the patient with all available information on risk status. Crisis center expertise in risk assessment can be specifically useful when access to onsite psychiatric staff is limited. In addition, crisis center staff are typically knowledgeable in a wide range of community based resources for discharged patients.
- ***Reduction of suicide risk.*** Perhaps the most important benefit lies in the opportunity for both the crisis center and ED to further contribute to the reduction of suicide risk in the community. As previously stated, individuals discharged following a suicide attempt are at significant risk for reattempts. While the specific benefit of crisis call center involvement in the discharge process has yet to be empirically tested, we have seen in the literature the tremendous benefits that follow up alone can provide. The simple postcard intervention conducted by Carter et al. (2005) nearly halved the number of repeat episodes of self harm within the group studied. According to a prominent researcher in the field of suicide prevention, it would follow that personal contact and an extended interest in the welfare of those discharged could only heighten the benefit (A. Beautrais, personal communication, September 21, 2009). For the Contra Costa Crisis Center,

  ….the one thing that was clear from the start of this brief pilot program was that all participants were grateful for the follow up calls they received and surprised that staff cared enough to contact them. Staff at the crisis center felt that many of these individuals were very isolated and potentially high risk and that there was something transformative about proactive outreach (J. Hampshire, personal communication, July 9, 2009).

ATTACHMENT A

LIFENET FOLLOW UP PROPOSAL

The following is a proposal that was developed by LifeNet in NYC for crisis center follow up with those discharged from an ED setting following evaluation for recent suicidal ideation. This pilot project was funded for six months by the New York State Office of Mental Health (NYSOMH). This proposal is provided for illustration only and can be adapted and/or borrowed from to suit the needs of individual centers.

Statement of Need:

*[**COMMENT:** Most proposals will require a general section on the need for the proposed service. Included in this section should be all the available literature to support your case on the need for follow up services post discharge and the role and value of crisis centers in the follow up. Much of this literature is provided in the early sections of this paper.]*

Purpose of Current Pilot and Targeted Population:

The purpose of the proposed pilot project is to improve follow up and continuity of care for individuals discharged from the emergency department who presented with recent or current suicidal ideation but whose risk level did not justify hospitalization. Demonstrating the potential effectiveness of such a pilot that links a mental health crisis and information and referral call center (the MHA of NYC LifeNet service) with [HOSPITAL] psychiatric emergency department may serve as the basis for replication with other emergency departments around the city and state. Such a pilot also has potential implications for effective approaches with other high risk populations.

The population of focus for this project will consist of all people discharged from the [HOSPITAL] psychiatric emergency room who meet the following criteria. The discharged person must:

- Have been assessed as having some level of suicidal risk at discharge from the ER, but at a risk level that has not justified hospitalization. *[COMMENT: The criteria here on who you accept to the follow up program will depend on crisis center resources and the primary focus of your pilot. Some centers may define the population of interest as any individual that presents to the ED with any form of suicidal ideation – some may define this as those discharged from the ED with some level of risk only. Whatever the decision it must be clearly defined.]*
- Be at least 18 years of age (to be able to provide legal consent)
- Reside in [CITY, STATE] (if restrictions apply to the crisis center)
- Have been provided with an outpatient treatment referral or already have an outpatient treatment provider (at a minimum must receive treatment as usual)

- Have consented to receive a follow up call or calls between the time of the ED discharge and completion of their first (or next) session with a treatment provider (see Attachment E for sample consent form)

The Organizations:

*[**COMMENT:** In providing information about your center it is important to establish the experience and value of your center in the suicide prevention arena. Membership of the Lifeline is an important component and the implication that membership has regarding training, risk assessment and standards of operation.]*

[LIFENET EXAMPLE] The Mental Health Association of New York City is a private, not-for-profit 501(c)(3) organization concerned with all aspects of mental health. MHA works to change attitudes about mental illness, to improve services for children and adults with psychiatric disabilities, and to promote behavioral health in the community through its programs and services. Since 1996, The Mental Health Association of NYC has provided a professional mental health crisis/information and referral call service ("LifeNet") that is available to all residents of New York City on a 24/7 basis under contract with the NYC Department of Health & Mental Hygiene. By agreement, mental health calls to the NYC-operated 3-1-1 and 2-1-1 services are also referred to LifeNet. The service maintains dedicated toll free numbers for English, Spanish, and Asian language callers. The service also has established working relationships with NYC's 21 mobile crisis teams (MCT) and with NYC emergency medical services (EMS).
LifeNet is also a member of the SAMHSA funded National Suicide Prevention Lifeline (NSPL) and as such adheres to their established risk assessment standards and intervention guidelines. LifeNet is staffed by masters level mental health professionals who are trained in crisis intervention and suicide assessment.

The proposed pilot project would add a "call out follow up service" as a natural extension of the traditional LifeNet service "call in" model. The current standard practice at LifeNet with all callers, not just those who report suicidal thoughts, can be summarized as follows (note that the approach with a third party caller is a variation of the basic approach summarized below):

1. Using an active listening approach, engage the caller and determine the client's purpose in calling, providing support and clarification as appropriate.
2. Complete a standardized risk assessment to assess for suicide risk
3. As appropriate to the circumstances, provide up to three treatment referrals
4. As appropriate to the circumstances, offer mobile crisis team services with subsequent follow up to determine if the team made contact with the client.
5. As appropriate to the circumstances, initiate an emergency 911 call, with subsequent follow up to determine if the client was transported by the police to a hospital emergency room.
6. Inform the caller that they should call back if they need additional assistance.
7. Document the call.

For this project, MHA is teaming with [HOSPITAL]. [THIS HOSPITAL] is a general hospital as defined in Public Health Law Section 2801, with 411 inpatient beds and a comprehensive multi-site ambulatory care network generating over 560,000 visits annually. *[COMMENT: More details on the specific hospital services were provided here but deleted due to relevance. If known, it may be good to describe the typical ED procedures for suicidal individuals in this section].*

Goals and Objectives:

There are two goals:

- To help assure that all suicidal people seen in the [HOSPITAL] psychiatric emergency room (but not admitted to the inpatient service) are connected or reconnected to treatment following their discharge.
- To reduce the level of risk in those who choose not to be connected to treatment.

Implementation, Timelines and Staffing:

The proposed project will implement the post-discharge follow up model described below. Staffing will include time from [HOSPITAL] emergency room personnel to obtain and transmit consents, and a dedicated staff member at MHA for overall project management and patient follow up. It will be important to be able to carefully track the status of each patient who has consented to follow up. For the reason, we will develop and utilize a dedicated client tracking database software application for this project.

1. Obtain consent at the time of the [HOSPITAL] ER discharge to receive follow up calls from LifeNet and to transmit an (electronic) copy of the ER discharge plan to LifeNet. The information transmitted must include the following elements:
    a. Name
    b. Phone number
    c. Additional contact (if available)
2. LifeNet will initiate a follow up call with the person within 24 hours of discharge
3. LifeNet will develop a safety plan with the person, modeled after the safety plan guidance developed by [safety plan]. *[See information regarding safety planning in Attachment B]*
4. Follow up calls will be the responsibility of a single designated individual (with appropriate back up coverage) for whom this function becomes their sole responsibility.
5. Place the next scheduled follow up call within 7 days of the initial contact [or sooner depending on need – but no later than]
    a. For clients who have agreed to enter treatment:
        i. Review the safety plan
        ii. Reassess the current level of risk (and as appropriate, initiate mobile crisis or 911 service)

iii. Determine if/when the client has been able to obtain an appointment with a treatment provider
iv. Provide alternative referrals as necessary
v. Confirm the intent to place another follow up call within 7 days
vi. Document the call

b. <u>For clients who have not agreed to enter into treatment but who have consented to follow up</u>:
    i. Review the safety plan
    ii. Reassess the current level of risk (and as appropriate, initiate mobile crisis or 911 service)
    iii. Confirm the intent to place another follow up call within 7 days
    iv. Document the call

c. <u>For clients who cannot be reached by phone upon follow up</u>:
    i. Make three attempts to establish contact *[No specification is made here as to the time period for these calls. the number and time period may vary by crisis center]*
    ii. Discontinue follow up after three unsuccessful attempts at contact
    iii. Document the attempts

6. Place the second scheduled follow up call
    a. <u>For clients who have agreed to enter treatment</u>:
        i. Review the safety plan
        ii. Reassess the current level of risk (and as appropriate, initiate mobile crisis or 911 service)
        iii. Determine if/when the client has been able to obtain an appointment with a treatment provider. End tracking if client has had the first appointment with the treatment provider.
        iv. Provide alternative referrals as necessary
        v. Confirm the intent to place another follow up call within 7 days if client has not yet had the first appointment.
        vi. Document the call
    b. <u>For clients who have not agreed to enter into treatment but who have consented to follow up</u>:
        i. Review the safety plan
        ii. Reassess the current level of risk (and as appropriate, initiate mobile crisis or 911 service)
        iii. Confirm the intent to place another follow up call within 7 days unless reassessment confirms minimal suicidal risk. End tracking if this is the second assessment of minimal risk.
        iv. Document the call
    c. <u>For clients who cannot be reached by phone upon follow up</u>:
        i. Make three attempts to establish contact
        ii. Discontinue follow up after three unsuccessful attempts at contact
        iii. Document the attempts

7. Subsequent follow up calls
    a. <u>For clients who have agreed to enter treatment</u>: Repeat the sequence under #5a above until confirmation that the client has entered treatment.
    b. <u>For clients who have not agreed to enter into treatment but who have consented to follow up</u>: Repeat the sequence under #5b above until two successive assessments of minimal suicidal risk.
    c. <u>For clients who cannot be reached by phone upon follow up</u>:
        i. Make three attempts to establish contact
        ii. Discontinue follow up after three unsuccessful attempts at contact
        iii. Document the attempts

<u>Sample Safety Plan</u>

A sample safety plan to be provided – meanwhile, please see Attachment B for a review of core safety plan elements.

<u>Deliverables, Outcomes and Measurement of Success</u>:

The logic model for evaluation of the proposed practice is presented in the table that follows.

There are two principal measures including: 1) risk assessment change ratings over time, and 2) number of people who begin or return to mental health treatment following phone contact with our crisis and referral line.

These can be used to quantify our intended outcomes: 1) callers are connected to mental health treatment (rather than simply referred to treatment) 2) and the risk level for persons refusing to begin treatment remain minimal upon follow up (excluding all person from this cohort for whom emergency 911 services are provided).

*[**COMMENTS:** (1) An additional valuable measure for centers would be the degree to which the caller adhered to the established safety plan which could then be correlated with any changes in level of risk. An issue that is very often difficult to assess is what the specific factors are that reduces risk when it is reduced. For many, linkage to treatment may be one outcome but it may not in fact ultimately affect the risk status. (2) In a formal research project the risk assessment tool would need to be one that has established sensitivity to change over time. A formal research project would also require IRB approval - As this is program evaluation and not research this would not be required.]*

Logic Model for Evaluation of Proposed Project

RESOURCES (INPUTS)	**PROGRAM COMPONENTS (ACTIVITIES)**	**OUTPUTS (OBJECTIVES)**	**OUTCOMES (GOALS)**
Staff: • ER discharge planners • Dedicated follow up call agents • Project supervisory time Space: • Call center work area Equipment: • Telephone • Computer workstation Other Services: • Modification of tracking software • Retraining in safety planning • Training in project protocol • Administrative services	ER Discharge: • Obtain consent for follow up • Document contact information • Provide treatment referrals • Transmit copy of discharge plan and contact information to LifeNet Initial Follow Up Call: • Risk assessment • Safety planning • Confirm treatment referrals • Document call Follow Up Call(s): • Risk assessment • Safety planning • Confirmation of treatment connection • Possibly provide additional treatment referrals • Document call	Risk**:** • Number of people for whom Level of risk does not increase before connecting with treatment Connection to Treatment: • Number of persons calling the hotline connected to treatment or continued in treatment • Number of people for whom reassessment indicates level of risk is minimal	• All suicidal people discharged from ER are connected or reconnected to treatment, or, • Upon continued reassessment, for persons discharged who do not chose to connect to treatment, the current level of risk is assessed as minimal

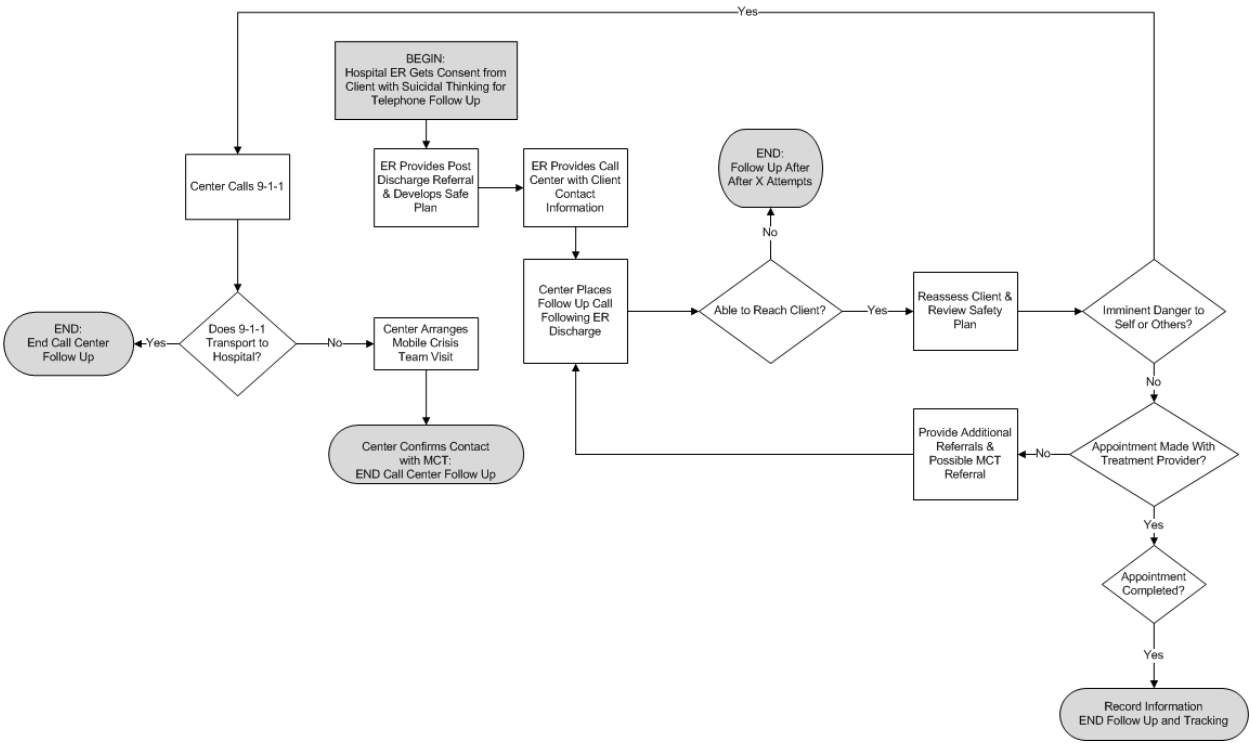
Budget

[COMMENT: The following budget reflects a projection for a 6 month pilot program. The proposal was ultimately funded at $35,000 for a three month period.]

Project Budget	
Budget Item	**Cost**
Staffing	
Salary: Follow Up Coordinator (vacant)	26,000
Fringe Benefits @21%	5,460
Total Staffing Cost	**31,460**
Other Expenses	
HOSPITAL subcontracted screening and consent services	10,000
Development of dedicated software for tracking and reporting	2,750
Travel	150
Total Other Expense Cost	**12,900**
Administration	**4,436**
Total Cost	**48,796**
Funding Sources	
OMH Grant	48,796
Other	0
Total	48,796

Schematic Representation

This flow chart depicts the potential collaborative model between a hospital psychiatric emergency room and a community based mental health call center such as LifeNet.



ATTACHMENT B

DEVELOPING A SAFETY PLAN

Submitted to Lifeline for use in the Lifeline Follow-Up Guidances Paper by B. Stanley (Columbia University) and G. Brown (University of Pennsylvania)

Many individuals who become suicidal experience suicidal feelings and urges with an ebb and flow. It can be useful to help callers develop strategies to decrease suicidal feelings to enable them to prevent acting on them. The safety plan intervention is a collaborative problem solving approach for suicidal individuals that can be developed during a crisis call once it has been decided that immediate emergency intervention is not required. The personalized safety plan is designed to be an additive component to structured crisis calls and can be used as a focus for discussion on follow-up calls by crisis workers. In follow-up, the safety plan can serve as a focus of discussion. The plan can be reviewed and modified in follow-up depending on how useful it has been. If the caller has not used the plan, despite feeling suicidal, the counselor can review barriers to implementation and alternative strategies.

More specifically, the safety plan intervention consists of several key components designed to help individuals cope with suicidal feelings and urges in order to avert a suicidal crisis resulting in an attempt or death. A central feature of this intervention is the hierarchically-arranged list of coping strategies identified for use during a suicidal crisis or when suicidal urges emerge. Callers will be encouraged to write the key components as they are discussed with the crisis counselor.

The main safety plan intervention components include:

1) ***Make the environment safe.*** The first step of the plan will identify the dangerous aspects of the environment and will be remedied to keep the caller safe (e.g., remove firearms, toss razor blades, keep pills with a friend or family member, who will dispense them daily to the caller.)
2) ***Identify the triggers.*** The trigger that led to present suicidality and triggers that have led to any past attempts, self-injurious behaviors, or suicidal ideation will be identified to help callers become aware of the specific warning signs of an impending suicidal crisis. Examples include: fights with family members or friends, loss, poor performance at work, hopeless thoughts, depressed mood, engaging in isolating behaviors.
3) ***Use problem-solving techniques to target suicidal cognitions and behaviors***. Callers will be taught to identify the life stressors or circumstances that precipitated or are contributing to their distress. They will then be encouraged to generate an abundance of alternative solutions to their problems. The crisis worker will provide direct and clear feedback about the generated solutions, without being judgmental, thereby empowering the caller to come up with his or her own solutions and implement them. Together with the crisis worker, they will explore the various possibilities, listing the pros and cons of each solution until a suitable and concrete plan is created. Emphasis

will be placed upon flexible thinking and defining new goals as necessary. They will be taught to use these skills hierarchically, from "within-self" to "going to the psychiatric ED" (i.e., from a - c below). They will be taught that if one skill does not work, they should move to the next skill, and so on. Suicide is never an option; rather, going to the ED is the final step of the plan, should nothing else work in the moment.

a. *Internal coping strategies*. Skills that require the caller to distract or self-soothe. Examples include: taking a hot shower, going for a walk, putting an ice pack on the back of the neck, listening to upbeat music, working on a meaningful project.
b. *External distracters*. Skills that require contacting another person, without necessarily disclosing suicidal thoughts. Examples include: calling a friend, going to the movies with a sibling, working on a project with a co-worker. Phone numbers are written down so that the caller can easily contact any of the people identified after he/she hangs up.
c. *Asking for help*. Skills that require the caller to tell another person about suicidal urges and ask another person for help distracting or soothing. If another person (e.g., relative, friend) is unable to help, the caller should contact a therapist, or go to the emergency department or call 911, if other strategies are unsuccessful.

4) ***Troubleshooting*.** Assess feasibility and troubleshoot the plan with the caller. Make sure that the caller is content with the plan and is motivated to follow the steps involved. If not, motivational enhancement strategies should be employed to help increase motivation to try something new (e.g., "Using these skills will put you in control of your emotions, rather than your emotions controlling you—it's your choice, but it can't hurt to try.")
5) ***Rehearsal*.** Ask for repetition to assure the caller has understood the plan and is motivated to follow-through.

ATTACHMENT C

CONTRA COSTA, CA - PILOT PROGRAM

The following is a report that was developed by the Contra Costa Crisis Center in California following a pilot project that provided follow up call services to individuals recently discharged from a local mental health facility. The content has not been changed though the name of the participating facility has been deleted.

Introduction

From June 2008 to February 2009, the Contra Costa Crisis Center in California conducted a pilot program in partnership with a [LOCAL BEHAVIORAL HEALTH CENTER]. Patients who were hospitalized following a suicide attempt or who expressed suicidal ideation while hospitalized were given the option of receiving follow-up calls from the Crisis Center after being discharged. Those who consented were contacted within 24 hours, then in subsequent days up to a period of one month, although individuals could stop participating at any time. The purpose of these calls was to help [HEALTH CENTER] patients feel safe and connected at a time when their suicide risk was heightened. All follow-up calls were done by Crisis Center staff who had received training in crisis assessment and suicide intervention. [HEALTH CENTER] provided $20,000 in funding to the Crisis Center to carry out the program.

Objectives

Lower the risk of suicide during the most vulnerable time—first-month post-hospital discharge.

- Enhance safety and connectedness for suicidal individuals who are isolated with tenuous coping skills.
- Build a bridge to community resources—including the Crisis Center—for at-risk individuals.

Process

[HEALTH CENTER] is a large health care provider in Contra Costa County, operating hospitals, clinics, and a behavioral health care facility. The Contra Costa Crisis Center is a nationally accredited crisis intervention and suicide prevention service. [HEALTH CENTER] and the Crisis Center have a long history of collaboration.

During this program, clinical case management staff at [HEALTH CENTER] provided patient referrals to Crisis Center clinical staff. Referrals were based on written consent, which was obtained during admission. The consent form only included the person's name, age, and phone number. Other information, such as gender and city of residence, was gleaned by

Crisis Center counselors who, for confidentiality reasons, also didn't receive information on whether the person was ideating about suicide, had attempted, or had access to means.

While it might have been more desirable to obtain consent upon discharge, [HEALTH CENTER] administrators decided that there was too much else going on at that time. This decision may have influenced the number of people who consented; however, information wasn't maintained on the number or percentage of individuals who declined.

During the pilot program, Crisis Center staff received referrals for 83 people. Of this number, 12 had invalid or out-of-service phone numbers and were unreachable. Another 12 received repeated phone messages, but never responded. As a result, Crisis Center counselors were able to follow-up with 59 of the referrals. The total number of follow-up calls made was 562—an average of nearly 10 per client. Calls ranged from three to 90 minutes with the first calls to each person typically shorter than subsequent calls. This was because rapport between Crisis Center counselors and clients increased over time, as did client trust. The total number of hours spent on the phone with clients was more than 250. Planning, preparation, training, daily tracking, and evaluation required an additional 100 hours of supervisory time.

In terms of demographics, 55 percent of clients were female and 45 percent were male. Ages ranged from 18 to 82, with the largest number 21 to 30 (25 percent), followed by 31 to 40 (20 percent), 51 to 60 (20 percent), and 41 to 50 (16 percent). As far as residence, 38 percent lived in central county, 40 percent lived in east county, 19 percent lived in west county, and 3 percent lived out of county.

Results

No one who participated in the program died by suicide or attempted suicide during the month after hospitalization. Since suicidal behaviors are strongest within the first 30 days following discharge, this alone provided compelling evidence of the program's value.

Two wellness/safety checks were conducted (in a wellness/safety check, police go to someone's home and determine whether the person is at risk). In both cases, the client provided consent. One client proceeded to leave a family member's home prior to police arrival, however. He had multiple mental health issues and seemed to feed off the attention he got when he made threats, then disappeared. The second client was determined by police to be well at the moment, although counselors at the Crisis Center ended up making 27 follow-up calls to her.

Three other clients re-admitted themselves to [HEALTH CENTER]. In one instance hospitalization was due to continued alcoholism. In the other two instances it was due to mental health concerns and psychiatric medication adjustments.

More than half the clients had notable mood swings during the program, and said that they appreciated the connection and stability created by regular contact with the Crisis Center. One person went so far as to announce the value of the service to members of her support group at the [HEALTH CENTER].

Because many clients were either difficult to reach or only intermittently available, final survey calls couldn't be made to everyone. Surveys were conducted with 32 clients, with the following results.

- 72 percent said that follow-up calls were "Helpful," 28 percent said they were "Somewhat Helpful," and 0 percent said they were "Not Helpful."
- 53 percent said that if they had known about the Crisis Center's 24-hour crisis lines before, they would have called them, 41 percent said might have called, and 6 percent said they wouldn't have called. It's worth noting that all of the people who said they might have called described having adequate support already in place with family and friends. Also, five persons for whom follow-up was completed now regularly contact the Crisis Center on their own, seeking emotional support as they negotiate challenges in their lives.
- 74 percent said that follow-up calls helped them feel safer and more connected, 24 percent said they felt "Somewhat" safer and more connected, and 2 percent said they didn't feel safer or more connected. The one person who said he didn't feel safer or more connected said that he appreciated the Crisis Center's support, but he was angry at [HEALTH CENTER].

ATTACHMENT D

RECOMMENDATIONS FOR OBTAINING CONSENT FOR FOLLOWING UP WITH ED DISCHARGES

Clear and consistent criteria for program eligibility and protocols for obtaining consent and information exchange must be well established prior to the initiation of a formal follow up program. These protocols must incorporate the needs of both the emergency department and crisis center and will require input from both parties. The following inclusion criteria and consent protocol are provided as a guideline.

Inclusion Criteria

Clear inclusion criteria must be communicated to all participating parties. Emergency room staff should have clear guidelines regarding which patients qualify for follow up and who should be approached for consent to participate. For example:

The population of focus for this project will consist of all people discharged from the [HOSPITAL] emergency department who meet the following criteria. The discharged person must:

- Be at least 18 years of age (to be able to provide legal consent)
- Reside in [CITY, STATE] (if restrictions apply to the crisis center)
- Have been provided with an outpatient treatment referral or already have an outpatient treatment provider (at a minimum must receive treatment as usual)
- Have been assessed as having some level of suicidal risk at discharge from the ED *[COMMENT: The criteria here on who is accepted to the follow up program must be clearly defined. It is very important that in discussions regarding risk that both parties are in agreement as to what constitutes the different risk levels e.g. the crisis center must be aware of the assessment tool/criteria used in the emergency department to determine low, moderate, severe risk.]*
- Have consented to receive a follow up call or calls between the time of the ED discharge and completion of their first (or next) session with a treatment provider (see Attachment E for sample consent form)

Recommended Protocol for Obtaining Consent

The crisis center must work closely with the emergency department to develop an appropriate protocol for obtaining consent from patients to participate in the follow up program. While the emergency department will have its own requirements in terms of administering a consent and internal documentation, the crisis center can suggest/request the following:

1. **Inform the patient of the availability of the follow up program.** A standardized script should be used. The sample consent form provided (Attachment E) introduces the follow up program and could be adapted to use for this purpose as follows:

   "Our emergency department is currently working with a crisis center to provide follow up telephone calls to patients that are discharged from our emergency room. Patients have found these follow-up calls to be helpful in keeping them safe and supported until they were feeling better or linked to treatment services. Would you be open to allowing them to contact you soon?"

   "When the crisis center calls you they will ask you questions about how you are doing, how safe you are feeling, and what actions you are taking to keep yourself safe. They will assess what kind of help you may still need and do whatever they can to assist. They will stay in contact until you are connected to care or are safe and no longer need follow up or if, for some reason, they are unable to reach you. You can also choose to have them stop following up with you at any time and are free to contact them directly whenever you need more help."

   If the patient agrees,

2. **Complete consent form.** Ask the patient to review the consent form thoroughly and answer any questions they may have. At a minimum, this consent form should include the following elements (see Attachment E for sample form)
   - Description of the program
   - Name
   - Phone number - may include alternate numbers, e-mail addresses, even contact information for significant others
   - Best days/times to call
   - Permission to leave messages

3. **Review confidentiality.** Again a standardized script should be used. For example: "Thank you for providing us with this information. We want you to know that this information is strictly confidential. If the crisis center wishes to share your information with others that can assist in your care, they must obtain your permission to do so. The only exception to this rule is if your life is in danger: In this case, the crisis center may only share information about you with individuals or agencies that they believe can assure your immediate safety."

4. **Fax a copy of the signed consent to the crisis center.** In the development of an MOU with the crisis center, an explicit statement must be made regarding the secure transmission of information. There should be an assigned line for receipt of faxes and the fax machine should be placed in an area that is only accessible to crisis line staff. Electronic records should be password protected.

5. **Provide the patient with a copy of the consent form and a crisis center card**. This form can provide the patient again with a brief description of the follow up program for review once discharged. In addition, while the patient is awaiting a call from the crisis center, it is important that they understand that the center is available to them 24 hours a day and can be accessed any time they feel the need for additional support.

6. **If the patient does not wish to be involved in the follow up program** they should still be provided with the crisis line card and informed of their right to call at any time.

ATTACHMENT E

SAMPLE CONSENT FORM FOR ED DISCHARGES

The *HOSPITAL EMERGENCY DEPARTMENT* is currently working with the *CRISIS CENTER* to provide telephone follow up services to individuals evaluated in our emergency department following any self injurious behavior. We believe this telephone follow up service could be helpful to you and support you in your recovery.

The *CRISIS CENTER* is (*maybe brief 3 - 4 lines on the crisis line service here: my thought is to just include the following – years in operation, staff make up, hours, role in community – you may want to state that the crisis center is not funded by or affiliated with the ED*).

As part of this follow up program, the *CRISIS CENTER* will provide supportive phone calls to you following your discharge from our emergency department. These calls may include (but are not limited to) emotional support, ongoing assessment of your mood and thoughts of suicide, and assistance with the development of a plan to keep you safe.

If you consent to participate in this program, you will receive your first call from the *CRISIS CENTER* within 24 hours of your discharge. The *CRISIS CENTER* will contact you thereafter at a minimum of ___ time(s) per week (depending on need) until such time as

(a) You are connected to appropriate care and/or are no longer in need of crisis line follow up
(b) The crisis line is unable to reach you and has made a minimum of three attempts

The confidentiality of any information disclosed during a call to the *CRISIS CENTER* will be upheld at all times. If the *CRISIS CENTER* wishes to share your information with others that can assist in your care, they must obtain your permission to do so. The only exception to this rule is if your life is in danger: In this case, the *CRISIS CENTER* may share information about you with individuals or agencies they believe can assure your immediate safety.

You can terminate involvement with the *CRISIS CENTER* follow up program at any time. You are also free to contact the *CRISIS CENTER* directly at any time during or after your formal involvement in the follow up program.

I have read and understand the program description provided above.

□ **Yes** I would like to participate in the *CRISIS CENTER* follow up program. I give consent for the [*EMERGENCY DEPARTMENT]* to provide the [CRISIS CENTER] with information relevant to my care.

□ **No** I would not like to participate in the CRISIS CENTER follow up program. I do not give consent for the [*EMERGENCY DEPARTMENT]* to provide the [CRISIS CENTER] with information relevant to my care.

Signed (Patient):_____

Date: _____

Signed (Staff): _____

Date: _____

CRISIS CENTER FOLLOW UP PROGRAM
WITH CONSENT SIGNED, PLEASE COMPLETE THE FOLLOWING

1. Name: _____

2. Date of Referral: _____

3. Telephone number for crisis center call: (Home) _____

   (Cell) _____

4. Best days and times to call: _____

5. Do you have Caller ID? ☐ Yes ☐ No

6. Should the crisis center block their identity when they call? ☐ Yes ☐ No

7. Do you have an answering machine? ☐ Yes ☐ No

8. If yes, is it okay for them to leave a message? They could say: "This is *CRISIS CENTER* calling to follow up, please call us back at (555) 555-5555 and ask for ____"
   - ☐ Do not leave message
   - ☐ Leave above message
   - ☐ Leave a different message:

   _____
   _____
   _____

9. If someone else answers when the crisis center calls, is it okay for them to leave a message with the person who answers the phone? Again, they could say: "This is *CRISIS CENTER* calling to follow up, please ask him/her call us back at (555) 555-5555 and ask for ____"
   - ☐ Do not leave message
   - ☐ Leave above message
   - ☐ Leave a different message:

   _____
   _____
   _____

10. Is there another contact person that could assist the crisis center if they are unable to reach you and are concerned? *(The crisis center will only use this contact following three unsuccessful attempts to reach you at the number you provided)* ☐ Yes ☐ No

11. Additional contact - Name: _____

    Relationship: _____

12. Telephone number for additional contact: (Home) _____

    (Cell) _____

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