

Closing a Deadly Gap in Behavioral Health Care

A Potentially Deadly Gap

The period of time between inpatient and outpatient behavioral health care services—known as a *care transition*—is a time of increased vulnerability and risk for patient suicide. The risk of suicide in the four weeks after leaving inpatient behavioral health care is 200–300 times greater than for the general population, and highest in the first few days after discharge.¹

We Can Do Better

Designed for inpatient and outpatient behavioral health organizations, the innovative strategies below provide guidance to improve the process of care transition. There is significant overlap in recommendations for inpatient and outpatient providers because the services are interconnected. Each step contributes to the patient’s safety before, during, and after the care transition.

Strategies For Inpatient Providers



Inpatient behavioral health care organizations provide acute care to mitigate immediate risk, begin treatment, and prepare patients for continuing care after hospitalization. These organizations are key leaders in establishing and sustaining safe and seamless transitions to outpatient care.

1. Develop collaborative protocols and procedures with the outpatient provider organization to ensure safe, seamless transfer of care, such as:
 - ◇ Detail the roles and responsibilities of each organization during the transition period, including how to coordinate follow up in the event of a missed first appointment.
 - ◇ Provide copies of necessary documents (safety plan, medications, transition plans, etc.).
2. Involve family members and other natural supports:
 - ◇ Remember that families and other supports come in many forms and involving them can decrease stigma and increase the likelihood of ongoing care.
 - ◇ Include peer specialists.
3. Collaboratively develop a safety plan with the patient, family, and other supports.
4. Follow up with the patient:
 - ◇ Call the patient and the family/supports within **24 hours** of discharge to follow up on discharge instructions and provide support during the care transition.
 - ◇ Maintain contact with the patient until the first outpatient appointment. Provide ongoing caring contact—such as postcards, texts, or emails—for several months.

¹ Chung, D. T., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olsson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. *BMJ Open*, 9(3), e023883. Retrieved from <http://dx.doi.org/10.1136/bmjopen-2018-023883>



Strategies For Outpatient Providers

While inpatient providers interact with patients for only a brief period, outpatient behavioral health organizations have an ongoing role to help individuals who have been suicidal continue their treatment path toward improved health and wellness.

1. Consider the inpatient provider as a member of your care team:
 - ◇ Establish good communication with the inpatient facility.
 - ◇ Work together to develop a seamless system of care.
2. Review your organization's systems:
 - ◇ Establish a system of triage, referral tracking, and outcomes review of referrals.
 - ◇ Examine billing patterns to utilize billing codes related to care transitions.
3. Connect with the patient and his or her family and/or other natural supports **before discharge**:
 - ◇ Meet the patient and family (e.g., in person, telephone, video conference).
 - ◇ Use peer specialists to connect and support the patient and family.
4. Narrow the transition gap:
 - ◇ Schedule a clinical intake with a provider trained in suicide care.
 - ◇ Offer stepped care, as appropriate, based on patient need and community resources.
5. Maintain good communication:
 - ◇ Notify the inpatient provider that the patient kept the outpatient appointment.
 - ◇ Collaborate with the inpatient provider to follow up on missed appointments.

For All of Us

A time of great risk can also be one of great opportunity. In recognizing the care transition period as crucially important, inpatient and outpatient behavioral healthcare organizational leaders, family members and

community supports can *work together* to close the care transition gap and build a safer future with fewer patient suicides.

For more information, please visit [SuicideCareTransitions.org](https://www.suicidecaretransitions.org).



The [National Action Alliance for Suicide Prevention](https://www.nationalactionalliance.org) is the public-private partnership working with over 250 national partners to advance the [National Strategy for Suicide Prevention](https://www.nationalstrategyforsuicideprevention.org) and make suicide prevention a national priority. Current priority areas include: [transforming health care](#), [transforming communities](#), and [changing the conversation about suicide](#).



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