

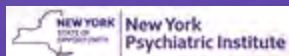
Zeroing In: Integrating Suicide and Overdose Prevention

Module 6: Monitoring and Follow-Up Across the Course of Treatment

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*Please take a brief
pre-training survey:*



Zeroing In On Our Series

- Module 1: Foundations of the integrated Zero Suicide + Zero Overdose approach
- Module 2: Screening for suicide risk and substance use in every setting
- Module 3: Risk assessment & triage for suicide and overdose
- Module 4: Integrated safety planning
- Module 5: Means reduction & overdose prevention strategies
- **Module 6 (*today!*): Monitoring and follow-up across the course of treatment**

Recap: Module 5

- ✓ Means reduction is a voluntary, collaborative effort included in safety planning that aims to temporarily reduce access to lethal means during periods of highest risk
- ✓ Plans must be specific, realistic, and adaptive in order for individuals to stick to the plan
- ✓ Medication safety and overdose prevention strategies can be critical as part of either suicide or overdose safety planning, given high degree of risk overlap

Overview: Module 6

- Follow-up and Monitoring Approaches
- Why to Regularly Re-screen
- Importance of Social & Peer Support
- Case Vignette
- Q&A and Next Steps

AIM: Assess, Intervene, & Monitor:

NYS' Implementation of the Clinical Components of the Zero Suicide Model

The third component of AIM focuses on **Follow-up and Monitoring**

Assess

- The use of validated screening tools to detect risk
- Comprehensive Risk Assessment

Intervene

- Universal Crisis Precautions
- Safety Planning Intervention
- Lethal Means Safety and Counseling
- Attempted Suicide Short Intervention Program (ASSIP)
- Evidence-based Treatment Approaches

Monitor

- Care Management Plans and Pathways
- Structured follow-up contact
- Attention to safe transitions
- Non-demand caring contacts

Rationale for Monitoring

- **Clients frequently get “lost to follow-up”**
 - Suicidal clients often disengage from treatment during highest-risk periods (“Ghosting”)
 - There can be an extended period of time between an acute care/crisis visit and connection to ongoing outpatient care
 - Care navigation is **challenging**, and there is often diffusion of responsibility
- **Monitoring is NEEDED because transitions are the highest risk time for suicide and overdose**



- Standard clinician training does not provide a framework for increasing clinical contact, which is sometimes necessary when people are at elevated risk
- Sometimes challenges the way we were taught to do therapy (e.g., “*don’t want to foster dependence*” etc.)

Rationale for Monitoring

Demonstrates that you care about the client and his/her/their safety

Provides a bridge to fill the gap between clinical contacts or levels of care

Provides a safety net –
Offer supports in real-time in the least restrictive setting

Allows clinician to detect fluctuations in suicide/overdose risk

Ensures safety between sessions/clinical contacts

Enhances continuity of care and treatment engagement

Decreases isolation and reduce risk

High Risk Periods That May Require Increased Monitoring

- *Always be vigilant to fluctuations in risk* across the course of treatment
- Be aware of *high-risk periods* and increase monitoring during those times
 - Care transitions
 - Discharge from inpatient hospitalization or treatment program
 - Discharge from ED visit
 - Incarceration
 - Transfer from one level of treatment to another (i.e., intensive to 1x/week outpatient)
 - Acute exacerbations of symptoms
 - Recent or anticipated life stressors
 - Anniversaries
 - Any time your clinical judgement dictates

Monitoring

- **Increasing clinical contact – *Can take many forms***
 - Increase the frequency and/or duration of outpatient mental health sessions
 - Team-based approach across providers
 - Problem-solve barriers to attending outpatient treatment, such as scheduling conflicts, insurance/access concerns, or transportation problems
- **Consider other supports available to the client**
 - Make referrals (*and assist with connection*) to needed ***adjunctive therapeutic or social services***
 - Consider options for increasing natural supports, including family/community engagement
- **Recruit others to help monitor the client in the home/community**
 - Involve friends and family in treatment (with permission) or to do “check-ins”
 - Obtain releases/consent prior to crisis situations as a part of standard treatment
 - Be in close contact with other treatment providers to coordinate care
- **Consider various outreach approaches:** *Phone, texts, emails, home visits, caring letters, digital therapeutics*

Outreach

- **Outreach is appropriate after missed appointments, after care transitions, or between sessions when you are concerned about a client**
 - Establish a plan with the client in advance on when, how, and who should be contacted
 - Know organizational policies about text/email
 - Communicate in advance what will happen if you cannot determine their safety
 - Ideally should occur within **48-72 hours post-discharge or transition** between levels of care

- **Outreach is NOT just rescheduling an appointment!**
 - Shows the client that you are concerned and care enough to check on them
 - Allows you to assess the client's current mood and level of risk
 - Allows you to provide real-time support and interventions as needed
 - Encourages re-engagement with treatment



Structured Follow-Up & Monitoring Intervention: *Guidance for Outreach*

- **Purpose:** Provide support and monitoring to individuals at elevated risk during high-risk times
- **Format:** Outreach is often done by phone, but can also be by text, email, telehealth, or in-person at home
- **Ongoing care:** After missed appointments, care transitions, or between sessions during high-risk periods
 - Same-day contact for missed appointments and within 48-72 hours of care transitions
- **Transitional care:** *Especially important* after discharge from ED, inpatient, treatment center, or incarceration
 - Within 48-72 hours of transition and then recur thereafter (*weekly, biweekly, etc.*)
 - Ideally until person is engaged in outpatient care, risk declines, or they decline
- **Structure:**
 - Calls should be **structured** and usually brief (*not a full therapy session*)
 - Obtain permission to call/leave voicemail in advance
 - Friendly, matter-of-fact, professional outreach
 - Follows the same format each time

Who Should Conduct Structured Follow-up and Monitoring?

- Ideally a provider who has a relationship with the client
 - Can be outpatient clinician or clinician who saw person in the ED or inpatient unit
 - Or... someone else on staff of the same facility
 - Or...crisis counselor from a crisis hotline
 - Or...trained professional, peer specialist, or paraprofessional

Remember: This is a clinical intervention, and so whoever does the SFU&M must be able to conduct crisis intervention if necessary (or reach someone who can)

Format

- Step 1: Mood check
Assess fluctuations in risk
- Step 2: Review and revision of safety plan
Discuss access to means
- Step 3: Discuss treatment engagement/motivation
Problem solve obstacles
- Step 4: Determine willingness for additional follow-up



Step 1: Mood Check

- **Ask:** *“How have you been feeling this week?”*
- **Assess Risk:** Determine if individual is at imminent risk and if immediate action is required

Determining Need for Immediate Action

Majority of calls will not end in rescue.

Voluntary: individual and clinician decide together that the individual needs emergency services

- Individual takes self to ER or arranges transport on own behalf
- Someone else (family member, friend, medic) helps the individual access treatment

Involuntary: Prior agreement is not required if individual is at imminent risk

Step 2: Review & Revise Safety Plan

- With each individual, **make sure the safety plan is helpful**
 - Determine if it has been used
 - If so, what sections were helpful/less helpful
 - If not, problem-solve
 - Review safety plan together and revise the plan as needed
 - Consider things that may change risk, like reduced substance tolerance after trying to abstain
- Review access to means to determine if there is need to **reduce access**
 - Medication
 - Firearms
 - Other Lethal Means

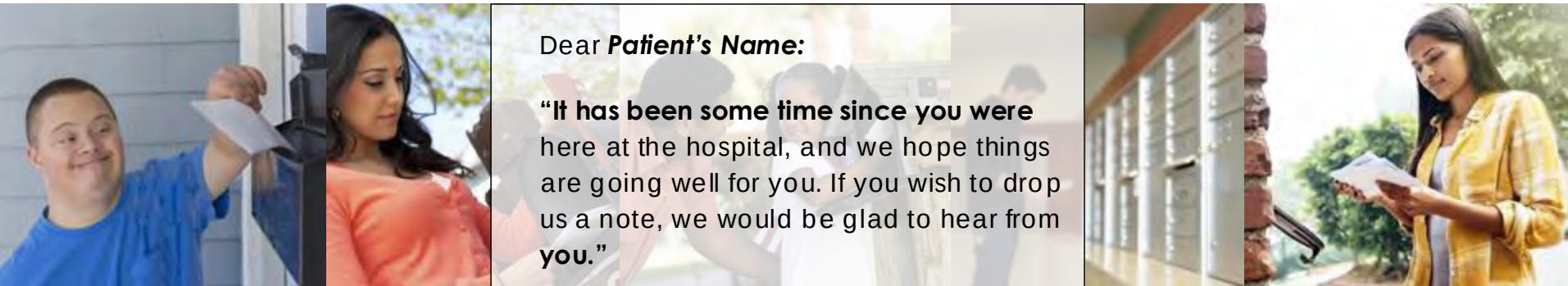
Remember: patients may offer more information over time as trust grows with clinician or provider, so there is benefit in revisiting often to ensure safety plan addresses current risk

Step 3: Treatment Engagement & Motivation

- Check that individual is aware of **current treatment options** and is involved in treatment
 - Review individual's plan for treatment
 - Reminder of upcoming appointments
 - Review treatment options
 - Problem solve obstacles
- Provide info on available **community support services**
 - Religious organizations, support groups, social organizations

Non-Demand Caring Contacts

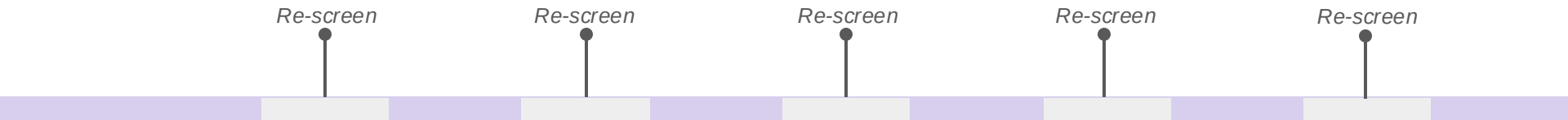
- Research shows that “Non-demand Caring Contacts” after a care transition can be a simple but powerful intervention
- Caring contacts let clients know that staff remember and maintain a positive attitude toward them
- Contact should make no demands to take any action or request anything specific from them; the purpose is to let them know you care and are thinking of them



Re-Screening at Regular Intervals

- For **all clients** in ongoing outpatient care, re-screen at regular intervals, at least quarterly
- For **clients at elevated risk**, re-screen at each outpatient session or before discharge from acute care settings to detect fluctuations in risk

***Remember, suicide and overdose risk fluctuate.** Just because a client is not reporting high risk today does not mean they will never experience escalations in risk.*



Social Support and Prevention

Share resources for family members and supportive others, and be aware of resources provided by your organization and in your community (e.g., respite care, support groups, etc.)

Consider including family members or other important supports in prevention

- Engaging in assessment to provide important collateral information
- Understanding brief interventions and their rationale
- Acting as co-therapists to help de-escalate, coach, and problem-solve
- Monitoring the client to maintain safety
- Updating the outpatient provider between sessions on progress and changes



Peer Support and Prevention

Peer support workers are people who have been successful in the recovery process. Through shared understanding, respect, and mutual empowerment, peer support workers help people stay engaged in the recovery process. Peer support services can extend the reach of treatment beyond the clinical setting into the everyday environment.

Connect individuals to peers through:

- Recovery Community Centers
- Peer Support Specialists
- Peer respite and drop-in centers
- Alternatives to Suicide (Alt2Su) Groups
- Local NAMI Chapters
- Faces & Voices of Recovery RCOs
- Does your organization have peers? Connect and collaborate!



Summary

For **ALL** clients...

<u>All</u> Clients	Outpatient Settings	Inpatient & ED Settings
Re-screening at regular intervals <i>(not just intake)</i>	▪ Re-screen with the C-SSRS <i>at least</i> quarterly (or when clinical judgment dictates)	▪ At least daily (sometimes every clinical contact) ▪ Again prior to discharge
Transition care	▪ Attention to high-risk periods, changes in level/continuity of care, and anniversaries ▪ After discharge from a higher level-of-care: ▪ Prioritize for appointment within 72 hours of discharge from a higher level of care ▪ Warm hand-offs with other providers and obtain records	▪ Post-discharge: ▪ Outpatient appointment scheduled <i>(and follow-up to make sure they attend and/or assist with problem-solving barriers)</i> ▪ Warm hand-offs and record sharing with other providers ▪ Non-demand caring contacts <i>(mailers, texts, emails)</i>
Care coordination	▪ Coordinate care and ongoing communication with other providers ▪ Make referrals <i>(and assist with connection)</i> to adjunctive therapeutic or social services ▪ Consider options for other social support, including family/community engagement	▪ Structured phone/text follow-up <i>(Within 48-72 hrs post-discharge, then weekly or biweekly thereafter at least until connected to care or they discontinue)</i>

For *clients at elevated risk...*

Elevated Risk	Outpatient Settings	Inpatient & ED Settings
Re-screening at regular intervals	▪ At each session <i>(or at least one session per week in more intensive settings)</i>	▪ At least daily <i>(sometimes every clinical contact)</i> ▪ Again prior to discharge
Increased clinical contact	▪ Can take multiple forms – more frequent sessions, longer duration, between session contact ▪ Encourage maintaining weekly appointments ▪ Flexibility in modality (tele vs. in-person), timing, or frequency of scheduling ▪ Between session contact with structured phone/ text/email follow-up or wellness checks as needed ▪ Consider options for other social support, including family/community engagement	▪ Staffing ratios and privileges should be based on risk level (1-to-1 versus line of sight, etc.) ▪ Be aware of environmental hazards and increase supervision accordingly
Transition care	▪ Attention to high-risk periods, changes in level/continuity of care, and anniversaries ▪ Prioritize for appointment within 72 hours of discharge from a higher level of care ▪ Warm hand-offs and obtain records from other providers/levels of care ▪ Same-day outreach after missed appointments with structured phone or text follow-up	Post-discharge: ▪ Outpatient appointment scheduled <i>(and follow-up to make sure they attend and/or assist with barriers)</i> ▪ Warm hand-offs and record sharing with other providers ▪ Non-demand caring contacts <i>(mailers, texts, emails)</i>
Care coordination	▪ Coordinate care and ongoing communication with other providers/settings ▪ Make referrals to appropriate adjunctive services	▪ Structured phone/text follow-up <i>(Within 48-72 hrs post-discharge, then weekly/ biweekly thereafter at least until connected to care or they discontinue)</i>

Case Example

- John is a 23-year-old single male with unstable housing
- Works as a carpenter but struggles to makes ends meet
- Was referred by a psychiatric inpatient unit for outpatient mental health treatment
- Recently made a suicide attempt by acetaminophen overdose shortly after he was arrested for a DUI. He was admitted to a psychiatric hospital where he received medical care for the overdose and psychiatric care for suicidal behavior.
- Despite the DUI, he does not believe he has a drinking problem. He has not been to court for the DUI yet but fears being incarcerated.
- He regrets that he attempted suicide and feels that he “made a mistake” and vows that he will not drink and drive or make another suicide attempt.

Case Example

- No prior treatment. Has periods of depression since his teens, especially when he is not dating anyone or has financial stress
- Reluctant to confide in others but said that he is willing to attend outpatient treatment
- Although his parents and brother are supportive, he does want not the clinician to contact them
- Currently denies any suicidal ideation, including any intent or plan, but feels somewhat hopeless about things getting better
- Daily alcohol and cannabis use; occasional other substance use at parties
- John was pleasant, quiet and cooperative during the intake evaluation. Although he responded to the clinician's questions, he was not very forthcoming about other information about his life.

Case Example

- **Risk factors:** Recent suicide attempt, DUI and legal sequelae, alcohol and cannabis use, recreational substance use, depression, recent psychiatric hospitalization, hopelessness, reluctance to confide in others
- **Protective factors:** Supportive family, employed, willing to attend treatment
- **What comes next?**
 - Determine suicide/overdose risk and develop treatment plan
 - Share crisis resources, Narcan, etc.
 - The clinician and John completed a Safety Plan together that John found to be useful
 - Schedule for an outpatient appointment on the next business day (Monday)

Case Example



Despite a reminder call on the day of, John did not show up for his appointment. The clinician tried to call him but there was no answer. The clinician left a message but John did not return the call.



It's now been 48 hours since the missed appointment and the clinician has not heard from John.



The clinician is concerned about John dropping out of treatment (and possibly his safety). What actions should they take?

Review of Module 6

- ✓ The goal of Monitoring and Follow-up is to increase clinical contact during high-risk periods of transition to demonstrate that you care about the client and their safety and provide a real-time safety net
- ✓ Re-screening and treatment engagement strategies should always be included as part of structured follow-up to help safety plans and treatment plans address current risk
- ✓ Social and peer support is incredibly important for people at risk of both suicide and overdose

Thank You!



Post-Training Survey:

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Q&A