Crisis Center Guidance:

Follow-up with Callers and Those

Discharged from Emergency Department

and Inpatient Settings

2021

NATIONAL SUICIDE PREVENTION LIFELINE

About

The National Suicide Prevention Lifeline (Lifeline) is a toll-free suicide prevention hotline network comprised of over 170 local crisis centers. The Lifeline is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by Vibrant Emotional Health. The Lifeline provides free and confidential crisis counseling to anyone in need 24/7 and has answered over 12 million calls since its launch in 2005.

This paper contains information gathered from research, interviews, and previously published Lifeline materials. Most of the research and interviews were gathered during the first few months of 2012. A review of recent research and content updates were completed in 2021. All of the recommendations and best practices come from information gathered about Lifeline network crisis centers maintaining follow-up programs at their agency, and relevant research pertaining to follow-up services over the past decade.

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Introduction

For over 50 years crisis centers have provided invaluable services to individuals at risk of suicide. Every month, over 100,000 calls, 23,000 chats, and 2,700 texts are answered through the National Suicide Prevention Lifeline ("Lifeline"). Crisis centers play an essential role in providing much needed care 24 hours a day, seven days a week to reduce feelings of hopelessness and suicidal intent (Gould, Kalafat, Munfakh, & Kleinman, 2007). Crisis hotlines also provide referrals to mental health and other appropriate services based on an individual's needs and play a key role in diversion from emergency services through expertise in crisis counseling, de-escalation, and safety planning. Emergency intervention can be initiated promptly through crisis centers when necessary and may result in a psychiatric hospitalization or other acute mental health service provision.

Ample evidence of the recurrence of suicidal ideation following discharge from an inpatient facility or emergency department demonstrates the need for services that will target this population for prevention (Appleby et al., 1999; Qin & Nordentoft, 2005). Research indicates that follow-up with hotline callers and people recently discharged from an emergency department (ED) or inpatient setting has positive results for both consumers and providers of mental health services (Fleischmann, 2008; Vaiva et al., 2006; Zanjani, Miller, Turiano, Ross, & Oslin, 2008). Crisis centers are uniquely positioned to be a crucial resource for people in need of follow-up care, as they have the resources, professionally trained staff, and technological capabilities to provide effective services and appropriate referrals.

The following document was produced by the Lifeline to provide crisis centers with evidentiary support for follow up, and to provide a range of resources that could facilitate the development and maintenance of crisis center follow-up programs. After a brief review of the literature, this report offers recommendations for essential elements of a follow-up program that are based on research and anecdotal evidence from crisis centers that already manage comprehensive programs. It also offers general guidance on building relationships and partnerships with local hospitals, basic tips on program sustainability, information on types of donors, fee for service models, and other resources available to centers that are helpful for program development.

The Case for Follow-up Programs

Suicide is the tenth leading cause of death in the United States, with over 47,000 people lost to suicide each year (Centers for Disease Control and Prevention (CDC), 2017). Studies have shown that there is an evident gap in services for suicide attempt survivors after a visit to the emergency department. In 2008, of the 1.1 million adults that attempted suicide, 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). Research indicates people are at high risk of suicide upon discharge from the hospital and alarmingly, studies in Europe found that suicide risk is greatest within one week after discharge (Appleby, et al., 1999; Qin & Nordentoft, 2005). Furthermore, patients previously admitted to the hospital for a suicide related incident have a higher risk of suicide after discharge than patients admitted to the hospital for other emergencies (Crandall, Fullerton-Gleason, Aguero, & LaValley, 2006). By providing attempt survivors a resource that reduces the gap in services between emergency and inpatient discharge and outpatient appointments, a critical step in preventing suicide and decreasing the number of visits to an emergency department can be taken (Knesper, 2011). Follow-up services offer a powerful level of care that fills this need. Follow-up programs are cost-effective and crisis centers are uniquely positioned to administer these services.

Follow-up after discharge is an effective and important intervention to reduce suicide. A study based in five countries that differ in size and economic development indicated that follow-up after emergency department discharge significantly reduced suicide (Fleischmann, 2008). The follow-up program included 9 contacts by trained professionals at crisis centers over a maximum period of 18 months. In England, a study found that use of 24 hour crisis teams and 7 day follow-up programs showed a significant reduction in suicide within 3 months of a patient's discharge from inpatient services (While et al., 2012). Furthermore, patients who have received telephonic follow-up have a lower suicide rate in five years and a significantly lower suicide rate in the first two years after discharge (Motto & Bostrom, 2001).

Crisis call centers are a crucial resource in linking patients to services and providing emotional support. Crisis centers help reduce emotional distress and suicidal ideation in callers (Gould, et al., 2007). In addition, crisis centers already have the resources, professionally trained staff, and telephone service capabilities to provide services and connect with patients recently discharged. Given that suicide risk is highest one week after discharge from an inpatient setting, the 24/7 availability of crisis centers' services are invaluable. For medium to high risk callers, studies show that centers help to minimize ideation, hopelessness, and psychological pain (Gould, et al., 2007; Kalafat, Gould, Munfakh, & Kleinman, 2007). Further, crisis center follow-up before a service appointment is associated with improved motivation, a reduction in barriers to

accessing services, improved adherence to medication, reduced symptoms of depression, and higher attendance rates (Simon, VonKorff, Rutter, & Wagner, 2000; Zanjani, et al., 2008).

Follow-up by crisis centers is also cost effective; it reduces utilization of emergency services and offers diversion to more appropriate services for patients who do not require admission to the hospital (Andrews & Sunderland, 2009; Vaiva, et al., 2006). A study in Australia found that proactive telephone support for individuals with recurrent admissions reduced the number of hospital days per patient by 45% and saved $AU895 per person (Andrews & Sunderland, 2009). In one year, a Lifeline crisis center in St. Louis, Missouri reduced psychiatric hospitalization state-wide by 7% by referring some callers to more appropriate mobile outreach services and outpatient facilities based on the callers' needs (National Suicide Prevention Lifeline, 2011).

Follow-up calls to suicidal individuals can reduce the perceived risk of future suicidal behavior. In a study evaluating a national initiative to have crisis centers in the National Suicide Prevention Lifeline network provide follow-up care to suicidal callers, the majority of interviewed follow-up clients reported that the intervention stopped them from killing themselves (79.6%) and kept them safe (90.6%). Counselor activities, such as discussing distractors, social contacts to call for help, and reasons for dying as well as individual factors such as baseline suicide risk were associated with callers' perceptions of the impact of the intervention on suicide risk (Gould, Lake, Galfalvy, Klienman, Munfakh, Wright, and McKeon, 2018).

More research needs to be done on the efficacy of specific models for follow-up service delivery, cost benefit analyses of follow-up programs, utilization of emergency services after follow-up program enrollment, and its ability to divert over use of EDs and inpatient hospitalizations.

Recommendations & Best Practices

The Lifeline views follow-up programs as an integral part of crisis centers' service delivery. While there are a variety of models in operation across the network, a review of center practice has highlighted certain elements as essential to a successful follow-up program. The Lifeline, therefore, recommends the following:

Recommendation 1: Create Clear Program Enrollment Criteria

Clear guidelines for all crisis counselors to use when speaking with callers are important to assess whether enrollment in the follow-up program would be appropriate. Center practices in this area vary: some centers ask callers with any degree of suicide risk to enroll in their follow-up program while others limit this program to those that present with a medium to high risk of suicide. Other centers only follow up with those recently discharged from an emergency department or inpatient setting. Your center may decide to create two follow-up programs based on a caller's risk level. For example, lower levels of risk may require only one follow-up call within a 48 hour period, whereas higher risk callers may require greater frequency.

Whatever criteria you choose in establishing your own center guidelines, it is important to ensure that the enrollment criteria are not based solely on the caller's level of suicidality, but also on your center's resources, staff time and capacity to properly follow up with individuals. Start small, and expand the program once the staff is comfortable with the procedures and enrollment criteria.

Recommendation 2: Create Clear Program Protocols

Establish a clear program protocol that can be used by staff doing follow-up. The protocol should include:

1. Creation of a safety plan (further described in Recommendation 4 and in the appendix)

2. Minimum number of follow-up contacts made to each participant

3. Maximum number of attempts to reach an individual before it is assumed they have dropped out of the program

4. Maximum duration (in days or weeks) of program involvement

5. General guidelines on content of follow-up calls

6. General goals for the follow-up care

While your center's protocol does not have to be rigid (i.e. individualized call schedules can be developed based on a caller's needs) it does need structure in order to ensure consistent and effective service provision. So while details of a caller's follow-up plan may vary depending on risk level and the goal of follow-up (i.e. follow-up until relinked to treatment – or follow-up until specific stressor has passed) the overall approach should remain the same. In general, follow-up calls should assess for continuing risk and review the safety plan for any changes that may need to be made. All calls should be brief and focused. Staff should ensure that the caller understands when their participation in the follow-up program will end. Lastly, as in all hotline calls, staff should invite the caller to stay in touch and call the Lifeline whenever they feel the need to talk to someone or if they are in crisis.

Recommendation 3: Openly Describe the Program to Participants and Gain Consent

Ensure that the caller clearly understands how the follow-up program operates – including the service that will be provided and what will NOT be provided. For example, the caller should be made aware that follow-up is designed to be time limited and not designed to replace short-term treatment. The sample consent form provided in the appendix highlights much of the information for review with the caller as you obtain consent to call them back. To increase caller consent, hotline staff can say, "Before we end the call, I want you to know that I am

concerned about you and that we want to help you stay safe. Is it OK if we call you back to see how you are doing?"

Recommendation 4: Establish a Safety Plan and Use it to Structure Follow-up Calls

A safety plan is a document that identifies ways in which an individual can keep themself safe. The safety plan intervention is a collaborative problem-solving approach for suicidal individuals that can be developed during a crisis call once it is established that immediate emergency intervention is not required. The plan is meant to be flexible and can change as an individual's level of distress changes. Structure your follow-up calls around the plan by reviewing and modifying it during the calls. Assess with the caller how useful the safety plan has been. If the caller has not used the plan despite feeling suicidal, the counselor can review barriers to implementation and alternative strategies. A sample safety plan has been provided in the appendix to guide you in this process.

Recommendation 5: Fully Integrate the Follow-up Program into your Center's Objectives

Ensure that the follow-up program is folded into all staff and volunteer trainings to promote full integration of the service and enhance sustainability of the program. In addition, train as many staff and volunteers as possible to be able to provide follow-up. Even if your center decides to have dedicated staff provide the majority of the follow-up service, having all staff trained will allow you to easily adjust enrollment numbers and staff time as the call volume fluctuates.

Recommendation 6: Consider a Range of Follow-Up Methods

Use of text, chat and email services can help engage more individuals in the follow-up program, especially if the person first contacted you by these means. While there is a scarcity of research on the topic, crisis centers have found that in using alternative methods of communication they can engage a wider demographic, particularly youth. Most often, staff will schedule a date and time to follow up with the individual by text or chat, just as they would with a phone call. Based on the needs of the individual and the safety plan, the staff will check in to ensure safety and risk level. Some centers ask the individual if they can switch to a phone call if the risk level has elevated since the previous chat or text.

Recommendation 7: Track and Evaluate Key Outcomes

A system to track and evaluate your center's follow-up program is essential. Clean data and easy reporting tools allow staff to closely examine program effectiveness and refine approaches to address specific needs. Data can make the difference in whether or not you can apply for funding opportunities. Suggestions for data elements to gather include:

- Number of people screened for follow-up

- Number actually enrolled

- Demographic information

- Average number of contacts made per individual

- Total number of contacts for the follow-up program

- During the time the individual was a participant in the program (a) were they admitted to the hospital or an inpatient setting, and/or (b) did they attempt suicide?

- Self-reporting on whether the individual accessed referral services or other services

- Satisfaction of the program on a 1-5 scale

Metrics and indicators help funders, major donors, and government agencies see the impact your programs have on your community. Indicators that show cost savings to an overburdened mental and behavioral health system are of particular importance. Track ED diversion rates or referrals to outpatient services to show these impacts.

Recommendation 8: Establish a Policy to Work with Familiar/Frequent Callers

Create a policy to address the needs of frequent/familiar callers while keeping the scope of services to these callers within the short-term nature of the follow-up program. Ensure that you have a consistent approach and plan for familiar callers and maintain a list or database with the names and description of these callers so all staff can access the information any time. Remember to reiterate the purpose of the follow-up program, which is to provide short-term, limited check-in calls based on a prepared safety plan. Familiar callers may need to be reminded of the limits you set with them. Be direct and de-escalate a situation if the caller becomes abusive. Abusive callers should not be enrolled in the follow-up program. You may want to debrief the call with a supervisor or co-worker to build skills in working with familiar callers. Tip sheets for working with familiar callers and addressing the behavior of abusive/harassing callers can be found on the Network Resource Center by all centers in the Lifeline network.

Recommendation 9: Establish a Policy to Work with Local Law Enforcement

Having a working relationship with your local police and 911 centers helps promote proper care for follow-up participants at imminent risk. Given that your staff will have more contact with follow-up program participants, it is possible that you will be asked to provide information to local law enforcement or other government agencies about particular participants. To deal with these information requests, your agency should develop an internal policy. Within that policy, the Lifeline recommends that your center ensures that law enforcement obtain a court ordered subpoena before accessing any requested information about specific individuals who use your services.

Partnering with Local Emergency and Inpatient Facilities

Referrals	Discharge Planners refer to crisis centers	Crisis centers engage ED staff and patients	ED sends patient information to crisis center	Crisis center housed within the ED
• Agencies refer to each other for patient care. • Centers provide marketing materials to EDs (ie business cards and brochures)	• Discharge planners at facilities discuss use of the crisis center services with patients before discharge. All materials are handed to patient	• Center staff provide assessment training and consultation to ED staff • Center staff discuss center services with patients before discharge • Centers help set up appointments with community mental health services for patients	• ED staff ask patients to consent to centers outreaching to them • Center involvement is pro forma with all patient discharges • Centers connect patients to appropriate mental health services if necessary	• Crisis center is located within a community mental health center with inpatient beds or within an ED setting • Follow-up with patients is integrated in discharge planning

PARTNERSHIP MODELS*

* This table is not exhaustive and many centers have blended partnership models.

In an effort to address the high risk for suicide following discharge from an inpatient or ED setting, crisis centers have taken the lead on creating new partnerships to provide follow-up services with patients recently discharged. Centers across the network have varying levels of engagement with EDs and inpatient facilities. These partnerships can be informal or formalized by memoranda of understanding (MOU). Some centers are making the partnership into a development opportunity by contracting with the hospitals, charging a fee for their service. Research indicates that emergency departments (ED) face significant overcrowding. In the United States, from 1992 – 2001, 52.8 million visits to the emergency department were mental health related (5.4% of total visits). Suicide attempts accounted for 7% of all mental health related visits and, as a fraction of total ED visits, increased by 47% over the course of the decade. (Larkin, Smith, & Beautrais, 2008).

Description of potential partnerships

- Marketing materials such as business cards and brochures can be placed in the ED or inpatient facility. Staff social workers and discharge planners at the partner facility can

also include these materials in their discharge packets. The materials will build community awareness about the programs and services the center offers.

- Centers can provide suicide risk assessment training and consultation for ED staff. These assessments can be done in person (at the hospital or via video telehealth conference) or by phone.

- Centers can establish contracts with the ED, inpatient facility or with the State to provide mental health assessments for all patients in the ED at admission and/or before discharge.

- Aftercare and after hours services are highly effective to help link patients to outpatient care and divert these patients to more appropriate services.

- EDs and inpatient facilities can obtain consent from patients to send crisis centers their contact information for follow-up services. These follow-up calls can be scheduled by the discharge planner, or they can simply assure the patient that someone from the crisis center will follow-up with them to check in about how they are doing within 24 to 72 hours.

- Centers can become an important bridge between EDs and individuals in need of care. For example, your center can establish mobile crisis outreach teams to connect hotline callers with the appropriate services if they are at higher risk of suicide.

Building a partnership with EDs and inpatient facilities can be a time consuming process. It is important to build relationships with key stakeholders and be prepared. The Follow-up Matters microsite provides support for crisis centers, emergency departments, and other stakeholders interested in creating follow-up partnerships. The microsite provides resources such as information on starting a follow-up partnership, access to research and statistics that support follow-up initiatives, tools for use in assessment and follow-up, sample materials, as well as examples and profiles of follow-up partnerships under the SAMHSA Follow-Up Grants.

In addition, the Lifeline's Crisis Center – Emergency Department Partnership Tool Kit has information that may be very useful including planning exercises, sample letters and presentations. All of the materials can be customized to fit your agency's needs and the Tool Kit can be found on the Network Resource Center by all centers in the Lifeline network.

In particular, take the time to review the Partnership Planning Exercises. This set of exercises will be useful as you plan your approach to engage with hospitals in your area. The following exercises and topics are covered in the section:

1. **Examine the Situation:** This is an exercise to create a simple analysis of your crisis center's strengths, weaknesses, opportunities and threats. It will help you determine your center's capacity to partner with a hospital or inpatient facility.

2. **Assess the Attitudes:** This exercise helps you find out what attitudes different stakeholders may have about the services your center is offering. If you have time, it may be worthwhile to actually survey these stakeholders to obtain a more accurate understanding of their attitudes and perceptions. Free online tools like Survey Monkey https://www.surveymonkey.com/ or Google Forms https://www.google.com/forms/about/ can be accessed to develop your survey.

3. **List Your Assets and Capabilities:** This exercise helps you define what services may be attractive to an ED or inpatient facility. Be realistic about the services you are able to provide. Think of the opportunities in phases – develop ideas for what you can provide today versus what you will be able to provide once a partnership is established and new infrastructure needs are met.

4. **Identify Your Communications Channels:** This exercise will help you determine other resources your center can provide in partnership with an ED. Although the exercise asks for communications resources, think about all of the community resources your center has that may be helpful in a partnership such as outreach, access to walk-in outpatient crisis appointments, detailed referral listings, or partnership with other community resources such as housing shelters or food banks.

5. **Create Your Partnership Building Strategy**: Once you have analyzed your center's capabilities, resources and strengths, this exercise will help you build a strategy for establishing a relationship with an ED. Take the time to clearly establish goals, identify your target audience, find out who in the ED has the power to decide on a partnership, and get a sense of the attitudes of the ED personnel. After these steps, you will be ready to create messaging, talking points, and communications materials directed at the different identified audiences.

6. **Brainstorm Activity Ideas:** This exercise will help you in brainstorm the different partnership models that you can establish with an ED. For example, think about smaller programs that you can offer to pilot with the ED before you establish a more robust partnership with more services.

7. **Make an Action Plan:** Building from your strategy, create an action plan with deadlines and responsible parties listed so you are organized and ready to begin outreach efforts to your local ED or inpatient facility.

In addition to the planning exercises, the Talking Points document can assist you in highlighting your agency's credibility and years of experience in suicide prevention and crisis service delivery. The Tool Kit is accessible through the Lifeline's members-only website. In addition, the appendix of this document has an updated summary of the current research on follow-up and sample memoranda of understanding from member crisis centers.

Keep in mind that once a relationship with a facility is developed, your work is not over. Implementation of the program may take time as well. Continue to develop your partnership by regularly meeting with ED staff to ensure that they are honoring the established agreements and promoting crisis center services.

Sustainability and Development

Fundraising and development are important to maintain sustainability of new programs. The Lifeline has developed a sustainability toolkit with information crisis centers can use to prepare documents and track relevant information for fundraising purposes. In addition to donations and grants available to non-profit centers, crisis centers have developed models to obtain fees for the services they provide. These materials are available on the members-only Network Resource Center.

Conclusion

Although our effort to develop best practices for follow-up protocols continues, these recommendations provide a framework for crisis centers to use as their programs evolve. Making follow-up a part of the crisis center's services will enable crisis centers to continue to play an invaluable, lifesaving role in the mental health system.

This document could not have been prepared without the crisis centers' participation in the Lifeline network; thank you for your continued support of the network and the amazing work that you do every day.

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Appendix A: Safety Planning Intervention

A safety plan is a list of coping strategies and sources of support individuals can use who have been deemed to be at risk of suicide. It is designed so that you can work collaboratively with an individual to create a prioritized plan that is brief and easy for the person to follow. Ask the individual to keep the plan in a place where they can easily access it (in a wallet or cell phone) when they have thoughts of suicide

The following are essential elements to explore and include in the development of a safety plan.[1] Work with the individual to create a plan based on these steps:

1. **Recognize warning signs:** What sorts of thoughts, images, moods, situations, and behaviors indicate to you that a crisis may be developing? Write these down in your own words.

2. **Use your own coping strategies – without contacting another person:** What are some things that you can do on your own to help you not act on thoughts/urges to harm yourself?

3. **Socialize with others who may offer support as well as distraction from the crisis:** Make a list of people (with phone numbers) and social settings that may help take your mind off things.

4. **Contact family members of friends who may help to resolve a crisis:** Make a list of family members (with phone numbers) who are supportive and who you feel you can talk to when under stress.

5. **Contact mental health professionals or agencies:** List names, numbers and/or locations of clinicians, local emergency rooms, crisis hotlines – carry the Lifeline number 1 -800-273-TALK (8255).

6. **Ensure your environment is safe:** Have you thought of ways in which you might harm yourself? Work with your counselor to develop a plan to limit your access to these means.

A safety plan template can be downloaded from the National Suicide Prevention Lifeline website here: https://suicidepreventionlifeline.org/wp-content/uploads/2017/09/Brown_tanleySafetyPlanTemplate1.pdf

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[1] Stanley, B., & Brown, G. K. (201 2). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. Cognitive and Behavioral Practice, 19, 256-264.

Appendix B: Lifeline Sample Consent Form

We are concerned about you and we want to help you stay safe. Would it be okay for someone from our crisis center (Crisis Center Name) to call you and see how you are doing? Making these follow-up calls is an important part of our services. We have found that these follow-up contacts can help keep people safe and feel supported until they are feeling better (and/or linked to treatment services). Would it be okay for us to contact you in (time period to be decided by the crisis worker completing this form)?

<div align="right">__YES __NO</div>

1. Name of client: _____

2. Name of crisis counselor completing this form: _____

3. Date of Referral: __/__/____

Safety plan is complete and in the caller's record. (If not, fill the below information)

4. Telephone #: _____
    Phone for? (circle):   Home#   Cell#   Office#

5. Best day(s) and times to call: _____

6. Preferred language for follow-up call: _____

7. Do you have an answering machine or voicemail on this telephone?   __YES   __NO
    If "Yes:"
    If you are not able to answer when we call, is it okay for us to leave a message?
    __ Do NOT Leave a Message
    __ Leave a Hotline Message
    __ Leave a Different Message (Details): _____
    _____

8. If someone else answers when (Crisis Center Name) calls, is it okay for them to leave a message with the person who answers the phone? __ YES __ NO __ No one else will answer
    If "Yes:"
    __ Do NOT Leave a Message
    __ Leave a Hotline Message
    __ Leave a Different Message (Details): _____
    _____

The information you have provided here and any other information exchanged between you and the (Crisis Center Name) staff is strictly confidential. If the (Crisis Center Name) wishes to share your information with others that can assist in your care, we must obtain your permission to do so. The only exception to this rule is if your life (or the life of others) is in danger. In this case, the (Crisis Center Name) may only share information about you with individuals or agencies that they believe can assure your immediate safety.

When a staff member from the (Crisis Center Name) calls you, they will ask you questions about how you are doing, how safe you are feeling at the time, and what actions you are taking to keep yourself safe. They will see what kind of help you may still need at the time, and do whatever they can do to help you.

You are also free to contact the (Crisis Center Name) directly at any time during or after your involvement in this follow up program to obtain more help.

Signed: _____

Date: _____

Appendix C: Annotated Bibliography

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> Objectives: The aim of the present study was to improve the health care of people repeatedly admitted to private hospitals. Method: An open trial in which frequent utilizers were offered telephone case management over a 12 month period, was conducted.

> Results: An average of 24 phone calls were made to the 99 who remained in the programme for the 12 months. Psychological distress declined significantly over the 12 months, and the number of days in hospital was reduced compared to the previous year. The cost benefit ratio was 1:8.4. Conclusions: The changes in well-being and hospitalization over the 12 months were substantial and are unlikely to be due to regression to the mean. A prospective randomized controlled trial comparing telephone case management with treatment as usual is indicated.

Appleby, L., Shaw, L., Amos, T., McDonnell, R., Harris, C., McCann, K., . . . Parsons, R. (1999). Suicide within 12 months of contact with mental health services: National clinical survey. *British Medical Journal,* 318, 1235-1239.

> Objective: To describe the clinical circumstances in which psychiatric patients commit suicide. Design: National clinical survey. Setting: England and Wales. Subjects: A two year sample of people who had committed suicide, in particular those who had been in contact with mental health services in the 12 months before death. Main outcome measures: Proportion of suicides in people who had had recent contact with mental health services; proportion of suicides in inpatients; proportion of people committing suicide and timing of suicide within three months of hospital discharge; proportion receiving high priority under the care programme approach; proportion who were recently non-compliant and not attending. Results: 10,040 suicides were notified to the study between April 1996 and March 1998, of whom 2,370 (24%; 95% confidence interval 23% to 24%) had had contact with mental health services in the year before death. Data were obtained on 2,177, a response rate of 92%. In general these subjects had broad social and clinical needs. Alcohol and drug misuse were common. 358 (16%; 15% to 18%) were psychiatric inpatients at the time of death, 21% (17% to 25%) of whom were under special observation. Difficulties in observing patients because of ward design and nursing shortages were both reported in around a quarter of inpatient suicides. 519 (24%; 22% to 26%) suicides occurred within three months of hospital discharge, the highest number occurring in the first week after discharge. 914 (43%; 40% to 44%) were in the highest priority category for community care. 488 (26% excluding

people whose compliance was unknown; 24% to 28%) were non-compliant with drug treatment while 486 (28%; 26% to 30%) community patients had lost contact with services. Most people who committed suicide were thought to have been at no or low immediate risk at the final service contact. Mental health teams believed suicide could have been prevented in 423 (22%; 20% to 24%) cases. Conclusions: Several suicide prevention measures in mental health services are implied by these findings, including measures to improve compliance and prevent loss of contact with services.

Inpatient facilities should remove structural difficulties in observing patients and fixtures that can be used in hanging. Prevention of suicide after discharge may require earlier follow up in the community. Better suicide prevention in psychiatric patients is likely to need measures to improve the safety of mental health services as a whole, rather than specific measures for people known to be at high risk. Key messages: Around a quarter of people who commit suicide have been in contact with mental health services in the year before death[---]over 1,000 cases annually Of these cases, 16% are psychiatric inpatients and 24% have been discharged from inpatient care in the previous three months. Problems of observation caused by ward design and nursing shortages are common in cases of inpatient suicide. Suicide in former inpatients occurs most commonly in the week after discharge. Non-compliance with treatment and loss of contact with services are common before suicide.

Beautrais, A., & Gibb, S. (2004). Attempted Suicide in Canterbury. C. S. Project. Christchurch, New Zealand: Canterbury Suicide Project, Christchurch School of Medicine & Health Services.

Aims: Non-fatal suicide attempts incur substantial costs in morbidity, subsequent mortality, and service utilisation. This study reviews trends in admissions to Christchurch Hospital for attempted suicide during the 10-year period 1993-2002, inclusive. The influences of age, gender, and method of suicide attempt on time trends were examined. Methods: Participants were a consecutive series of 3,711 individuals admitted to Christchurch Hospital for attempted suicide from 1993 to 2002. The following measures were available: age, gender, method of suicide attempt, and admission date. Logistic regression analysis was used to test trends over time. Results: The number of admissions for attempted suicide increased from 1993 to 2002. Admissions increased for females (but not for males) and for those persons aged over 25. There was an increase in the number of admissions for female youth, but not for male youth or youth overall. Admissions for cutting/stabbing increased, while admissions for overdose/poisoning decreased. Conclusions: Trends observed at Christchurch Hospital for admissions for attempted suicide contrast with New Zealand's death by suicide rate, which has declined slightly over the last decade. Increases in attempted suicide admissions in adults, older adults, and females highlight the need for intervention strategies to be targeted at both males and females of all ages.

Boschelli, M., Schrader, L., & Borrell, G. (2003). A model of mobile crisis intervention, suicide intervention, and collaboration with law enforcement. *Rural Mental Health,* 28.

> A 911 dispatch to the scene of a behavioral health emergency answered only by the police resulted in the shooting death of a mentally ill patient. Community outcry led to the development of a centralized crisis hotline and mental health mobile teams with a unique rotational system partnered as first responders to the scene with law enforcement to intervene in mental health or substance abuse crises in a multicultural community. This model is designed for municipalities with populations under 100,000 and brings immediate outreach mental health, suicide intervention and substance abuse services to those in need twenty-four hours a day.

Centers for Disease Control and Prevention (CDC). (2012). Deaths: Preliminary Data for 2010 Retrieved February 29, 2012, from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf.

> Objectives: This report presents preliminary US data on deaths, death rates, life expectancy, leading causes of death, and infant mortality for 2010 by selected characteristics such as age, sex, race, and Hispanic origin. Methods: Data in this report are based on death records comprising more than 98 percent of the demographic and medical files for all deaths in the United States in 2010. The records are weighted to independent control counts for 2010. Comparisons are made with 2009 final data.

> Results: The age-adjusted death rate decreased from 749.6 deaths per 100,000 population in 2009 to 746.2 deaths per 100,000 population in 2010. From 2009 to 2010, age-adjusted death rates decreased significantly for 7 of the 15 leading causes of death: Diseases of heart, Malignant neoplasms, Chronic lower respiratory diseases, Cerebrovascular diseases, Accidents (unintentional injuries), Influenza and pneumonia, and Septicemia. Assault (homicide) fell from among the top 15 leading causes of death in 2010, replaced by Pneumonitis due to solids and liquids as the 15th leading cause of death. The age-adjusted death rate increased for 5 leading causes of death: Alzheimer's disease, Nephritis, nephrotic syndrome and nephrosis, Chronic liver disease and cirrhosis, Parkinson's disease, and Pneumonitis due to solids and liquids. Life expectancy increased by 0.1 year from 78.6 in 2009 to 78.7 in 2010.

Crandall, C., Fullerton-Gleason, L., Aguero, R., & LaValley, J. (2006). Subsequent suicide mortality among emergency department patients seen for suicidal behavior. *Academic Emergency Medicine,* 13, 435-442.

> Objectives: To determine whether suicide mortality rates for a cohort of patients seen and subsequently discharged from the ED for a suicide-related complaint were higher

than for ED comparison groups. Methods: This was a nonconcurrent cohort study set at a university-affiliated urban ED and Level 1 trauma center. All ED patients 10 years and older, with at least one ED visit between February 1994 and November 2004, were eligible. ED visit characteristics defined the cohort exposure. Patients with visits for suicide attempt or ideation, self-harm, or overdose (exposed) were compared with patients without these visits (unexposed). Exposure classification was determined from billing diagnoses, E-codes (E950-E959), and free-text searching of the ED tracking system data for suicide, overdose, and spelling variants. Emergency department patient data were probabilistically linked to state mortality records. The principal outcome was suicide death. Suicide mortality rates were calculated by using person-year (py) analyses. Relative rates (RR) and 95% confidence intervals (95% CIs) were calculated from Cox proportional hazards models. Results: Among the 218,304 patients, the average follow-up was 6.0 years; there were 408 suicide deaths (incidence rate [IR]: 31.2 per 100,000 py). Males (IR: 48.3) had a higher rate than females (IR: 13.5; RR: 3.6; 95% CI = 2.8 to 4.6). A single ED visit for overdose (RR: 5.7; 95% CI = 4.5 to 7.4), suicidal ideation (RR: 6.7; 95% CI = 5.0 to 9.1), or self-harm (RR: 5.8; 95% CI = 5.1 to 10.6) was strongly associated with increased suicide risk, relative to other patients. Conclusions: The suicide rate among these ED patients is higher than population-based estimates. Rates among patients with suicidal ideation, overdose, or self-harm are especially high, supporting policies that mandate psychiatric interventions in all cases.

Fleischmann, A. (2008). Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. *Bulletin of the World Health Organization, 86*, 703-709. doi: 10.2471/blt.07.046995

Objective: To determine whether brief intervention and contact is effective in reducing subsequent suicide mortality among suicide attempters in low and middle-income countries. Methods: Suicide attempters (n = 1867) identified by medical staff in the emergency units of eight collaborating hospitals in five culturally different sites (Campinas, Brazil; Chennai, India; Colombo, Sri Lanka; Karaj, Islamic Republic of Iran; and Yuncheng, China) participated, from January 2002 to October 2005, in a randomized controlled trial to receive either treatment as usual, or treatment as usual plus brief intervention and contact (BIC), which included patient education and follow-up.

Overall, 91% completed the study. The primary study outcome measurement was death from suicide at 18-month follow-up. Findings: Significantly fewer deaths from suicide occurred in the BIC than in the treatment-as-usual group (0.2% versus 2.2%, respectively; $c^2 = 13.83$, P < 0.001). Conclusion: This low-cost brief intervention may be an important part of suicide prevention programmes for underresourced low- and middle- income countries.

Gould, M. S., Kalafat, J., Munfakh, M. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide and Life Threatening Behavior,* 37, 338-352.

In this study we evaluated the effectiveness of telephone crisis services/hotlines, examining proximal outcomes as measured by changes in callers' suicide state from the beginning to the end of their calls to eight centers in the US and again within 3 weeks of their calls. Between March 2003 and July 2004, 1,085 suicide callers were assessed during their calls and 380 (35.0%) participated in the follow-up assessment. Several key findings emerged. Seriously suicidal individuals reached out to telephone crisis services. Significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks. A caller's intent to die at the end of the call was the most potent predictor of subsequent suicidality. The need to heighten outreach strategies and improve referrals is highlighted.

Gould, M. S., Lake, A. M., Galfalvy, H., Kleinman, M., Munfakh, J. L., Wright, J., & McKeon, R. (2018). Follow-up with Callers to the National Suicide Prevention Lifeline: Evaluation of Callers' Perceptions of Care. Suicide & life-threatening behavior, 48(1), 75–86.

Continuity of care for suicidal individuals engaged with a variety of health and mental health care systems has become a national priority, and crisis hotlines are increasingly playing a part in the risk management and continuum of care for these individuals. The current study evaluated a national initiative to have crisis centers in the National Suicide Prevention Lifeline network provide follow-up care to suicidal callers. Data were obtained from 550 callers followed by 41 crisis counselors from 6 centers. Two main data sources provided the information for the current study: a self-report counselor questionnaire on the follow-up activities completed on each clinical follow-up call and a telephone interview with follow-up clients, providing data on their perceptions of the follow-up intervention's effectiveness. The majority of interviewed follow-up clients reported that the intervention stopped them from killing themselves (79.6%) and kept them safe (90.6%). Counselor activities, such as discussing distractors, social contacts to call for help, and reasons for dying, and individual factors, such as baseline suicide risk, were associated with callers' perceptions of the impact of the intervention on their suicide risk. Our findings provide evidence that follow-up calls to suicidal individuals can reduce the perceived risk of future suicidal behavior.

Kalafat, J., Gould, M. K., Munfakh, J. L. H., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. *Suicide and Life Threatening Behavior,* 37, 322-337.

The effectiveness of telephone crisis services/hotlines, examining proximal outcomes as measured by changes in callers' crisis state from the beginning to the end of their calls to

eight centers in the U.S. and intermediate outcomes within 3 weeks of their calls, was evaluated. Between March 2003 and July 2004, 1,617 crisis callers were assessed during their calls and 801 (49.5%) participated in the followup assessment. Significant decreases in callers' crisis states and hopelessness were found during the course of the telephone session, with continuing decreases in crisis states and hopelessness in the following weeks. A majority of callers were provided with referrals and/or plans of actions for their concerns and approximately one third of those provided with mental health referrals had followed up with the referral by the time of the follow-up assessment. While crisis service staff coded these callers as nonsuicidal, at follow-up nearly 12% of them reported having suicidal thoughts either during or since their call to the center. The need to conduct suicide risk assessments with crisis callers and to identify strategies to improve referral follow-up is highlighted.

Knesper, D. J. (2011). Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge from the Emergency Department or Psychiatry Inpatient Unit. Newton, MA: American Association of Suicidology & Suicide Prevention Resource Center.

This is a comprehensive report offering recommendations for the ongoing care of patients at risk for suicide who have been treated in emergency departments and hospitals. Based on an encyclopedic review and analysis of existing research, the 150-page report is the first review of continuity of care as a means to prevent suicide. The report includes ten principles for improved continuity of care, and provides real-world examples of seven integrated systems of care in the U.S. and Europe. Other key recommendations for practice and research address: targeting high-risk individuals; improving education and training for suicide risk assessment; responding to patients who have become disengaged from treatment; coordinating care; and improving infrastructure to provide continuity of care.

Larkin, G. L., Smith, R., & Beautrais, A. (2008). Trends in US emergency department visits for suicide attempts, 1992–2001. *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* 29, 73-80.

This article describes trends in suicide attempt visits to emergency departments in the United States (US). Data were obtained from the National Hospital Ambulatory Medical Care Survey using mental-health-related ICD-9-CM, E and V codes, and mental-health reasons for visit. From 1992 to 2001, mental-health-related visits increased 27.5% from 17.1 to 23.6 per 1000 (p < .001). Emergency Department (ED) visits for suicide attempt and self injury increased by 47%, from 0.8 to 1.5 visits per 1000 US population (ptrend = .04). Suicide-attempt-related visits increased significantly among males over the decade and among females from 1992/1993 to 1998/1999. Suicide attempt visits increased in non-Hispanic whites, patients under 15 years or those between 50–69 years of age, and the privately insured. Hospitalization rates for suicide attempt-related ED visits declined

from 49% to 32% between 1992 and 2001 (p = .04). Suicide attempt-related visits increased significantly in urban areas, but in rural areas suicide attempt visits stayed relatively constant, despite significant rural decreases in mental-health related visits overall. Ten-year regional increases in suicide attempt-related visits were significant for the West and Northeast only. US emergency departments have witnessed increasing rates of ED visits for suicide attempts during a decade of significant reciprocal decreases in postattempt hospitalization. Emergency departments are increasingly important sites for identifying, assessing and treating individuals with suicidal behavior.

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services,* 52, 828-833.

Objective: This study tested the hypothesis that professionals' maintenance of long-term contact with persons who are at risk of suicide can exert a suicide-prevention influence. This influence was hypothesized to result from the development of a feeling of connectedness and to be most pertinent to high-risk individuals who refuse to remain in the health care system. Methods: A total of 3,005 persons hospitalized because of a depressive or suicidal state, populations known to be at risk of subsequent suicide, were contacted 30 days after discharge about follow-up treatment. A total of 843 patients who had refused ongoing care were randomly divided into two groups; persons in one group were contacted by letter at least four times a year for five years. The other group--the control group--received no further contact. A follow-up procedure identified patients who died during the five-year contact period and during the subsequent ten years. Suicide rates in the contact and no-contact groups were compared. Results: Patients in the contact group had a lower suicide rate in all five years of the study. Formal survival analyses revealed a significantly lower rate in the contact group (p=.04) for the first two years; differences in the rates gradually diminished, and by year 14 no differences between groups were observed. Conclusions: A systematic program of contact with persons who are at risk of suicide and who refuse to remain in the health care system appears to exert a significant preventive influence for at least two years. Diminution of the frequency of contact and discontinuation of contact appear to reduce and eventually eliminate this preventive influence.

National Suicide Prevention Lifeline (2011). *Crisis hotlines: A reliable safety net in a challenging budget environment.* Unpublished fact sheet.

Qin, P., & Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization. *Archives of General Psychiatry,* 62, 427-432.

Background: Persons with a history of admission to a psychiatric hospital are at high risk for suicide, but little is known about how this is influenced by factors related to psychiatric hospitalization. Objective: To explore suicide risk according to time since admission, diagnosis, length of hospital treatment, and number of prior hospitalizations.

Design: Nested case-control design. Setting: Individual data are drawn from various Danish longitudinal registers. Participants: All 13 681 male and 7488 female suicides committed in Denmark from January 1, 1981, to December 31, 1997, and 423 128 population control subjects matched for sex, age, and calendar time of suicide. Main Outcome Measure Risk of suicide is estimated by conditional logistic regression. Data are adjusted for socioeconomic factors. Results: This study demonstrates that there are 2 sharp peaks of risk for suicide around psychiatric hospitalization, one in the first week after admission and another in the first week after discharge; suicide risk is significantly higher in patients who received less than the median duration of hospital treatment; affective disorders have the strongest impact on suicide risk in terms of its effect size and population attributable risk; and suicide risk associated with affective and schizophrenia spectrum disorders declines quickly after treatment and recovery, while the risk associated with substance abuse disorders declines relatively slower. This study also indicates that an admission history increases suicide risk relatively more in women than in men; and suicide risk is substantial for substance disorders and for multiple admissions in women but not in men. Conclusions: Suicide risk peaks in periods immediately after admission and discharge. The risk is particularly high in persons with affective disorders and in persons with short hospital treatment. These findings should lead to systematic evaluation of suicide risk among inpatients before discharge and corresponding outpatient treatment, and family support should be initiated immediately after the discharge.

Simon, G. E., VonKorff, M., Rutter, C., & Wagner, E. (2000). Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. *British Medical Journal,* 320, 550-554.

Objective: To test the effectiveness of two programmes to improve the treatment of acute depression in primary care. Design: Randomised trial. Setting: Primary care clinics in Seattle. Patients: 613 patients starting antidepressant treatment. Intervention: Patients were randomly assigned to continued usual care or one of two interventions: feedback only and feedback plus care management. Feedback only comprised feedback and algorithm based recommendations to doctors on the basis of data from computerised records of pharmacy and visits. Feedback plus care management included systematic follow up by telephone, sophisticated treatment recommendations, and practice support by a care manager. Main outcome measures: Blinded interviews by telephone 3 and 6 months after the initial prescription included a 20 item depression scale from the Hopkins symptom checklist and the structured clinical interview for the current DSM-IV depression module. Visits, antidepressant prescriptions, and overall use of health care were assessed from computerised records. Results: Compared with usual care, feedback only had no significant effect on treatment received or patient outcomes. Patients receiving feedback plus care management had a higher probability of both receiving at least moderate doses of antidepressants (odds ratio 1.99, 95% confidence

interval 1.23 to 3.22) and a 50% improvement in depression scores on the symptom checklist (2.22, 1.31 to 3.75), lower mean depression scores on the symptom checklist at follow up, and a lower probability of major depression at follow up (0.46, 0.24 to 0.86). The incremental cost of feedback plus care management was about $80 (£50) per patient. Conclusions: Monitoring and feedback to doctors yielded no significant benefits for patients in primary care starting antidepressant treatment. A programme of systematic follow up and care management by telephone, however, significantly improved outcomes at modest cost.

Stanley, B., Brown, G. K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice,* 19, 256-264.

The usual care for suicidal patients who are seen in the emergency department (ED) and other emergency settings is to assess level of risk and refer to the appropriate level of care. Brief psychosocial interventions such as those administered to promote lower alcohol intake or to reduce domestic violence in the ED are not typically employed for suicidal individuals to reduce their risk. Given that suicidal patients who are seen in the ED do not consistently follow up with recommended outpatient mental health treatment, brief ED interventions to reduce suicide risk may be especially useful. We describe an innovative and brief intervention, the Safety Planning Intervention (SPI), identified as a best practice by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org), which can be administered as a stand-alone intervention. The SPI consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis. The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means. A detailed description of SPI is described and a case example is provided to illustrate how the SPI may be implemented.

Substance Abuse and Mental Health Services Administration (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings.* (NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockland, MD.

This report presents the first information from the 2008 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The survey interviews approximately 67,500 persons each year. Unless otherwise noted, all

comparisons in this report described using terms such as "increased," "decreased," or "more than" are statistically significant at the .05 level.

Vaiva, G., Ducrocq, F., Meyer, P., Mathieu, D., Philippe, A., Libersa, C., & Goudemand, M. (2006). Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: Randomised controlled study. *British Medical Journal,* 332, 1241-1245.

Objective: To determine the effects over one year of contacting patients by telephone one month or three months after being discharged from an emergency department for deliberate self poisoning compared with usual treatment. Design Multicentre, randomised controlled trial. Setting: 13 emergency departments in the north of France. Participants 605 people discharged from an emergency department after attempted suicide by deliberate self poisoning. Intervention: The intervention consisted of contacting patients by telephone at one month or three months after discharge from an emergency department for attempted suicide to evaluate the success of recommended treatment or to adjust treatment. Control patients received treatment as usual, in most cases referral back to their general practitioner. Main outcome measures: The primary outcome measures were proportion of participants who reattempted suicide, number of deaths by suicide, and losses to follow-up at 13 months' follow-up. Secondary outcome measures were types and number of contacts with health care. Results: On an intention to treat basis, the three groups did not differ significantly for further suicide attempts, deaths by suicide, or losses to follow-up: contact at one month (intervention 23% (34/147) v controls 30% (93/312), difference %, 95% confidence interval − 2% to 15%), three months (25% 36/146) v 30%, difference 5%, − 4% to 14%). Participants contacted at one month were less likely at follow-up to report having reattempted suicide (12% v 22% in control group, difference 10%, 2% to 18%). Conclusion: Contacting people by telephone one month after being discharged from an emergency department for deliberate self poisoning may help reduce the number of reattempted suicides over one year.

While, D., Bickley, H., Roscoe, A., Windfur, K., Rahman, S., Shaw, J., . . . Kapur, N. (2012). Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *The Lancet, Early Online Publication,* 1-8.

Background: Research investigating which aspects of mental health service provision are most effective in prevention of suicide is scarce. We aimed to examine the uptake of key mental health service recommendations over time and to investigate the association between their implementation and suicide rates. Methods: We did a descriptive, cross-sectional, and before-and-after analysis of national suicide data in England and Wales.

We collected data for individuals who died by suicide between 1997 and 2006 who were in contact with mental health services in the 12 months before death. Data were obtained as part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. When denominator data were missing, we used information from the Mental Health Minimum Data Set. We compared suicide rates for services implementing most of the recommendations with those implementing fewer recommendations and examined rates before and after implementation. We stratified results for level of socioeconomic deprivation and size of service provider. Findings: The average number of recommendations implemented increased from 0·3 per service in 1998 to 7·2 in 2006. Implementation of recommendations was associated with lower suicide rates in both cross-sectional and before-and-after analyses. The provision of 24 hour crisis care was associated with the biggest fall in suicide rates: from 11·44 per 10 000 patient contacts per year (95% CI 11·12—11·77) before to 9·32 (8·99—9·67) after (p<0·0001). Local policies on patients with dual diagnosis (10·55; 10·23—10·89 before vs 9·61; 9·18—10·05 after, p=0·0007) and multidisciplinary review after suicide (11·59; 11·31—11·88 before vs 10·48; 10·13—10·84 after, p<0·0001) were also associated with falling rates. Services that did not implement recommendations had little reduction in suicide. The biggest falls in suicide seemed to be in services with the most deprived catchment areas (incidence rate ratio 0·90; 95% CI 0·88—0·92) and the most patients (0·86; 0·84—0·88). Interpretation: Our findings suggest that aspects of provision of mental health services can affect suicide rates in clinical populations. Investigation of the relation between new initiatives and suicide could help to inform future suicide prevention efforts and improve safety for patients receiving mental health care.

Zanjani, F., Miller, B., Turiano, N., Ross, J., & Oslin, D. (2008). Effectiveness of telephone- based referral care management: A brief intervention to improve psychiatric treatment engagement. *Psychiatric Services,* 59, 776-781.

Objective: This study examined the effectiveness of a telephone-based referral care management (TBR-CM) intervention for improving engagement in psychiatric treatment. Methods: From September 2005 to May 2006, 169 primary care patients at the Philadelphia Veterans Affairs Medical Center completed a psychiatric diagnostic interview and were identified as needing psychiatric care. From this total of eligible patients, 113 (67%) gave informed consent and were randomly assigned to receive either usual care or the intervention. Usual care consisted of participants' being schedule for a behavioral health care appointment, followed by a letter and reminder by telephone. The intervention group received the same, plus one or two brief motivational telephone sessions. Participant interviews and medical records provided study data. Results: Research participants were primarily African American and 22-83 years old. In the sample, 40 patients (39%) had severe depression, 40 (39%) had substance use problems, and 33 (22%) had co-occurring severe depression and substance abuse.

Overall, 40 participants (70%) in the intervention group compared with 18 (32%) in the usual care group engaged in at least one psychiatric treatment appointment (p<.001). Analyses also indicated that on average the intervention group attended more appointments (more than three) compared with the usual care group (less than two) (p=.008). Conclusions: The TBR-CM intervention program was effective at improving psychiatric treatment engagement. Future research is necessary to examine effectiveness of TBR-CM in more heterogeneous and larger samples and to evaluate economic benefits versus costs of intervention delivery.

*All sample materials are meant to serve as a guide, and are not necessarily endorsed or standard practices of the Lifeline network. We truly appreciate and thank the centers who have agreed to share their materials with the rest of the network in this document.