This guide is based on the Structured Follow-Up & Monitoring Module.
To be used as supplementary material, **not** as a substitute for the training.
The training can be found here: NYASSC Training Page

A Guide for Clinicians:

Structured Follow-Up and Monitoring

What is structured follow-up and monitoring?

Structured follow-up and monitoring (SFUM) is a best practice intervention used by clinicians to proactively follow and monitor individuals at high risk for suicide. The intervention consists of four steps that guide clinicians regarding how and when to contact and continuously assess individuals who have recently been discharged from a hospital stay or Emergency Department visit due to suicide risk. The intervention provides support and a safety net as these individuals transition from crisis help to outpatient care and community supports during a high-risk period for suicide attempts.

Who should use structured follow-up and monitoring?

SFUM works best when **the clinician who initially saw the individual** conducts the intervention. This can include ED/urgent care clinicians or an inpatient clinician who was involved in the patient's care during hospitalization. Otherwise, other staff members from the same treatment facility can conduct the intervention. SFUM should be conducted by **trained professionals and paraprofessionals** who can conduct risk assessments and clinically intervene.

When should structured follow-up and monitoring occur?

SFUM should be conducted with a suicidal individual **after a suicidal crisis** or with patients with **recently increased suicidal ideation.** The follow-up should preferably occur **within 24-72 hours of discharge from an inpatient unit or emergency department.**

The number and frequency of calls depends on the resources at your clinic, but **two or more follow-ups are recommended**, one within 24-72 hours of discharge and one following the first outpatient appointment**.** SFUM should continue until the individual is in treatment, rejects further treatment or follow-ups, or their risk of suicide diminishes sufficiently.

Why is structured follow-up and monitoring important?

When an individual is discharged from an ED visit or inpatient stay there is **a break in continuity of care during an increased risk period** for patients who have recently experienced a suicide crisis. A safety net is necessary in the period between discharge and commencing outpatient care in order to provide support for maintained safety and engagement in outpatient care. The SFUM intervention is designed to **bridge this gap.**

SFUM provides information about services or plans for aftercare, helps identify individuals of imminent risk and provide them with rescue, and provides support between a crisis visit and outpatient care including ongoing risk evaluations and safety assessments. As a result, SFUM **enhances the continuity of care by facilitating engagement in treatment and decreasing isolation** during elevated risk to help manage suicidality.

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What are the steps of structured follow-up and monitoring?

Step 1: Mood check and risk assessment

The first step involves getting **a general idea of how the individual is feeling** (specifically with regard to suicidal ideation, depression, anxiety, agitation, substance use, and functioning). You can use the C-SSRS screen to directly assess suicidal ideation, intent, and behavior.

Additional useful questions to ask: *How have you been feeling since we last spoke? Have you been seeing your therapist? Is there anything you've been struggling with lately?*
If an individual is showing signs of **imminent** risk, the SFUM format should be halted – shift into crisis intervention and stay on the phone to help de-escalate.

Step 2: Review and revise the safety plan

Review the patient's safety plan together and make sure that it is both **useful** and **being used.** Assess and address **what *is* and *is* not useful** about the safety plan, then **replace unhelpful items** with more beneficial steps.

Ensure that both the clinician and the patient have access to the **new and revised** copy of the safety plan and ensure that their access to means is reduced.

Step 3: Treatment engagement and motivation

Check that your patient is aware of current options for treatment, review plans made for treatment in the past, and remind patients of upcoming treatment sessions. When patients reject treatment, help them to reconsider and try to identify and problem-solve any barriers or obstacles to treatment. During this process, praise the patient's ability to identify barriers, validate their struggle with these barriers, and then attempt to resolve the issues. You can explore the pros and cons of treatment and ambivalence.
Some common barriers and obstacles to treatment include:

- **Logistical Barriers:** Any physical barriers to treatment such as financial issues, lack of insurance coverage, and lack of transportation to and from treatment sessions.
- **Motivational Barriers:** Internal barriers within the individual such as denying the severity of the mental health problem, believing that the problem can be handled without treatment, previous negative experiences with health professionals or a mistrust of treatment, and stigma regarding treatment. Some individuals might find it useful if a trusted person accompanies them to their first treatment session.
- **Structural Barriers:** Issues related to the health care system such as finding it hard to schedule appointments, having a lack of providers available, long waiting lists, and inconvenient services.

REMEMBER: Just because someone rejects clinical interventions does not mean they will also reject beneficial community support services such as **social organizations**, **peer support**, **religious organizations**, or **support groups.**

Step 4: Obtain consent and willingness for additional follow-up

Assess whether further calls are warranted. Ensure that you **obtain consent and willingness** for additional follow-ups before you hang up. If possible, **set the time and date of the next follow-up before the end of the current contact.** If the high-risk individual refuses to give consent for future follow-ups, make sure they understand they will not be receiving more intervention.

What is the nature of structured follow-up and monitoring?

- REMEMBER: You must obtain permission prior to reaching out to a client.
- SFUM phone calls should be **brief.** In fact, the average follow-up phone call lasts **15 minutes.**
- SFUM is **usually done by telephone but can also be conducted via email, text, or home visits** if your organization allows.
- **Be persistent even if the individual is hard to reach;** most high-risk individuals appreciate the effort you have made to check on them**. Organizations should decide in advance on a procedure regarding what to do if the individual is unreachable.**
- **Keep records** of all contacts and follow-ups you make with a high-risk individual and **develop a notification system** for your next contact. **Determine the length of follow-up period based on the individual's circumstance and mental health status.**
- All calls should be **goal-directed** and **maintain focus on the agenda,** not open-ended.
- However, all calls should also be **supportive** of the patient and attentive to their needs, wishes, and values.
- The tone of the call should be **kind, professional, respectful, and friendly** – mirror and summarize statements said by the client without judgment.
- Some high-risk individuals may decide not to engage in outpatient treatment but may be willing to do telephone contacts; thus, **SFUM is important as it might be only contact, they get from a clinical professional.**