Bridging Gaps in Follow-up Appointments After Hospitalization and Youth Suicide

Mental Health Care Disparities Matter

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The study by Fontanella and colleagues1 provides a reminder of a critical gap in care that demands attention: that between inpatient and outpatient mental health care. In a study of 139,694 youth with Medicaid insurance aged 10 to 18 years who experienced psychiatric hospitalization, attendance at a follow-up mental health appointment within 1 week of discharge was associated with half the risk for suicide within the subsequent 6 months compared with individuals who did not attend such an appointment. While these findings make clinical sense, Fontanella et al1 are clear that with 22 suicides in the studied group during this period, these results on reduced suicide risk merit replication.

Only 74,632 psychiatrically hospitalized youths (56.5%) in the study attended a follow-up mental health appointment within 7 days of discharge. Attending such an appointment was associated with 2 service-related factors: longer lengths of stay in the hospital and any mental health service utilization prior to hospitalization. Black youth, individuals receiving Medicaid because of low income, and individuals with histories of chronic medical illness, self-harm, or substance abuse were less likely to have attended a mental health appointment within 1 week of discharge.

It is well known that psychiatric inpatients have an especially high rate of suicide after being discharged. In this study, the clinical risk factors associated with nonattendance are concerning, because comorbid chronic medical illness, previous self-harm, and substance abuse are all associated with increased risk for suicide. This means that the youth for whom follow-up care was strongly indicated were least likely to receive it. The groundbreaking work of Kapur and colleagues2 at the University of Manchester has shed much-needed light on the gaps in care that may contribute to the suicides of patients who are already in the mental health system. The work of Kapur et al led to recommended changes in the way that mental health systems in the United Kingdom deliver care for patients who are suicidal. Among these recommended changes were provision of follow-up care at transitions from inpatient to outpatient care, assertive follow-up care and monitoring for nonattendance, 24-hour availability of crisis care, policies on the treatment of patients with co-occurring substance use disorders, planned transitions from child to adult mental health care, adherence to national guidelines for the treatment of depression, and multidisciplinary reviews of each completed suicide, with input from the individual's family members.

The degree of adherence to these and other recommendations was associated with regional declines in suicide rates in the United Kingdom.2 The implementation of these recommendations would likely help to address the service gap identified by Fontanella and colleagues,1 as well as some of the clinical issues associated with nonattendance, and could reduce the suicide rate in the United States as well.

Beyond the question of whether care has occurred, the quality of the care matters. For example, in the study by Kapur et al,2 regional suicide rates decreased when there was evidence of adherence to national treatment guidelines for depression. There is increasing evidence for the effectiveness of one brief intervention: the development, with the patient, of a safety plan consisting of a set of strategies that the patient can use to resist acting on suicidal urges. The most definitive demonstration of the utility of safety planning was a landmark clinical trial3 that randomized emergency departments to provide either a brief safety-planning intervention or treatment as usual for patients experiencing suicidal urges. In emergency departments that provided safety-planning...
interventions, patients showed a lower rate of suicide attempts and a higher rate of outpatient mental health care at follow-up. One pilot study from 2018 found that in adolescent psychiatric inpatients with suicidal urges, a brief inpatient intervention combined with a smartphone safety-planning app reduced the postdischarge suicide attempt rate compared with adolescents who received only the usual care. In these 2 studies, the intervention had a greater effect than postdischarge treatment adherence did. This supports the view that it is the quality, not just the quantity, of care that is critical in protecting patients who are at high risk for future suicide attempts.

The study by Fontanella and colleagues also shed a troubling spotlight on racial health care disparities, with Black youth less likely to attend a follow-up mental health appointment within 1 week of discharge. This is particularly worrisome because, from 2007 to 2017, the rate of suicide attempts increased 74% and the rate of suicide deaths increased 89% among Black youth, increases that greatly exceeded those for White youth. Racial and ethnic health disparities are a recurrent theme in US health care, most recently evident in the markedly higher rates of morbidity and mortality among Black and Latinx individuals infected with the coronavirus disease 2019.

What is required to end racial and ethnic health disparities like those identified by Fontanella et al? First, we need to develop a research agenda to study ways to ameliorate disparities in health care. Research into mental health disparities is less likely than other types of research to receive funding from the National Institute of Mental Health, limiting progress in addressing these issues. Alegria and colleagues identified several promising approaches for decreasing disparities for youth in racial/ethnic minority groups, including expanding access to mental health care (particularly via school-based mental health services), developing culturally appropriate care, and further examining clinician-related contributions to disparities. Alegria et al delineated a research agenda that combines evidence-based methods to target the many well-documented mechanisms underlying mental health disparities (eg, neighborhood violence, socioeconomic disparities, and childhood adversity) across individual, family, neighborhood, and organizational levels.

Second, while we await definitive research on mental health disparities, health care systems can take steps to quantify and address the shortfalls in quality and the disparities in health care. Health systems need to audit their performance by patient race, ethnicity, and income. When disparities in care and outcome are identified, the root causes need to be determined. These causes could include implicit or explicit bias among treating clinicians, as well as incomplete exploration of the barriers associated with adherence to treatment recommendations and the possible solutions to those barriers. Such solutions could address transportation, cost, and competing childcare needs.

Third, health care clinicians and educators need to become conscious of our own implicit biases that may contribute to health care disparities. One place to start is a 2019 essay by Fayanju, a Black woman who is a breast cancer surgeon. In this essay, she describes how her experiences as a person of color and her sharply defined observations of the Black women she treats motivate and inform her research into the dramatic racial disparities in health care treatment access and outcome in women with breast cancer. This essay makes a powerful argument for the importance of research into health disparities in any area of health care, and the essay’s observations and conclusions are certainly applicable to the racial disparities identified by Fontanella et al.

The goal of such research is not merely to document the sources of disparities but to devise actionable interventions and policies that bridge these gaps in care. We need to label these disparities as what they are: unacceptable. Just as we must address the gaps that occur between transitions in care, we must also bridge gaps that are defined by race, ethnicity and class, so that all people receive the care that they need and deserve. In so doing, we can reverse the disturbing upward trend in suicide in US youth in general, and in Black youth in particular.
REFERENCES