Pathway to Care

Goal 7: Individuals assessed to be at risk will receive care in accordance with the Suicide Safe Care Pathway. Agencies will use quality management tools to monitor adherence to the Suicide Safe Care Pathway guidelines.

Rationale

A number of health care organizations, such as the Agency for Healthcare Policy and Research and the American Psychiatry Association, have issued practice guidelines that define desired practice based on research evidence and expert consensus. Guidelines such as these outline factors that should be considered in making treatment decisions. Guidelines can help mental health providers utilize evidence-based and best practice care recommendations to educate individuals in care and guide care decisions.

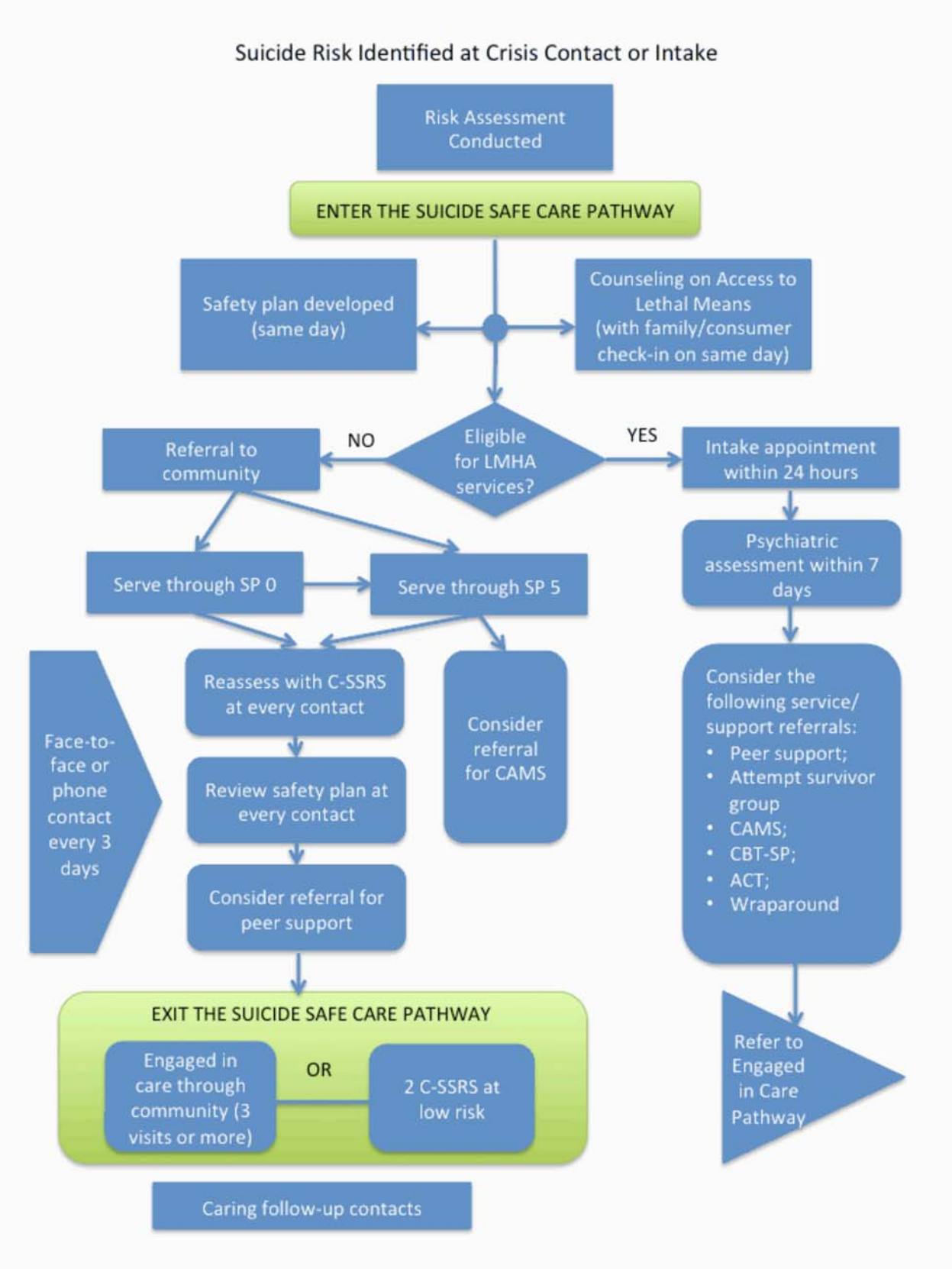
The Suicide Safe Care Pathway is intended to describe best practices for individuals at risk for suicide who will be monitored or treated in a community setting. It is intended to support shared decision making between providers and individuals in care, while promoting best practices during high-risk periods. At any one point in time, behavioral health organizations are likely to have only a small percentage of individuals on the Suicide Safe Care Pathway, but those individuals deserve a level of care and monitoring reflective of the importance of individual safety to the health care system.

Organization of the Pathway

The Suicide Safe Care Pathway is presented as two flowcharts identifying individuals who are at risk of suicide. One flowchart targets individuals who are not yet engaged in community-based care and the other targets those individuals within community-based care. The flowcharts reflect standards for continued monitoring, on-going safety planning, treatment planning, and frequency of contact. Additional guidance on each step within the flowchart is provided in the accompanying narrative. A two-page version of each Pathway is available in the appendix and can be printed and laminated for easy reference.

Education about the Suicide Safe Care Pathway

Individuals (and caring others) should be educated about the Suicide Safe Care Pathway when being placed on it. The individual should be informed about what the Suicide Safe Care Pathway means for them, as well what to expect from the provider. The provider will share that he or she will stay in regular contact with the individual. The individual should be encouraged to check in with the provider proactively if they will miss an appointment, and if he or she misses an appointment unexpectedly, the provider will try to reach him that day. Providers should gather several emergency contacts, identifying people who are likely to know where the individual may be if the provider is unable to contact the individual directly. Sample educational handouts are available in the appendix.


Suicide Risk Identified at Crisis Contact or Intake
Risk Assessment Conducted
ENTER THE SUICIDE SAFE CARE PATHWAY
Safety plan developed (same day)
Counseling on Access to Lethal Means (with family/consumer check-in on same day)
Eligible for LMHA services?
NO
YES
Referral to community
Intake appointment within 24 hours
Psychiatric assessment within 7 days
Serve through SP 0
Serve through SP 5
Face-to-face or phone contact every 3 days
Reassess with C-SSRS at every contact
Review safety plan at every contact
Consider referral for peer support
Consider referral for CAMS
Consider the following service/ support referrals:
• Peer support;
• Attempt survivor group
• CAMS;
• CBT-SP;
• ACT;
• Wraparound
EXIT THE SUICIDE SAFE CARE PATHWAY
Engaged in care through community (3 visits or more)
OR
2 C-SSRS at low risk
Refer to Engaged in Care Pathway
Caring follow-up contacts

Description of Crisis and Intake Pathway

Entering the Suicide Safe Care Pathway – Individuals who have been assessed and determined to be at risk for suicide (see Assessment chapter) should be placed on the Suicide Safe Care Pathway. It is critical that the organization identify a strategy to communicate that an individual is on the Suicide Safe Care Pathway. The preferred method is a clear indicator within the electronic health record, where the indicator is present on any screen reflecting that individual. Teams may also consider maintaining an electronic list of individuals on the Pathway, reviewing the list with providers on a daily basis.

Safety Plan Developed – A provider should collaborate with the individual to develop a safety plan on the same day as the risk assessment. The individual should not leave the care setting without a well-developed safety plan (see Safety Planning chapter).

Counseling on Access to Lethal Means – The provider should also ensure that he/she has provided counseling to the individual on limiting access to lethal means (see Safety Planning chapter). After a plan is developed to limit access, the provider should follow-up on the same day to ensure that the appropriate steps have been taken. The provider may request a phone call from the individual or his/her caring other or may follow-up directly.

Referral to Community – If the individual is not eligible for services through the LMHA or prefers services in the community, the individual will continue to be served through crisis services. The individual may be served in Level of Care 0 (Crisis Services) for up to 30 days, with a focus on maintaining safety until the individual is engaged in services with another provider. If engagement in care has not occurred or available care does not include best practice suicide-focused treatment, the provider should consider offering the individual care in Level of Care 5 (Transitional Services). This will allow the provider to continue to monitor for safety during the care transition period as well as to make available a brief intervention aimed at reducing suicidal risk.

On-going Monitoring of Risk – For individuals on the Pathway, providers should continue to *assess risk using the C-SSRS* at every contact. This remains the most critical aspect of the monitoring role. In addition, the provider should *review the safety plan* with the individual at every contact, asking about what strategies the individual has used, how helpful it has been at reducing distress or providing effective distraction, and identifying new strategies when needed.

Consider Referral for Peer Support – Many individuals may benefit from having a peer specialist provide support during the care transition period. The peer specialist can assist the individual in navigating access into the preferred care system, advocating for the individual's needs, and providing support during a period of crisis. Peer specialists may be especially impactful for individuals who have limited social support.

Consider Provision of CAMS – Many individuals may benefit from brief intervention focused on reducing suicidality and providers should consider providing Collaborative

Assessment and Management of Suicidality (CAMS). CAMS can be provided for individuals served in Level of Care 5 (Transitional Services).

Contact Frequency – While individuals remain on the Suicide Safe Care Pathway and receiving crisis services, they should be seen with face-to-face or phone contact a minimum of every three (3) days.

Exiting the Suicide Safe Care Pathway – Individuals being monitored through crisis services should remain on the Suicide Safe Care Pathway until they are at reduced risk for suicide or engaged in care with another provider. Individuals are considered at reduced risk if they have had two consecutive C-SSRS assessments at low risk. Individuals are considered engaged in care when they have attended at least three appointments with the community provider.

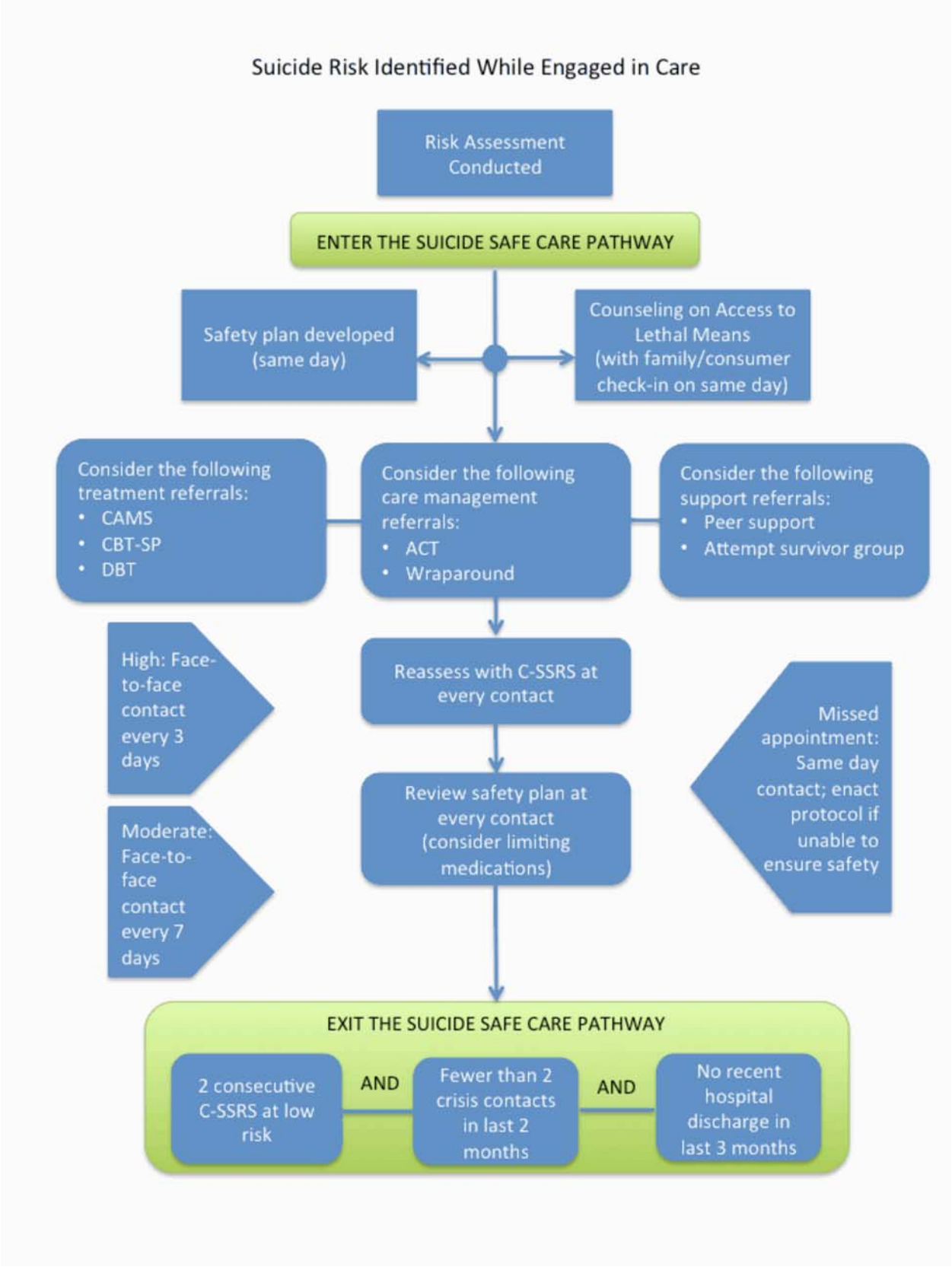
Caring Follow-up Contacts – When individuals meet criteria to be removed from the Suicide Safe Care Pathway, either due to reduced risk or engagement in services, the organization should provide caring contacts for an established period of time (see Care Transition chapter).

Referral into LMHA Services – For individuals who are referred for services within the LMHA, priority scheduling is important. Whenever possible, the crisis provider should provide a warm transfer to the intake provider to complete the eligibility assessment, person-centered planning, and initial service authorization. If a warm hand-off is not possible, an intake appointment should be scheduled within 24 hours.

Referral to Psychiatric Assessment – For individuals entering services within the Suicide Safe Care Pathway, a psychiatric assessment appointment should be scheduled within seven (7) days of entering the Pathway. Processes should be put in place to allow staff to schedule priority psychiatric appointments for individuals on the Pathway.

Consider Referrals for Best Practice Services and Supports – Individuals who enter the Suicide Safe Care Pathway should be educated about options for services and supports that can reduce the individual's risk for suicide. For individuals with a history of frequent hospitalization, an evidence-based care management approach should be considered. Assertive Community Treatment (ACT) should be considered for adults and Wraparound for children and adolescents. Suicide-focused treatments should also be considered, based on availability within the agency. Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), Collaborative Assessment and Management of Suicidality (CAMS), and Dialectical Behavior Therapy (DBT) are each evidence-supported options. Lastly, individuals may benefit from peer support through a certified peer specialist and/or engagement in an attempt survivor group.

Continue to the Engaged in Care Pathway – Following the intake appointment, scheduling of initial treatment sessions, and planning for services and supports, providers should refer to the Engaged in Care Pathway for additional guidance.


Suicide Risk Identified While Engaged in Care
Risk Assessment Conducted
ENTER THE SUICIDE SAFE CARE PATHWAY
Safety plan developed (same day)
Counseling on Access to Lethal Means (with family/consumer check-in on same day)
Consider the following treatment referrals:
• CAMS
• CBT-SP
• DBT
Consider the following care management referrals:
• ACT
• Wraparound
Consider the following support referrals:
• Peer support
• Attempt survivor group
High: Face-to-face contact every 3 days
Moderate: Face-to-face contact every 7 days
Reassess with C-SSRS at every contact
Review safety plan at every contact (consider limiting medications)
Missed appointment: Same day contact; enact protocol if unable to ensure safety
EXIT THE SUICIDE SAFE CARE PATHWAY
2 consecutive C-SSRS at low risk
AND
Fewer than 2 crisis contacts in last 2 months
AND
No recent hospital discharge in last 3 months

Description of the Engaged in Community-Based Care Pathway

Entering the Suicide Safe Care Pathway – Individuals who have been assessed and determined to be at risk for suicide (see Assessment chapter) should be placed on the Suicide Safe Care Pathway. It is critical that the organization identify a strategy to communicate an individual is on the Suicide Safe Care Pathway. The preferred method is a clear indicator within the electronic health record, where the indicator is present on any screen reflecting that individual. Teams may also consider maintaining an electronic list of individuals on the Pathway, reviewing the list with providers on a daily basis.

Safety Plan Developed – A provider should collaborate with the individual to develop a safety plan on the same day as the risk assessment. The individual should not leave the care setting without a well-developed safety plan (see Safety Planning chapter).

Counseling on Access to Lethal Means – The provider should also ensure that he/she has provided counseling to the individual on limiting access to lethal means (see Safety Planning chapter). After a plan is developed to limit access, the provider should follow-up on the same day to ensure that the appropriate steps have been taken. The provider may request a phone call from the individual or his/her caring other or may follow-up directly.

Consider Referrals for Best Practice Services and Supports – Individuals who enter the Suicide Safe Care Pathway should be educated about options for services and supports that can reduce the individual's risk for suicide. For individuals with a history of frequent hospitalization, an evidence-based care management approach should be considered. Assertive Community Treatment (ACT) should be considered for adults and Wraparound for children and adolescents. Suicide-focused treatments should also be considered, based on availability within the agency. Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), Collaborative Assessment and Management of Suicidality (CAMS), and Dialectical Behavior Therapy (DBT) are each evidence-supported options. Lastly, individuals may benefit from peer support through a certified peer specialist and/or engagement in an attempt survivor group.

On-going Monitoring of Risk – For individuals on the Pathway, providers should continue to *assess risk using the C-SSRS* at every contact. This remains the most critical aspect of the monitoring role. In addition, the provider should *review the safety plan* with the individual at every contact, asking about what strategies the individual has used, how helpful it has been at reducing distress or providing effective distraction, and identifying new strategies when needed.

Contact Frequency – While an individual remains on the Suicide Safe Care Pathway and receiving services, providers should maintain close contact in order to monitor safety and provide regular support. Individuals identified as "Urgent/High Risk" should receive face-to-face contact at a minimum of every three (3) days. Individuals identified as "Emergent/Moderate Risk" should receive face-to-face contact at a minimum of every

seven (7) days. Face-to-face contact can be with any of the service or support providers and should be communicated to other providers on the team.

Missed Appointments – If an individual on the Suicide Safe Care Pathway misses an appointment without notice, the provider should immediately try to contact the individual to check on their current safety. If the provider is unable to contact the individual immediately, the organization should enact its protocol for missed appointments (see Care Transitions chapter). The organization should use various strategies to ensure the individual (or a caring other) is reached the same day.

Exiting the Suicide Safe Care Pathway – Individuals will remain on the Suicide Safe Care Pathway until they meet the following criteria:

- Two (2) consecutive C-SSRS assessments at low risk,
- Fewer than two (2) crisis contacts within the past two (2) months, and
- No recent hospital discharge due to suicidal ideation or behavior (within past 3 months).

Individuals exiting the Pathway should continue to be screened at regular intervals with the C-SSRS and continue with any suicide-specific treatments until discharge is clinically indicated. Exiting the Pathway does not indicate that the issues that contributed to elevated risk are resolved, but instead indicates intensive management may not be necessary.

Quality Management

Organizations should create reporting processes to monitor the extent to which providers are able to adhere to the Suicide Safe Care Pathway guidelines. Staff supervisors and program managers should monitor provider adherence. Lack of adherence may be due to a number of factors, so supervisors should strive to address barriers to adherence with care providers. Agencies will need to ensure that productivity standards reflect the increased demands related to monitoring/treating individuals on the Suicide Safe Care Pathway and allow for the additional contacts required.

Examples of quality management indicators that should be tracked to monitor adherence to the Suicide Safe Care Pathway include:

- Percent of individuals correctly identified for Pathway (unless electronic);
- Percent of individuals with same day safety plan at Pathway entry;
- Percent of individuals receiving counseling on access to lethal means on same day as Pathway entry;
- Percent of contacts with documented C-SSRS;
- Percent of contacts with review of safety plan;
- Percent of individuals in Crisis Services with contact every 3 days;
- Percent of individuals maintained on Pathway until engaged in care (3 visits) or assessed at low risk;
- For individuals referred to LMHA services, percentage of times initial appointment is within 24 hours of referral;
- For moderate risk, percent of individuals with contact every 7 days;

- For high risk, percent of individuals with contact every 3 days;
- Hours to contact after missed appointment; and
- Percent of individuals re-engaged in care after missed appointment.