

Suicide Safe Care Pathway – Crisis or Intake

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 Service Package 0 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 Service Package 5. 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 Service Package 5.

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).

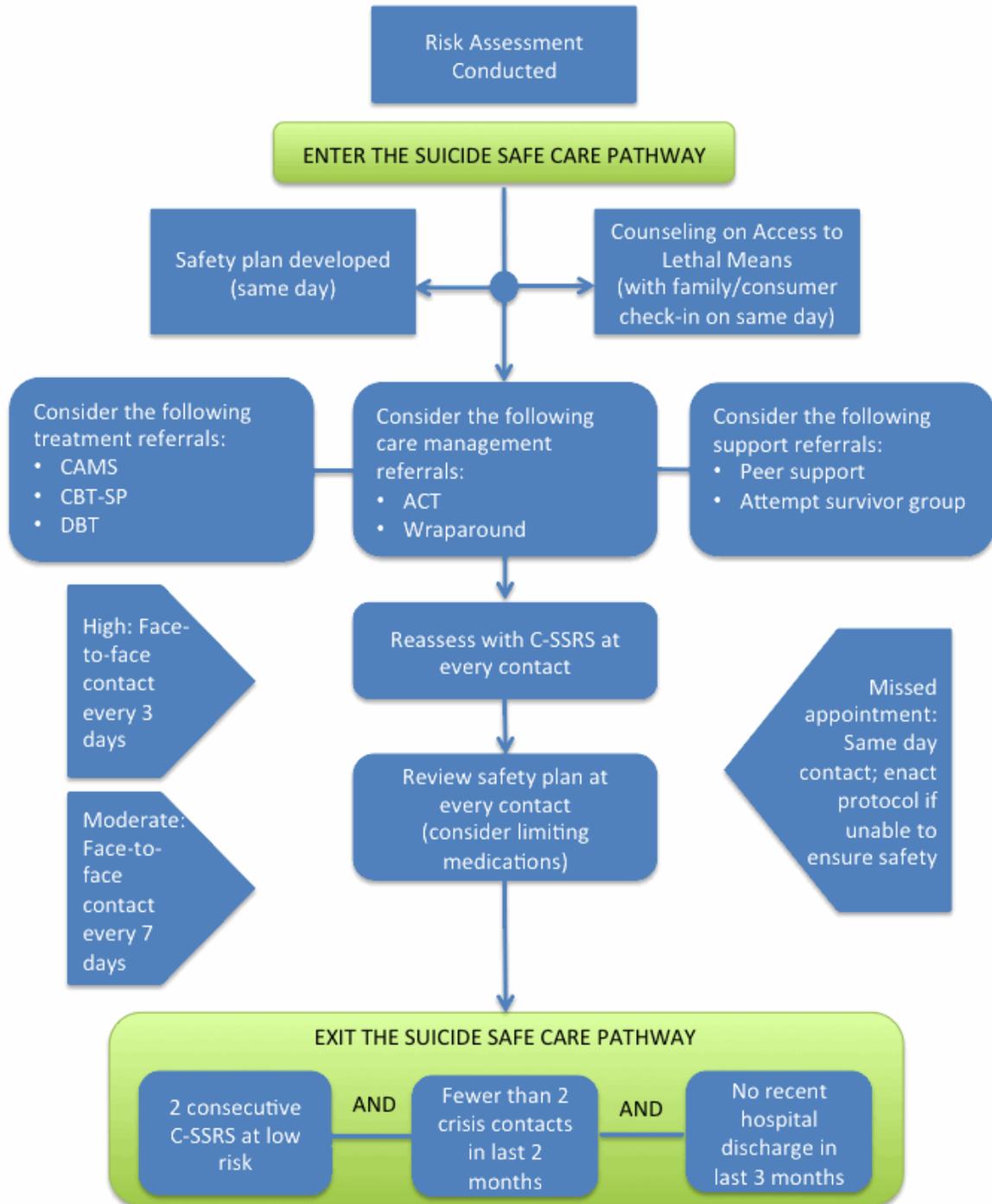
Referral into LMHA Services – For individuals who are referred for services within the LMHA, priority scheduling is important. Whenever possible, the crisis provider should provide a warm transfer to the intake provider to complete the eligibility assessment, person-centered planning, and initial service 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 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



Suicide Safe Care Pathway – Engaged in Care

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.