Vermont Program for Quality in Health Care, Inc.

# ESSENTIAL ELEMENTS OF A SUICIDE CARE PATHWAY

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**A. Care pathway elements.** A typical pathway in acute care must include the following performance elements, including being specific about who (what role?) completes each component, when it is completed, and how it is documented. This presumes that a complete environmental safety assessment has already been completed, and treatment locations have already been designated as ligature resistant or not. Pathways may differ based on ligature resistant status and location of care (medical vs mental health area). When this is the case, the specifics associated with the care pathway should be clear. Care pathways should be informed by people with lived experience; should be flexible to allow patient-centered, compassionate care; and should enhance, not over-ride, clinician judgement. Alterations to the care pathway for an individual patient should be documented as part of care decision making.

**1. Evidence-based screening.** Initial screening using an evidence-based screening tool should be completed. The care pathway should:

1. Clearly identify which patients are to be screened, including if it is clinically indicated (those with mental health presenting complaints) or universal (all comers);
2. Who (what role) will do the initial screening;
3. When the screening will be done, e.g., triage vs initial assessment;
4. The instrument to be used, including whether different instruments will be used for different age groups and settings; and
5. How and where the screening should be documented in the record.

Ideally, the initial screening will lead to risk stratification, such as negligible, mild, moderate, or high risk. This initial screening is primarily for triage purposes and is conservative. Secondary screening or brief assessment by a trained clinician, such as the emergency physician, social worker, or mental health professional, can also happen to help further define or modify the individual's risk strata in situ.

**Examples of evidence-based screening tools include:**

- PHQ-9
- C-SSRS Triage Version (aka C-SSRS Screener)
- National Suicide Prevention Lifeline Risk Assessment Standards
- The Patient Safety Screener
- ASQ Suicide Risk Screening Tool

**2. Mitigation.** Safety precautions for those who screen positive should be deployed, tailored to the individual's risk level, with a primary focus on those who are designated "high" risk. This includes, when appropriate, making the environment (treatment location) safe, observation, and restricting access to lethal means (e.g., clothing that could be used as a ligature).

**3. Suicide risk assessment.** The suicide care pathway should define who gets a comprehensive suicide risk assessment by a trained professional. This assessment should lead to a risk formulation and can be used to change the risk strata and mitigation procedures. It should consider acute vs. chronic risk and in situ risk within treatment locations, such as EDs and medical units vs. in the community.

Examples of evidence-based risk assessment tools include:

- SAFE-T
- C-SSRS Risk Assessment Version
- C-SSRS Severity Rating Scale Baseline Version
- Scale for Suicide Ideation – Worst (SSI-W; Beck et al., 1997)
- Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991)
- Assessment and Management of Suicide Risk (AMSR)

**4. Interventions.** Brief interventions can help decrease suicide risk, help patients manage suicide-related symptoms after discharge, and promote continued engagement with treatment. These interventions include safety planning, Counseling on Access to Lethal Means (CALM), and other emerging interventions, like JASPR. Pathways should stipulate who should get the intervention, who delivers the intervention, and how interventions are documented.

> *Notes on safety planning: When feasible safety planning should include family or other caregivers that might be helping to support the individual, such as group home personnel. Collaborative safety planning should occur prior to discharge from any acute care setting (ED, medical inpatient unit, mental health inpatient unit).*

Examples of evidence-based interventions:

- Stanley-Brown Safety Plan
- Counseling on Access to Lethal Means (CALM)
- JASPR

In addition, a site should consider if additional evidence-based interventions will be provided, such as Collaborative Assessment and Management of Suicidality or Cognitive Behavioral Therapy for Suicidal Ideation. *This is primarily relevant to inpatient mental health units.*

**6. Care transitions.** Communication of risk across settings and locations of care should be defined in the pathway, including when moving from the ED to medical units, within medical units (ICU to acute care), from medical units to inpatient psychiatric units, and from acute care settings to outpatient settings.

**7. Discharge planning.** Discharge planning should include consideration of resources to further mitigate suicide, including outpatient mental health services, crisis resources, and suicide prevention resources, like 988. To the greatest extent possible, the discharge plan should be specific, and delivered in a format that is understandable and health-literacy appropriate. Medical (primary care), mental health, and social service follow-up should be considered. Appointments for follow-up should be scheduled before discharge when possible.

**8. Post-discharge follow-up.** Post-discharge follow-up contact should be carefully considered. Caring contact post cards and post-visit telephone follow-up calls are options. The care pathway should identify who is responsible for the cards/calls, content of the cards/calls, frequency, and time window(s).

**9. Outpatient.** Care pathways in outpatient care can be built based on the same basic principles described above. They can either be initiated in outpatient settings or care pathways initiated in acute care can be transitioned to outpatient care. For example, an outpatient care pathway should create a new safety plan for an at-risk individual or state how an already established safety plan created in acute care will be reviewed and updated as needed in outpatient care. In addition, outpatient care pathways should consider:

1. Stipulating criteria for coming "on" and "off" the pathway;
2. Identifying the frequency of re-assessment and adjustment of care pathways;
3. Identifying frequency of appointments with medical and mental health provider; and/or
4. Identifying actions taken if a patient on the pathway cancels or no-shows an appointment.

All of these actions should be tailored to the patient's suicide risk strata.