



Working together to improve health care quality, outcomes, and affordability in Washington State.

Suicide Care Report and Recommendations

2018

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Executive Summary

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs.

Suicide is both a preventable outcome and a public health issue. The effect of a suicide on family members, friends, and clinical providers is long-lasting and profound. Rates of suicide are higher among those who are non-Hispanic American Indian/Alaska Native, middle-aged adults, and veterans and other military personnel and show great geographic variation. Sexual minority youth (i.e., those who identify as lesbian, gay, bisexual, transgender, or queer) show higher rates of thoughts about suicide and suicide attempts. The rate of suicide in Washington State is higher than the national average.

The workgroup worked closely with and built from the [Washington Suicide Prevention Plan](#) released in January 2016 and the previous Bree Collaborative [recommendations on integrating behavioral health into primary care](#) released in March 2017. Recommendations are applicable to in- and out-patient care settings including for care transitions, behavioral health providers and clinics, and for specialty care (e.g., oncology) around the following focus areas:

- Identification of Suicide Risk
- Assessment of Suicide Risk
- Suicide Risk Management
- Suicide Risk Treatment
- Follow-up and Support After a Suicide Attempt
- Follow-up and Support After a Suicide Death

The workgroup’s goal is integration of implementable standards for suicide care, assessment, management, treatment, and supporting suicide loss survivors into clinical care pathways.

Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Suicide is a leading cause of death nationally with certain groups at higher risk. The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from February to September 2018.

See **Appendix B** for the Suicide Prevention and Care workgroup charter and a list of members.

See **Appendix C** for results of the Guideline and Systematic Review Search Results.

Purpose Statement

Suicide is both a preventable outcome and a public health issue.¹ The effect of a suicide on family members, friends, and clinical providers is long-lasting and profound.^{2,3} Rates of suicide have increased in nearly every state from 1999 to 2016 with a 19% increase in Washington State.⁴ Suicide is the second leading cause of death among those aged 15-34 and the fourth leading cause of death among those aged 35-44, resulting in approximately one death every twelve minutes.^{5,6} Rates of suicide are higher among those who are non-Hispanic American Indian/Alaska Native, middle-aged adults, those who live in rural areas, and veterans and other military personnel and show great geographic variation.^{4,6,7} Sexual minority youth (i.e., those who identify as lesbian, gay, bisexual, transgender, or queer) show higher rates of thoughts about suicide and suicide attempts.⁸ The rate of suicide in Washington State is higher than the national average and over 75% of all violent deaths in Washington State are suicides.⁹ Almost half of all deaths by suicide involve firearms with suffocation at 24% and poisoning at 19% followed by falls and jumps, cutting and piercing, drowning, and other all under 5%.⁹

Suicide is a response to multiple internal (e.g., depression, substance abuse) and external factors (e.g., lack of social support, financial stress).¹⁰ Emerging evidence supports suicidality as independent from other mental health diagnoses (e.g., depression, anxiety) necessitating treatment specifically for suicidal thoughts and behaviors.¹¹ Approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period.^{12,13,14} Episodes of major depressive disorder typically last 16 weeks, almost all being clinically significant.¹¹ Economic recession appears to be associated with increases in behavioral health disorders, substance use disorders, and suicidal behavior.¹⁵

Within the last month prior to suicide, approximately 45% of those who die by suicide had contact with primary care.¹⁶ Screening for and comprehensive access to treatment for depression have been shown to occur infrequently and health delivery systems have not typically supported the infrastructure necessary to provide this care.¹⁷ Additionally, best practice care management processes are used less often for depression and other behavioral health diagnoses than for asthma, diabetes, or congestive heart failure in primary care, showing a gap both in comprehensive assessment and evidence-based, supportive treatment.¹⁸

The United States Preventive Services Task Force does not currently recommend suicide risk screening in primary care but does recommend depression screening in primary care.^{19,20} However, the patient health questionnaire-9 questions (PHQ-9) includes a question that has been shown to be a predictor of a subsequent suicide attempt (i.e., *Over the last 2 weeks, how often have you been bothered by any of the following problems? Thoughts that you would be better off dead, or of hurting yourself*).^{21,22} The Joint Commission recommends screening for suicidal ideation.²³ Washington State requires that healthcare providers (i.e., therapists, counselors, social workers, chiropractors, naturopaths, physicians, physical therapists, pharmacists, nurses, physician assistants and osteopathic physicians, surgeons and physician assistants) take an approved suicide prevention course as part of continuing education requirements.²⁴ High unmet need, the siloed nature of behavioral health and physical health care, and barriers with payment, regulatory, and legal systems involved in health care delivery were identified in the 2001 Institute of Medicine Crossing the Quality Chasm series as contributing to low-quality care.²⁵

Recommendation Focus Areas

The workgroup worked closely with and built from the [Washington Suicide Prevention Plan](#) released in January 2016 and the previous Bree Collaborative [recommendations on integrating behavioral health into primary care](#) released in March 2017. The workgroup's goal is integration of implementable standards for suicide care, assessment, management, treatment, and supporting suicide loss survivors into clinical care pathways. Recommendations are applicable to in- and out-patient care settings including for care transitions, behavioral health providers and clinics, and for specialty care (e.g., oncology) around the following focus areas:

Identification of Suicide Risk	<p>Screen all patients over 13 annually for behavioral health conditions (i.e., mental health, substance use), associated with increased suicide risk using a validated instrument(s), including:</p> <ul style="list-style-type: none"> • Depression • Suicidality (i.e., suicidal ideation, past attempts) • Alcohol misuse • Anxiety • Drug use
Assessment of Suicide Risk	<p>Based on results from identification above, further identify risk of suicide with a validated instrument and identify additional risk factors including:</p> <ul style="list-style-type: none"> • Mental illness diagnosis • Substance use disorder(s) • Stressful life event • Other relevant psychiatric symptoms or warning signs (at clinician's discretion)
Suicide Risk Management	<ul style="list-style-type: none"> • Ensure individuals at risk of suicide have pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment). • Keep patients in an acute suicidal crisis in an observed, safe environment. • Address lethal means restriction (e.g., guns, medications). • Engage patients in collaborative safety planning. • If possible, involve family members or other key support people in suicide risk management.
Suicide Risk Treatment	<ul style="list-style-type: none"> • Use effective evidence-based treatments provided onsite that directly target suicidal thoughts and behaviors rather than focusing on specific mental health diagnoses through integrated behavioral health or off-site with a supported referral. • Document patient information related to suicide care and referrals.
Follow-up and Support After a Suicide Attempt	<ul style="list-style-type: none"> • Ensuring the patient is connected to evidence-based follow-up treatment. • Provide contact and support during transition from inpatient to outpatient sites. • Ensure supported pathway to adequate and timely care, as outlined above (e.g., collaborative safety planning, onsite or referral to offsite behavioral health)
Follow-up and Support After a Suicide Death	<ul style="list-style-type: none"> • Follow-up and support for family members, friends, and for providers involved in care including screening for depression, suicidality, anxiety, alcohol misuse, and drug use.

Do not use these recommendations in lieu of medical advice.

Patients and Family Members

- Talk to your primary care provider or other care team members about a wish to be dead, thoughts of suicide, or thoughts of harming yourself or others.
- Also talk to your primary care provider or other care team members about any mental health concerns, including feeling low or depressed, feeling anxious, concerns about drinking or drug use, or any other concerns about behavioral or physical health.

Primary Care Providers and Behavioral Health Care Providers

- Complete the Washington-state required training on suicide-prevention as part of continuing education requirements. More information from the Washington State Department of Health on the required training is [here](#).
- **Identification of Suicide Risk**
 - Explain to patients the purpose of screening for depression, suicidality, alcohol misuse, anxiety, and drug use including the safety and security of the information.
 - Screen all patients over 13 annually for mental health and substance use conditions, associated with increased suicide risk using a validated instrument(s), including:
 - Depression (e.g. PHQ-2, PHQ-3 and/or PHQ-9)
 - Suicidality (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
 - Alcohol misuse (e.g., AUDIT-C)
 - Anxiety (e.g., GAD-2)
 - Drug use (e.g., ASSIST, DAST-10, single item cannabis and other drug use questions)
- **Assessment of Suicide Risk**
 - Based on results from suicide risk identification above, assess risk of suicide with a validated instrument such as a version of the C-SSRS that assesses suicide intent, current plans and means in varying levels of detail.
 - Assess additional risk factors such as:
 - Presence of mental illness diagnosis (e.g. bipolar disorder, schizophrenia) as identified in the medical record.
 - Severe substance use disorder(s) (e.g., opioid use disorder, severe alcohol use disorder) as identified in the medical record.
 - Asking about any recent experience of a stressful life event (e.g., family or marital conflict, unemployment, social isolation)
 - Other relevant psychiatric symptoms or warning signs (at clinician’s discretion)
- **Suicide Risk Management**
 - Do not use a no-suicide contract. This is no longer supported by evidence.
 - Track “suicide risk” as a separate item in a patient’s problem list when risk factors are present even when suicidal ideation has not been explicitly expressed.
 - Keep patients in an acute suicidal crisis in an observed, safe environment.

- Ensure individuals at risk of suicide have a pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment).
- Address lethal means safety such as asking about safe firearm and medication (e.g. opioids, anxiety, or sleeping medications) storage in the house.
- Engage patients in collaborative safety planning if risk factors are present even if suicidal ideation has not been expressed, including:
 - Warning signs of suicidal crisis.
 - Internal coping strategies (i.e., activities that can be done alone).
 - Socialization strategies for distraction and support.
 - Contact numbers for friends and family members to ask for help.
 - Providing professionals or agencies to contact during crisis, including Suicide Prevention Lifeline 1-800-273-TALK (8255) and local emergency numbers.
 - Treatment strategies may be involved in the safety plan.
- If possible, involve family members or other support people in suicidal risk management.
- **Suicide Risk Treatment**
 - Refer to onsite behavioral health or conduct a supported warm handoff to offsite behavioral health for effective evidence-based treatments that directly target suicidal thoughts and behaviors rather than focusing on specific diagnoses (e.g., depression, anxiety). The interventions with the most robust evidence include:
 - Following-up with a patient by initiating a non-demanding caring contact.
 - Dialectical behavior therapy.
 - Suicide-specific cognitive behavioral therapy.
 - Collaborative assessment and management of suicidality (CAMS).
 - Offer case management services as needed to support suicidal patients in treatment.
 - Document patient information related to suicide care and referrals.
 - The Joint Commission recommends the provider(s) to *“Document why the patient is at risk for suicide and the care provided to patients with suicide risk in as much detail as possible, including the content of the safety plan and the patient’s reaction to and use of it; discussions and approaches to means reduction; and any follow-up activities taken for missed appointments, including texts, postcards, and calls from crisis centers.”*
- **Follow-up and Support After a Suicide Attempt**
 - Ensure the patient is connected to evidence-based follow-up treatment.
 - Provide contact and support during transition from an inpatient to outpatient setting.
 - Refer to peer support specialists after inpatient care, if available.
 - Assess suicide risk at every visit within the same organization or between organizations as care is transitioned.
 - Ensure supported pathway to adequate and timely care, as outlined above using:
 - Collaborative safety planning
 - Onsite or referral to evidence-based treatments.
 - Case management.
 - Documentation.

Specialty Care (e.g., Oncology)

- **Identification of Suicide Risk**
 - Explain to patients the purpose of screening for suicide risk including for depression, alcohol misuse, anxiety, and drug use including the safety and security of the information.
 - Screen all patients over 13 annually for mental health and substance use conditions, associated with increased suicide risk using a validated instrument(s), including:
 - Depression (e.g. PHQ-2, PHQ-3 and/or PHQ-9).
 - Suicidal ideation (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
 - Alcohol misuse (e.g., AUDIT-C).
 - Anxiety (e.g., GAD-2).
 - Drug use (e.g., ASSIST, DAST-10, single item cannabis and other drug use questions).
- Refer to primary care for further assessment of suicide risk, if warranted.

Care Settings (including Primary Care Practices, Hospitals, Health Systems)

- **Integrating Behavioral Health**
 - Ideally behavioral health concerns will be addressed in primary care through integrated behavioral health diagnoses for whom accessing services through primary care would be appropriate as outlined in the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#).
 - Review and follow the recommendations above including those to primary care practices (e.g., *Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff, At a minimum, ensure that for each patient with an identified behavioral health need, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.*)
- **Identification and Assessment of Suicide Risk**
 - Display crisis line information and suicide prevention materials. Give them to patients and their supporters at appointments or interventions relevant to suicide, including discharge after a suicide attempt.
 - Clarify clinical roles and workflow related to suicide care (e.g., which staff members will participate in suicide risk identification, assessment, management, and treatment and how this care will be coordinated).
 - Train clinicians and staff how to identify and respond to patients who exhibit suicidal ideation. Use resources such as the Suicide Prevention and the Clinical Workforce: Guidelines for Training from the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention, available [here](#).
 - Build screening for depression, suicidality, alcohol misuse, drug use, and anxiety into the clinical pathway using a validated instrument.
 - Track a patient's scores on the above within the electronic health record.
 - Track "suicide risk" as a separate problem on a patient's problem list in the electronic health record.

- Display preventive messaging around safe storage of firearms and medication.
- **Suicide Risk Management and Treatment**
 - Develop a care protocol for patients who present in an acute suicidal crisis keeping the patient in a safe environment under observation.
 - Train staff on how to conduct a collaborative safety plan.
 - If not available onsite, facilitate access to psychiatric consultation services in a systematic manner to assist the care team in offering effective evidence-based suicide care the same day as much as possible.
 - For emergency departments:
 - Keep patient in a safe environment under observation assuring absence of lethal means.
 - Evaluate patient for acute risk (e.g., using the C-SSRS, or Patient Safety Screener (PSS-3)).
 - Complete a collaborative safety plan as outlined previously.
 - Contact primary care for follow-up and behavioral health care provider(s) (if known).
- **Follow-up and Support After a Suicide Death**
 - Provide follow-up and support for family members of someone who has died by suicide.
 - Follow the identification protocols outlined for patients including offering screening for suicidality, depression, anxiety, alcohol misuse, and drug use.
 - Offer referrals to onsite behavioral health, if available, or a supported warm handoff to offsite behavioral health.
 - Provide follow-up and support for providers involved in the care of a patient who has died by suicide.
 - Offer screening for suicidality, depression, anxiety, alcohol misuse, and drug use.
 - Offer referrals to onsite behavioral health, if available, or a supported warm handoff to offsite behavioral health.
 - Consider incorporating elements of a just culture, as used by the Henry Ford System in the Zero Suicide philosophy, focusing on a non-punitive learning environment coupled with accountability.
 - The Suicide Prevention Resource Center outlines how care delivery systems can respond to a patient suicide [here](#).

Health Plans

Partially adapted from SAMHSA's *ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers*²⁶

- Reimburse for Medicare primary care providers participating in a collaborative care program or receiving other integrated behavioral health services as outlined in CMS Federal Register Final Rule for Docket Number CMS-1654-F (e.g., G0502, G0503, G0504).
- Work with health care purchasers to identify and provide data on outcome measurements relevant to their population to better ensure treatment efficacy and patient access (e.g., NCQA behavioral health treatment within 14 days, NCAQ anti-depressant medication management).
- Develop and maintain strong, respectful relationships with practices including sharing information, decision-making, costs, and savings as appropriate.
- Review reimbursement structures for clinical services involved in suicide care that currently have no or low levels of reimbursement.

Employers

- When designing benefits, work to eliminate inadvertent barriers to behavioral health care services and integrating care for employees including equalizing benefit structures for behavioral health and physical health care.
- If an employee assistance program is offered, promote employee understanding of behavioral health benefits including suicidality.
- Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction, interventions around alcohol consumption).

Washington State Health Care Authority

- Certify patient decision aids around treatment options for common behavioral health conditions (e.g., depression, anxiety, alcohol use, substance abuse).

Table 1: Implementing Suicide Care Recommendations		
Focus Area	Patient Perspective	Pathway to Implementation
Identification of Suicide Risk	<i>I am asked about depression, any thoughts I may have of harming myself, alcohol and drug use, and anxiety at my first visit and at least annually thereafter. I understand why I am being asked these questions and feel comfortable talking to my doctor about my feelings.</i>	<p>Usual Care: The patient’s risk of suicide is not assessed or is occasionally assessed. There is no information available that shows if a patient has ever made a suicide attempt or been asked behavioral health questions that may be related to a suicide attempt even if this has occurred from a visit with another provider.</p> <p>Steps Toward Implementation: Screening for suicide risk is incorporated as a pilot for selected group(s) of patients. Patients may only be identified through an explicit question or questions about suicidal ideation or through being identified as having depression.</p> <p>Optimal Care: All patients are screened for suicidality using validated tools (e.g., question 9 of the PHQ-9, the first two questions of the Columbia Suicide Severity Rating Scale (C-SSRS)) and being asked about any previous suicide attempts as well as for depression, anxiety, alcohol misuse, and drug use. Patients are actively involved in their own care.</p>
Assessment of Suicide Risk	<i>I understand that if I do have thoughts about harming myself, my care team will ask me questions to help them better understand the risk that I will hurt myself.</i>	<p>Usual Care: Further assessment of suicide risk may be lacking and/or providers may be unsure how best to address the risk factors identified in the initial identification. There may be a lack of training or a lack of a clinical pathway that includes behavioral health.</p> <p>Steps Toward Implementation: Patients who are identified at a higher suicide risk may only receive screening with a tool directly asking about suicide risk rather than a more comprehensive assessment looking at additional risk factors.</p> <p>Optimal Care: If a patient does exhibit risk for suicide, either through screening positive for suicidal ideation or showing higher risk in another area such as high anxiety or depression, the patient is asked additional questions about suicide risk such as the complete six question C-SSRS or another validated instrument. In addition, the provider checks the patient record for a diagnosis of a mental health disorder and/or a severe substance abuse disorder and asks the patient about any stressful life events. Other warning signs as identified by the provider may also lead to next steps of managing suicide risk through a collaborative safety plan.</p>

<p>Suicide Risk Management</p>	<p><i>If my screening results suggest that I may be at a higher risk for suicide I am assessed that same visit for acute risk, I am engaged in collaborative safety planning.</i></p>	<p>Usual Care: Staff may be uncertain as to next steps after a patient risk for suicide has been identified. Referrals to offsite behavioral health may be made but not in such a way that supports the patient who may fall out of care.</p> <p>Steps Toward Implementation: Providers and staff receive training on how to conduct a collaborative safety plan. The role of staff members is clearly defined, understood by all, and effectively communicated to the patient.</p> <p>Optimal Care: After suicide risk has been identified and assessed, providers or other staff focus on mitigating imminent risk. Providers or staff have a conversation about addressing lethal means safety such as asking about safe firearm and medication storage in the house. Patients receive collaborative safety planning in the clinical visit or through a same-day conversation with another staff such as a social worker in which the patient and staff discuss the warning signs of a suicidal crisis, developing internal coping strategies, socialization strategies for distraction and support, contact numbers for friends and family members to ask for help, and information about professionals or agencies to contact during a crisis. Treatment strategies may be involved in the safety plan.</p>
<p>Suicide Risk Treatment</p>	<p><i>I receive onsite evidence-based suicide treatments or receive a supported referral to offsite behavioral health. I understand the reasons for the type of treatment that I receive.</i></p>	<p>Usual Care: Patients may be stuck in a cycle of collaborative safety planning instead of receiving comprehensive, effective, and evidence based treatment that directly targets suicidality due to lack of onsite behavioral health or lack of a referral pathway supporting the patient. Additionally, if a referral is made, the patient may not follow-through with care.</p> <p>Steps Toward Implementation: Integrated behavioral health or a referral pathway is developed that supports the patient. Providers clearly understand the different roles for staff.</p> <p>Optimal Care: The patient receives case management and a supported warm handoff to offsite behavioral health or same-day referrals to onsite behavioral health. Treatment for suicide risk directly targets suicidality and any other identified behavioral health issues. Treatment follows an evidence-based framework such as following-up with a patient by initiating a non-demanding caring contact, dialectical behavior therapy, suicide-specific cognitive behavioral therapy, and/or collaborative assessment and management of suicidality (CAMS).</p>

<p>Follow-up and Support After a Suicide Attempt</p>	<p><i>After a suicide attempt I am connected with my primary care provider(s) and/or behavioral health. I receive evidence-based treatment.</i></p>	<p>Usual Care: After a suicide attempt, the patient may not receive any follow-up. Risk of a subsequent suicide attempt is high.</p> <p>Steps Toward Implementation: Protocols are in place to support patients after a suicide attempt, but may be inconsistently applied. Patients may be connected with primary care and with treatment in some cases.</p> <p>Optimal Care: Patients are fully supported after a suicide attempt. They are directly connected with primary care and with behavioral health care provider(s) (if known). Primary care provides contact and support through the transition from inpatient to an outpatient setting. Patients may be referred to peer support specialists and suicide risk is assessed at every visit. Patients receive collaborative safety planning, evidence-based treatment, and case management. Providers document the care given to patients and feel comfortable at all steps along the pathway.</p>
<p>Follow-up and Support After a Suicide Death</p>	<p><i>After my family member has died by suicide, I am supported by primary care and asked questions about behavioral health concerns. I am offered a referral to behavioral health and know how to access care.</i></p>	<p>Usual Care: Family members and providers involved the care of someone who dies by suicide have no follow-through or support.</p> <p>Steps Toward Implementation: Family members may receive some outreach from a care provider but no options to talk about their own feelings or any referral to behavioral health.</p> <p>Optimal Care: Primary care provides follow-up and support for family members of someone who has died by suicide. Family members are offered screening for suicidality, depression, anxiety, alcohol misuse, and drug use and a referral to onsite or offsite behavioral health. Issues such as guilt and blame are addressed in behavioral health. Providers who were involved in the care of someone who died by suicide are also supported and offered screening and behavioral health interventions. The clinic considers incorporating elements of a just culture into the overarching culture. Peer support for both family members and providers is offered.</p>

Recommendation Details

Identification and Assessment of Suicide Risk

The workgroup recommends screening all patients over age 13 annually for both depression and for suicidal ideation using a validated instrument, but does not specify or require a specific instrument as multiple instruments have been used in clinical practice.

The patient health questionnaire nine question (PHQ-9) is widely used in practice to assess severity of depression. The ninth item on the PHQ-9, *Over the last 2 weeks, how often have you been bothered by any of the following problems? Thoughts that you would be better off dead, or of hurting yourself*, has been associated with elevated risk of suicide over the subsequent two years, however 39% of suicide attempts within 30 days of answered “not at all.”²⁷ Recent research suggests that adding additional patient-specific factors (e.g., prior suicide attempts, mental health and substance use diagnoses, medical diagnoses, psychiatric medications dispensed, inpatient or emergency department care) to PHQ-9 scores better predicts risk of suicide among primary care and specialty behavioral health.²⁸ The Ask Suicide-Screening Questions (ASQ) shows high sensitivity in pediatric emergency departments and may be better suited to children and adolescents, however the PHQ-9 has also been validated in adolescent populations.^{29,30,31}

The Columbia Suicide Severity Rating Scale (C-SSRS) assesses risk for suicide and steps providers can take or level of support needed. The C-SSRS is widely used and been tested with good results in multiple populations (e.g., diagnoses, practice locations, ages).³² Other tools to screen and assess for suicide risk include:³³

- Behavioral Health Measure-10® (BHM-10®)
- Behavioral Health Screen (BHS)
- Brief Symptom Inventory 18® (BSI 18®)
- Outcome Questionnaire 45.2® (OQ-45.2®)
- Suicide Behavior Questionnaire-Revised (SBQ-R)
- M-3 Checklist™
- Reasons for Living (RFL)
- Patient Safety Screener (PSS-3)

The workgroup also recommends screening for alcohol misuse, drug use, and anxiety as these have also been associated with suicide risk independent of depression. The Alcohol Use Disorders Identification Test (AUDIT) is designed to screen for low to moderate alcohol use with ten questions, and has been validated across many populations.³⁴ The AUDIT-C is a shorter three-item version of the full AUDIT instrument to identify hazardous drinking or alcohol use disorder, including alcohol abuse or dependence and has been validated in primary care settings for men and women.^{35,36,37} The Bree Collaborative also developed [recommendations around integrating the Screening, Brief Intervention, and Referral to Treatment \(SBIRT\) model into primary care, prenatal, and emergency room settings](#) in January 2014. SBIRT is an evidence-based paradigm seeking to encourage health care providers to systematically “*identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.*”³⁸ The workgroup recommends that all patients be screened for alcohol and drug use and if positive, be offered brief intervention onsite and referral to treatment if alcohol misuse and drug use is

severe. The Generalized Anxiety Disorder scale (GAD-7) has seven items with a shorter two-item version (GAD-2) that has been validated in primary care settings.³⁹

Suicide Risk Management

The workgroup recommends that once suicide risk has been identified and assessed, providers and staff should mitigate imminent risk and support the patient along a pathway to timely and adequate care as indicated by the assessment.⁴⁰ Ideally behavioral health concerns will be addressed in primary care through integrated behavioral health diagnoses for whom accessing services through primary care would be appropriate as outlined in the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#). High-quality behavioral health care should draw from trauma-informed care appropriate to an individual as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) [here](#).

For patients at risk for suicide, the workgroup recommends engaging the patient in collaborative safety planning, a brief intervention in which the patient develops a plan to remain safe. Safety planning can be conducted in multiple settings (e.g., primary care, in- and out-patient behavioral health, emergency department).²³ Note, this is not a no-suicide contract which is no longer supported by evidence. Key components should include:⁴¹

- Recognition of warning signs of a suicidal crisis
- Addressing lethal means restriction (e.g. safe firearm and medication storage)
- Internal coping strategies
- Socialization strategies for distraction and support
- Contact numbers for friends and family members to ask for help
- Professionals/agencies to contact during crisis, including Suicide Prevention Lifeline 1-800-273-TALK (8255) and local emergency numbers

Lethal means reduction was a key part of the Henry Ford Perfect Depression Care initiative. The Henry Ford Health System launched a Perfect Depression Care initiative in 2001 with the goal of eliminating suicide among members.⁴² Key strategies to eliminate suicide included improving access to care (e.g., drop-in group visits, same-day evaluations by a psychiatrist, and department-wide certification in cognitive behavior therapy), restricting access to lethal means of suicide (e.g., protocol for weapons removal), eliminating suicide screens and risk stratification, assuming that every patient with mental illness has an increased risk of suicide, under the banner of a just culture (i.e., no punishment for not achieving zero suicides). The rate of suicide decreased by 75% from approximately 89 to 22 per 100,000.⁴³

Suicide Risk Treatment

Hospitalizations after identification of suicide risk or referrals for mental health treatment are often not sufficient or timely enough to address patient need. Risk of suicide after discharge from the hospital are high and underlying needs are often not addressed.⁴⁴ Many patients do not complete their referral for behavioral health.⁴⁵

After collaborative safety planning, the workgroup also recommends using effective evidence-based treatments that directly target suicidal thoughts and behaviors instead of just targeting diagnoses (e.g., depression, anxiety).¹¹ This can be accomplished onsite or through a warm handoff to offsite behavioral health. All care providers should have access to the care plan. The interventions with the most robust evidence include:

- Following-up with a patient by initiating a non-demand caring contact especially for patients who reject treatment (e.g., postcard, phone call, text message) to show that patients have not been forgotten⁴⁶
- Dialectical behavior therapy that includes:⁴⁷
 - Mindfulness
 - Distress tolerance
 - Interpersonal effectiveness
 - Emotion regulation
- Suicide-specific cognitive behavioral therapy to internalize specific skills related to cognition, behavior, and interacting with others.^{48,49} Cognitive behavioral therapy and dialectical behavioral therapy share many components.
- Collaborative assessment and management of suicidality (CAMS) is a flexible care framework with the patient being involved in developing the treatment plan delivered in an outpatient setting shown to reduce suicidal ideation and distress.^{50,51}
 - Learn more about CAMS [here](#).

These interventions can be done through a supported referral to specialty care. More information about evidence-based interventions can be found on the Zero Suicide website [here](#) including a video outlining the interventions listed above.

Additionally, the Joint Commission's 2016 Sentinel Event Alert on suicide encourages the evidence-based interventions outlined above that engage patients, use collaborative assessment and treatment planning, utilize problem-focused clinical intervention to target suicidal "drivers," and actively train and also care such as:²³

- *Engaging the patient and family members/significant others in collaborative discharge planning to promote effective coping strategies.*
- *Discussing the treatment and discharge plan with the patient and sharing the plan with other providers having responsibility for the patient's well-being.*
- *Determining how often patients will be called and seen.*
- *Establishing real-time telephone or live contact with at-risk patients who don't stay in touch or show up for an appointment, rather than having staff or resources just leave reminder messages or emails.*
- *Directly addressing patients' thoughts about suicide at every interaction.*
- *Using motivational enhancement to increase the likelihood of engagement in further treatment.*

Follow-up and Support After a Suicide Attempt

A previous suicide attempt is highly predictive of a subsequent suicide attempt even many years after the initial attempt.^{29,52} For patients who have attempted suicide, the workgroup strongly recommends providing contact and support during transition from the in-patient to out-patient setting if the patient has been hospitalized. Suicide risk should be assessed at every visit within the same organization and also between organizations during transitions of care. After the patient has been stabilized, care should follow the (1) suicide risk management and (2) evidence-based behavioral health treatment as outlined above.

Follow-up and Support After a Suicide Death

Family members and friends of someone who dies by suicide are at an increased risk for depression, post-traumatic stress disorder, and are themselves at higher risk for suicide.⁵³ A suicide death can also be traumatic to the provider(s) and care team.

For family and friends

Family and friends who have lost a loved one to suicide should be screened for depression, suicidal ideation, alcohol misuse, drug use, and anxiety using a validated instrument as described above. Supported referrals to behavioral health providers may also be helpful with inclusion of addressing depression and any guilt or trauma experienced as a result of the suicide.

Support groups have been found by survivors of suicide loss to be helpful.⁵⁰ The American Foundation for Suicide Prevention lists practical information for family and friends immediately after a loss [here](#) and support groups by state [here](#). Additional resources on healing and hope after a suicide are available [here](#). Resources from the American Association of Suicidality can be found [here](#).

For providers

A death by suicide can also be traumatic to the providers and care team. Providers should also be offered to be screened for suicidal ideation, depression, alcohol misuse, drug use, and anxiety and supported through their process. Referrals to additional behavioral health supports should also be offered. The American Association of Suicidality lists resources for clinicians who have lost a patient to suicide [here](#). The workgroup also recommends considering incorporating elements of a just culture, as used by the Henry Ford System in the Zero Suicide philosophy, focusing on a non-punitive learning environment coupled with accountability.

Behavioral Health Integration Recommendations (March 2017)

This Report and Recommendations is focused on integrating behavioral health care services into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate. The workgroup used available evidence and existing models to develop eight common elements that outline a minimum standard of integrated care. These eight elements are meant to bridge the different models used throughout Washington State and across the country and include:

- Integrated Care Team
 - Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, understand their roles and participate in typical practice activities in-person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.
- Patient Access to Behavioral Health as a Routine Part of Care
 - Access to behavioral health and primary care services are available on the same day as much as feasible. At a minimum, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
- Accessibility and Sharing of Patient Information
 - The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. Clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.
- Practice Access to Psychiatric Services
 - Access to psychiatric consultation services is available in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan. For patients with more severe or complex symptoms and diagnoses, specialty behavioral health services are readily available and are well coordinated with primary care.
- Operational Systems and Workflows to Support Population-Based Care
 - A structured method is in place for proactive identification and stratification of patients for targeted conditions. The practice uses systematic clinical protocols based on screening results and other patient data, like emergency room use, that help to characterize patient risk and complexity of needs. Practices track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.
- Evidence-Based Treatments
 - Age language, culturally, and religiously-appropriate measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving. The goal of treatment is to provide strategies that include the patient's goals of care and appropriate self-management support.
- Patient Involvement in Care

- Patient goals inform the care plan. The practice communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning. Patient activation and self-care is supported and promoted.
- Data for Quality Improvement
 - System-level data regarding access to behavioral care, the patients' experience, and patient outcomes is tracked. If system goals are not met, quality improvement efforts are employed to achieve patient access goals and outcome standards.

WA Suicide Prevention Plan (January 2016)

The Washington Suicide Prevention Plan released in January 2016 to coincide with Governor Inslee's Executive Order 16-02 on firearm fatality and suicide prevention includes three strategic directions including two that overlap with these recommendations. Each strategic direction is supported by goals. Read the plan [here](#).

- Put comprehensive suicide prevention programming in place, train the general public and health professionals, restrict access to lethal means, publicize resources
 - GOAL: Designated health professions are trained in suicide assessment, treatment and management.
 - GOAL: Screening for and limiting access to lethal means is conducted to reduce suicide risk for people in crisis.
 - Train primary care and behavioral health professionals to integrate lethal means counseling into routine and acute care and discharge procedures.
 - GOAL: Community members are aware of local resources, including behavioral health services and crisis lines.
 - Widely market existing local behavioral health resource guides and databases, and how to find and use them
 - Display crisis line information and suicide prevention materials in primary care, behavioral health and emergency department settings. Give them to patients and their supporters at appointments or interventions relevant to suicide, including discharge after a suicide attempt.
- Expand access to care for people at risk, improve continuity of care, involve the patient's chosen support network and engage in postvention
 - GOAL: Access to mental healthcare, substance abuse treatment and crisis intervention services is expanded.
 - Use systems approaches (such as case management, electronic health record alert systems and patient care coordinators) to improve timely and effective care for patients at risk.
 - GOAL: Emergency departments and inpatient units provide for the safety, well-being and continuity of care of people treated for suicide risk.
 - Continuity of care and peer support.
 - GOAL: Families and concerned others are involved, when appropriate, throughout a person at risk's entire episode of care.
 - Educate health and social service providers on involving a self-defined care network in suicide-related treatment.

Measurement

Healthcare Effectiveness Data and Information Set

The Centers for Medicare and Medicaid Services adopted behavioral health measures for Accountable Care Organizations in 2016 focused on depression readmission or response at 12 months.⁵⁴ The National Committee for Quality Assurance recently developed Healthcare Effectiveness Data and Information Set (HEDIS) measures for 2017 that include expectation of depression remission and/or response within five to seven months. Studies have supported this shorter time to readmission using evidence-based collaborative care interventions. The Collaborative supports an expectation of depression remission and/or response within five to seven months.

HEDIS 2017 includes two depression-specific measures:

- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- Depression Remission or Response for Adolescents and Adults

The HEDIS measure, *Depression Remission or Response for Adolescents and Adults*, allows health plans to assess and report the percentage of health plan members 12 years and older with a diagnosis of depression who had evidence of response or remission within 5 to 7 months of their initial diagnosis. Remission is documented by a PHQ-9 score less than 5 points and response is indicated by a 50% decrease over the initial PHQ-9 score. This is one of only two measures for which health plans have the option of using an Electronic Clinical Data System (ECDS) such as a registry or other clinical management tracking system in addition to their EHR to capture reporting data. More information can be found here: www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017

[Healthy People 2020](#) includes metrics on the suicide rate for the population at large and for adolescents, on major depressive episodes, on integrated behavioral health, and on access to mental health care.⁵⁵

- **MHMD-1: Reduce the suicide rate**
 - Baseline: 11.3 suicides per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)
 - Target: 10.2 suicides per 100,000 population
 - Target-Setting Method: 10 percent improvement
- **MHMD-2: Reduce suicide attempts by adolescents**
 - Baseline: 1.9 suicide attempts per 100 population occurred in 2009
 - Target: 1.7 suicide attempts per 100 population
 - Target-Setting Method: 10 percent improvement
- **MHMD-4: Reduce the proportion of persons who experience major depressive episodes (MDEs)**
 - MHMD-4.1: Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)
 - Baseline: 8.3 percent of adolescents aged 12 to 17 years experienced a major depressive episode in 2008
 - Target: 7.5 percent
 - Target-Setting Method: 10 percent improvement
 - MHMD-4.2: Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs)

- Baseline: 6.5 percent of adults aged 18 years and over experienced a major depressive episode in 2008
 - Target: 5.8 percent
 - Target-Setting Method: 10 percent improvement
- **MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral**
 - Baseline: 79.0 percent of primary care facilities provided mental health treatment onsite or by paid referral in 2006
 - Target: 87.0 percent
 - Target-Setting Method: 10 percent improvement
- **MHMD-6: Increase the proportion of children with mental health problems who receive treatment**
 - Baseline: 68.9 percent of children with mental health problems received treatment in 2008
 - Target: 75.8 percent
 - Target-Setting Method: 10 percent improvement

Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade, MS	Deputy Director	Washington Health Alliance
Peter Dunbar, MB, ChB, MBA	CEO	Foundation for Health Care Quality
John Espinola, MD, MPH	Executive Vice President, Health Care Services	Premera Blue Cross
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed, MD	Chief Medical Officer	Confluence Health
Richard Goss, MD	Medical Director	Harborview Medical Center – University of Washington
Jennifer Graves, RN, MS	Senior Vice President, Patient Safety	Washington State Hospital Association
Christopher Kodama, MD	President, MultiCare Connected Care	MultiCare Health System
Daniel Lessler, MD, MHA	Chief Medical Officer	Washington State Health Care Authority
Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Mary Kay O’Neill, MD, MBA	Partner	Mercer
John Robinson, MD, SM	Chief Medical Officer	First Choice Health
Terry Rogers, MD (Vice Chair)	Retired	
Jeanne Rupert, DO, PhD	Medical Director, Community Health Services	Public Health – Seattle and King County
Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
Lani Spencer, RN, MHA	Vice President, Health Care Management Services	Amerigroup
Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Shawn West, MD	Family Physician	Edmonds Family Medicine

Appendix B: Suicide Care Charter and Roster

Problem Statement

Suicide rates are increasing due to complex factors and rates within Washington State are higher than the national average.ⁱ Suicide is the second leading cause of death among those aged 15-34, the fourth leading cause of death among those aged 35-44, and results in approximately one death every twelve minutes.^{ii,iii} Approximately 50% of American adults know someone who has died by suicide, increasing the likelihood of anxiety, depression, and post-traumatic stress.^{iv} Suicide rates are higher among those who are male, non-Hispanic white, American Indian/Alaska Native, middle-aged, and veterans.³ Sexual minority youth (i.e., those who identify as lesbian, gay, bisexual, transgender, or queer) show higher rates of suicidal ideation and suicide attempts.^v Suicide is a response to multiple internal (e.g., depression, substance abuse) and external factors (e.g., lack of social support, financial stress) indicating the need to intervene through the health care system.^{vi}

Aim

To develop implementable standards integrating suicide prevention, assessment, management, treatment, and supporting suicide loss survivors into clinical care pathways.

Purpose

To propose evidence-based recommendations for in- and outpatient care including care transitions, behavioral health, and specialty care for suicide to the full Bree Collaborative on:

- Comprehensive prevention.
- Assessment and recognizing risk factors.
- Crisis response planning, management, and treatment of suicide risk.
- Follow-up and support after a suicide attempt and/or support for suicide loss survivors after a death.
- Addressing barriers to integrating recommendations.
- Implementation pathway(s) with process and patient outcome metrics.
- Identifying other areas of focus or modifying areas, as needed.

Duties & Functions

The Suicide Prevention workgroup will:

- Research evidence-based and expert-opinion informed guidelines and best practices (emerging and established).
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.

ⁱ American Association of Suicidology. USA Suicide 2016; Final Data File. Accessed: February 2018. Available:

www.suicidology.org/Portals/14/docs/Resources/FactSheets/2016/2016dataggsv1b.pdf?ver=2018-01-15-211057-387

ⁱⁱ Kochanek KD, Murphy SL, Xu J, Arias E. Mortality in the United States, 2016. NCHS Data Brief No. 293. December 2017. Available:

www.cdc.gov/nchs/data/databriefs/db293.pdf

ⁱⁱⁱ Murphy SL, Xu J, Kochanek KD, Curtin SC, Arias E. Deaths: Final Data for 2015. Centers for Disease Control and Prevention. National Vital Statistics Reports. Volume 65, Number 4. June 30, 2016. Available: www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_06.pdf.

^{iv} Cerel J, Maple M, van de Venne J, Moore M, Flaherty C, Brown M. Exposure to Suicide in the Community: Prevalence and Correlates in One U.S. State. Public Health Reports. 2016;131(1):100-107.

^v Stone DM, Luo F, Ouyang L, Lippy C, Hertz MF, Crosby AE. Sexual orientation and suicide ideation, plans, attempts, and medically serious attempts: evidence from local Youth Risk Behavior Surveys, 2001-2009. Am J Public Health. 2014;104(2):262-271.

^{vi} Stone D, Holland K, Bartholow B, Crosby A, Davis S, Wilkins N. Preventing Suicide: A Technical Package of Policy, Programs, and Practices. 2017. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available: www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.

- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative or the workgroup chair.

The chair of the workgroup will be appointed by the chair of the Bree Collaborative.

The Bree Collaborative program director will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. The program director will conduct meetings along with the chair, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members to be added at the discretion of the chair.

Name	Title	Organization
Hugh Straley, MD (chair)	Chair	Bree Collaborative
Kate Comtois, PhD, MSW	Psychologist	Harborview Medical Center
Karen Hye, PsyD	Clinical Psychologist	CHI Franciscan Health
Matthew Layton, MD, PhD, FACP, DFAPA	Clinical Professor, Department of Medical Education and Clinical Sciences	Elson S. Floyd College of Medicine, Washington State University
Neetha Mony, MSW	Statewide Suicide Prevention Plan Program Manager	Washington State Department of Health
Julie Richards, MPH	Research Associate	Kaiser Permanente Washington Health Research Institute
Julie Rickard, PhD	Physician & Healthcare Consultant	Confluence Health
Jennifer Stuber, PhD	Associate Professor	University of Washington School of Social Work
Jeffrey Sung, MD	Member	Washington State Psychiatric Association

Appendix C: Guideline and Systematic Review Search Results

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports	(2017) Anxiety in Children (2016) Data Linkage Strategies to Advance Youth Suicide Prevention (2015) Nonpharmacological Versus Pharmacological Treatments for Adult Patients With Major Depressive Disorder
Cochrane Collection	(2016) Psychosocial interventions for self-harm in adults (2015) Interventions for children and adolescents who self-harm (2014) Prevention of suicide in university and other post-secondary educational settings (2012) Collaborative care for people with depression and anxiety
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	(2016) U.S. Preventive Services Task Force Screening for depression in children and adolescents: U.S. Preventive Services Task Force recommendation statement. (2016) Eastern Association for the Surgery of Trauma Prevention of firearm-related injuries with restrictive licensing and concealed carry laws: an Eastern Association for the Surgery of Trauma systematic review. (2016) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for the management of major depressive disorder. (2015 Revised) American Psychiatric Association Practice guideline for the treatment of patients with major depressive disorder, third edition. (2015 Revised) National Guideline Alliance, National Guideline Alliance Depression in children and young people: identification and management in primary, community and secondary care. (2014) U.S. Preventive Services Task Force Screening for suicide risk in adolescents, adults, and older adults in primary care: U.S. Preventive Services Task Force recommendation statement. (2013) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide.
Health Technology Assessment Program	n/a
Centers for Disease Control and Prevention	Webpage: Suicide Prevention (2017) Preventing Suicide: A Technical Package of Policy, Programs, and Practices
Institute for Clinical and Economic Review	n/a
BMJ Clinical Evidence Systematic Overview	(2015) Deliberate self-harm (and attempted suicide)
Veterans Administration Evidence-based Synthesis Program	(2015) Systematic Review of Suicide Prevention in Veterans (2012) Suicide Risk Factors and Risk Assessment Tools: A Systematic Review (2012) Suicide Prevention Interventions and Referral/Follow-up Services: A Systematic Review (2009) Strategies for Suicide Prevention in Veterans
U.S. Surgeon General	(2012) National Strategy for Suicide Prevention
National Action Alliance for Suicide Prevention	(2018) Recommended standard care for people with suicide risk: Making health care suicide safe

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