Washington State Health Care Authority

HCA Suicide Care Pathway

Partnership between the Washington State Health Care Authority Division of Clinical Quality and Care Transformation (CQCT), Division of Behavioral Health and Recovery (DBHR), and Employees and Retirees Benefits (ERB).

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Common Acronyms used in this Document

HCA – Health Care Authority

SAMHSA- Substance Abuse and Mental Health Services Administration

WA DOH- Washington State Department of Health

DBHR- Division of Behavioral Health and Recovery

CQCT- Clinical Quality and Care Transformation

ERB- Employees and Retirees Benefits

Px- Prevention

BH- Behavioral Health

SUD- Substance Use Disorder

EBP- Evidence Based Program

CRIS- Crisis Response Improvement Strategy

988- new three digit National Suicide Prevention Lifeline

Introduction

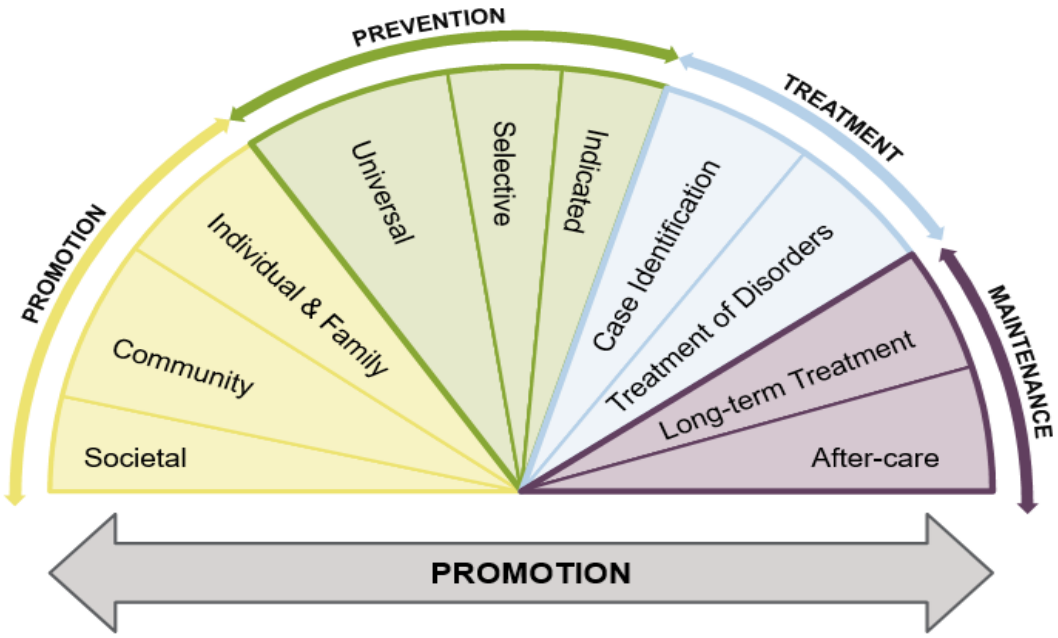
Suicide is a national public health priority in the United States with a national suicide rate of 14.1 in 2023 up from 10.7 in 2001 (CDC, 2023; Garrett and Curtin, 2023). This national pandemic is reflected in Washington State,where the rate of suicide per 100,000 people is 15.3 making it the 10th leading cause of death in the state (CDC 2023). One suicide affects many people. Based on a sample of 1,736 adults including 812 lifetime suicide-exposed respondents who reported age and number of exposures, each suicide resulted in 135 people exposed (Cerel, et al, 2019).

Suicide occurs at different rates by age group, race, and economic level in Washington state. The rate of suicide is double for people who are American Indian/Alaskan Native as compared to the state age adjusted rate, with the second highest rate is among people who are White. The rate of suicide is highest among men of all age groups, but suicide is the second leading cause of death for 10–34-year-olds in Washington (University of Washington, 2019; DOH death certificates 2016). The effects of a suicide ripple through the community, so an effective approach by providers at every level of care is necessary to ensure an individual's and a community's needs are met. In response to the growing need for providers to employ a variety of effective approaches, the Washington Health Care Authority has developed a suicide care pathway that follows nationally recognized research in prevention, treatment and postvention. The goal is to provide individuals, families, providers, and communities the tools needed promote mental wellness, prevent suicidal thoughts, and respond after a suicide or mental health crisis.

The implementation of the 988 Suicide and Crisis Lifeline is a national response and priorization of suicide prevention. In 2020, the US Congress designated the new 988 dialing code to expidiate mental health services to those in crisis. The Substance Abuse and Mental Health Services Adminstration (SAMSHA), the primary federal agency leading efforts to advance the behavioral health of the nation, recognizes the need for states, territories, tribes, crisis centers, counties, communities, emergency service providers, and other partners to speak with one voice so that there is a clear understanding about what the 988 Lifeline is and how it works. At the state level, the Washington State Department of Health is the coordinatoring entity for crisis response teams statewide to respond to those experiencing suicidal ideation. With this new focus on suicide prevention nation-wide we have intergated 988 information and established best practices in this document, but does not represent a comprehensive set of protocols and procedures to prevent or responded to a suicide crisis. Instead this document establishes a set of best practices and guidelines that spans across the range of mental, emotional, and behavioral interventions.

The Spectrum of Mental Emotional Behavioral Health covers interventions from promotion to maintenance (Figure 1). An understanding of the different components of the spectrum is essential to a comprehensive suicide prevention care. Here are the definitions of the different components of the spectrum:

Figure 1: The Spectrum of Mental, Emotional and Behavioral (MEB) Interventions



Mental Health Promotion

Focused on the public or a whole population. Interventions strive to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion, and strengthen their ability to cope with adversity (National Research Council).

Mental Health Prevention

Universal Prevention:

Focused on the public or a whole population that has not been identified based on risk. The intervention is desirable for everyone in that group. Universal interventions have advantages when their costs per individual are low, the intervention is effective and acceptable to the population, and there is a low risk from the intervention.

Selective Prevention:

Focused on individuals or a population subgroup whose risk of developing mental disorders is significantly higher than average. The risk may be imminent, or it may be a lifetime risk. Risk groups may be identified based on biological, psychological, or social risk factors that are known to be associated with the onset of a mental, emotional, or behavioral disorder. Selective interventions are most appropriate if their cost is moderate and if the risk of negative effects is minimal or nonexistent.

Indicated Prevention:

Focused on high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder, or biological

markers indicating predisposition for such a disorder, but who do not meet diagnostic levels at the current time. Indicated interventions might be reasonable even if intervention costs are high and even if the intervention entails some risk.

Mental Health Treatment

Treatment addresses resources, interventions, and services for individuals diagnosed with a substance use or other mental health disorders. Treatment also seeks to connect providers across the spectrum to enable seamless integration for patients that are transitioning in care.

Mental Health Maintenance

These services support individual's abilities to live productive lives in the community, preventing relapse, recurrence, or maintain the individual's level of optimum mental wellness.

The complexity of suicide prevention requires an approach that incorporates all necessary providers, stakeholders, and community members to ensure a high level of protection and care.

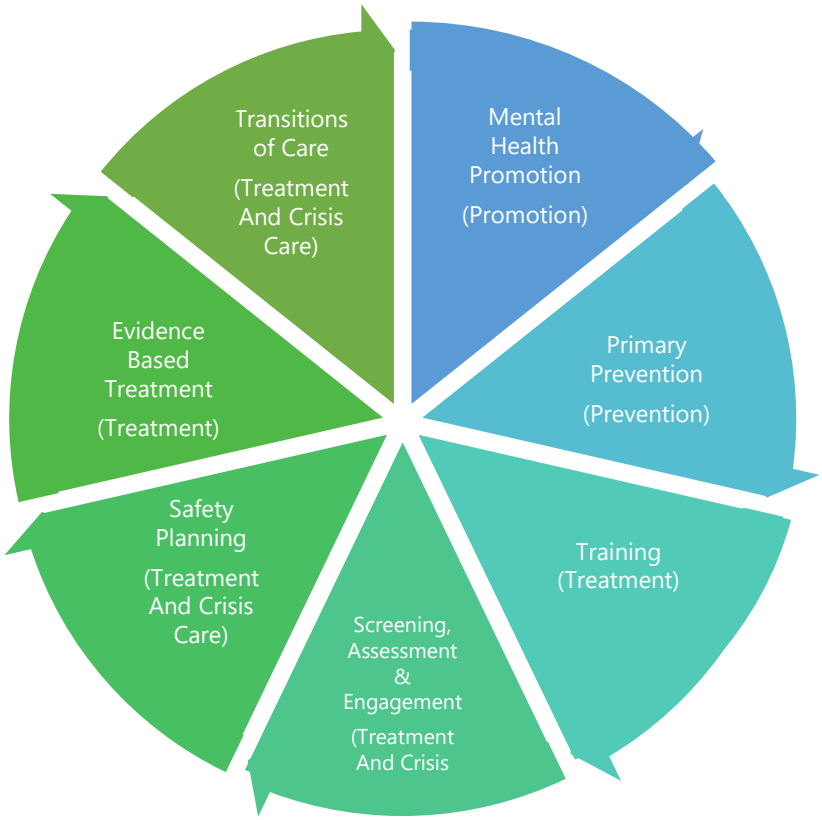
The goal of this document is to serve both in a research and practical purpose to address suicide prevention with a suicide care pathway from promotion to recovery. From a research perspective, this document will adapt and change over time as new information becomes available, and from a practical perspective, should inform clinical and prevention professionals' strategies for increasing wellness, preventing suicidal ideation, providing treatment, and recovery services to individuals, families, and communities.

Suicide Care Pathway

In 2016, Washington State established core principles and key recommendations regarding suicide prevention through the State's Suicide Prevention Plan. The plan identified the following core principles (WA DOH, 2016):

(1) Suicide is a preventable public health problem.
(2) Everyone has a role in to play in suicide prevention.
(3) We should change how we discuss suicide and mental health to reduce stigma.
(4) Reduce factors that contribute to suicide risk.
(5) Suicide doesn't affect all communities equally or in the same way and programming should reflect the needs and respect the culture of the communities they serve.
(6) People experiencing mental illness, substance use disorders, trauma, loss and suicidal ideation, or suicidal attempts deserve dignity and respect throughout their care.

Driven by these principles, the Health Care Authority (HCA) has developed a suicide prevention pathway following the Spectrum of Mental, Emotional, and Behavioral Health Interventions (MEB) to address services and programs through promotion, prevention, treatment, and maintenance. Figure 2 illustrates the elements of the Suicide Care Pathway and what category of the MEB Spectrum represented. It is important to understand that though we hope we incorporate all relevant elements of care, our suicide care pathway will evolve and change as new information and research is available. Now let's explore each component of the suicide care pathway. Figure 2:



Mental Health Promotion

Mental health promotion uses a universal approach to strengthen mental wellbeing. Promotion takes many forms, but the goal is to provide a community with the tools and skills to improve mental wellness and resiliency to then decrease mental health disorders and prevent suicidal ideation from occurring.

Mental health promotion is essential to suicide prevention because it increases a community's adaptability, connectedness, help-seeking behaviors and reduces stigma, high-risk behaviors, and disinformation. Mental health promotion involves strategies that focus on improving the mental well-being of individuals, families, and systems. Programs or activities that promote and build resiliency skills, emotion regulation, interpersonal skills, hope, and connectedness include:

Media campaigns promoting wellness practices and building of resilience, such as:

- Healthy coping skills and strategies, such as regulating emotions, problem-solving, decision-making skills, mindfulness/meditation, physical exercise, nutrition, etc.
- Healthy relationships and staying connected to others and the community.
- Destigmatizing of mental health disorders.
- Common evidence-based language shared by community members and providers.
- Strategies for increasing one's flexibility and adaptability to change.
- Strategies to feel a sense of purpose and hope.

Policies that help communities/organizations promote healthy behaviors:

- Implementing policies at your organization to prioritize wellness of your staff and your clients
- Work with community partners to implement policies and programs that promote wellness in different sectors of the population. For example:
    - Schools
        - Anti-Bullying policies in schools
        - Positive school climate programs
        - School policies about substance use
    - Businesses
        - Wellness programs for staff

Education:

- Implement or partner with an organization who is implementing evidence-based or research-based programs that have shown positive mental health outcomes for a non-clinical population. Offering these programs to individuals, prior to diagnosis, can increase their mental wellness and protect them from ever developing mental health challenges. These programs can be but are not limited to:
    - 988 key messages
    - Washington Partner Toolkit
    - Parent education
    - Classroom management
    - Youth skill building
    - Mentoring

HCA Division of Behavioral Health and Recovery (DBHR), Substance Use Disorder Prevention and Mental Health Promotion Section approved programs for our Mental Health Promotion Projects (MHPP) https://www.theathenaforum.org/EBP

Primary Prevention

Primary prevention focuses on reducing risk factors and increasing protective factors by improving the quality of life of a population. Prevention strategies are designed to address three population levels: universal, selective, and indicated. Universal strategies focus on the general public or a population subgroup that has not been identified on the basis of risk. Selective strategies focus on individuals or subgroups that have been identified to be at higher-than-average risk for developing a disorder. Indicated strategies focus on individuals who are having signs or symptoms but do not meet diagnostic criteria for a disorder. There are a wide variety of prevention strategies, such as awareness raising (information dissemination), skill building (education programs), environmental strategies (focus on community-level impact, e.g., policy, protocols), community organizing to implement prevention services, problem identification and referral, and alternative strategies (providing pro-social and healthy activities in the community). Here are some examples of the prevention strategies for suicide prevention:

Community Awareness

Community-based organizations are often best suited to identify the local needs and resources for their suicide prevention effort. An important aspect of community-based suicide prevention work is increasing the community's awareness that suicide is preventable, how to prevent suicide, and how to access local resources for prevention and treatment services, as well as crisis resources.

There are several strategies that can be utilized to increase community awareness around suicide prevention, these include but are not limited to:

- Media Campaigns developing effective messaging for the community on suicide prevention. Messaging may include but not limited to the following topics:
    - What are the risk factors that put an individual at higher risk for suicide.
    - What are the factors that increase one's wellness and therefore helps to protect them from developing suicidal ideation.
    - What are the warning sign for suicide and what to do when you see the signs.
    - Educate on how to ask someone if they are experiencing thoughts of suicide.
    - What are the prevention, treatment and crisis resources in your community.
    - Reduce stigma of mental health challenges.
    - Normalizing help seeking behaviors: Promote people asking for help.
    - Community resources to help individuals feel a sense of connection with their community.
- Town Halls or Community Events focused on educating on effective suicide prevention
- Postvention: Educate communities and media on what to do when a community has a person die from suicide.
    - Postvention toolkits for community members, schools, media, clergy, behavioral health providers, prevention providers

- Increase community protection through increased mental health promotion programs and strategies

Education

Implement or partner with organizations that are implementing evidence-based, research-based, or best practices suicide prevention programs for a non-clinical population. For example:

- Community awareness and campaigns around 988 - with 988 emerging as the primary response for those experiencing a mental health crisis. it is important for individual to know this resource exists and can be used through call, text or chat. https://988lifeline.org/talk-to-someone-now/
- Gatekeeper trainings for the public that inform them about the warning signs and symptoms of suicide and what action steps to take when a suicidal crisis arises. Examples of these trainings include:
  - Mental Health First Aid
  - Youth Mental Health First Aid
  - Question, Persuade, and Refer (QPR)
- Educational Programs for Youth: these programs teach youth about the signs and symptoms of suicide, risk and protective factors, what to do in a suicidal crisis, how to improve their own mental wellness, and often have the youth engage in service projects to increase other youth and adults' knowledge of effective suicide prevention. In addition, the programs often train adults in the community in effective suicide prevention and increase youth reaching out to adults for help. Examples of these programs include:
  - Sources of Strength
  - Coping and Support Training (CAST)
- Classroom management programs shown to have suicide outcomes, such as PAX Good Behavior Game.
- Additional programs on the HCA DBHR SUD Prevention and MH Promotion Section, for our Mental Health Promotion Projects (MHPP) found here: https://www.theathenaforum.org/EBP

Capacity Building

Capacity building: engage in steps to increase your communities/agencies ability to implement effective suicide prevention strategies/programs. Increasing capacity can include:

- Seek out local, state, and federal grant opportunities. HCA DBHR provides a Mental Health Promotion and Suicide Prevention Grant for community-based organizations. Visit Athena Forum Grants for more information.
- Increase partnership with other community providers, local businesses, local governments, coalitions, etc. to increase collaboration and utilization of already existing funds.
  - State Prevention Consortium and Plan
  - Consortium for the Prevention of Suicide
  - Crisis Call Centers
- Designated Suicide Prevention Coordinator or Champion in your agency. Increase your agencies focus on effective suicide prevention by having designated staff time for such efforts.
- Identify your agency's role in implementing the Washington State Suicide Prevention Plan.

Treatment

Training

Training is the cornerstone of suicide prevention because it provides actionable language and resources for clinical staff, prevention professionals, and community members. According to the Washington CRIS Committee, Practice guidelines (both clinical and operational) will be a major focus for the state (Steering committee, 2021). This guide on training is aimed at providing a roadmap on how to effectively structure training for various levels of staff. This guide does not provide a comprehensive list of trainings. All training should include information about the 988 crisis line and how staff can appropriately utilize this line for clients, based on their clinical role.

Effective Training

Safe suicide care, within an organization, begins the moment a patient walks through the door. It is important that all staff members have the necessary skills to provide excellent care, which will allow staff to be more effective in providing suicide care. Any staff member who has contact with clients can make a difference in reducing suicide if they are supported and trained effectively.

Support Staff

Front line support staff are in a special position as they are the first contact someone dealing with suicide may have. Even staff who may have minimal contact with clients, such as maintenance, should be provided the skills to identify risk and notify clinical staff. It is important to understand employees' beliefs, training, and current skills needed to care for people at risk for suicide. These employees should receive training that is appropriate for their role.

- Key staff training takeaways (www.zerosuicide.org)
- Provide staff training equivalent with their roles in providing safer suicide care.
- Repeat training at least every three years.
- Ensure that training contains the following elements:
    - The fundamentals of the organization's suicide reduction philosophy.
    - Policies and protocols relevant to the staff member's role and responsibilities.
    - Basic, research-informed training on suicide identification for all staff.
    - Advanced training to deepen skills and increase confidence and effectiveness.
- Make sure all staff understand their role in safer suicide care and how they can connect a client with clinical staff.
- Provide an opportunity for debrief/supervision either ongoing or as needed for staff to feel comfortable.

Remember, support staff should not be expected to take on a clinical role in providing suicide care, but they should have the skills, ability, and confidence to identify risk and notify clinical staff.

Clinical Staff

Treatment providers are expected to receive training on an ongoing basis, whether for licensure or upkeep of clinical skills. While this expectation is set at the state level, organizations should develop and implement training and training best practices for their clinicians. These could

include support in obtaining training, guidance on meeting state training requirements, or developing in-house-trainings. Regardless of the training plan, organizations should have a basic training that they provide to all clinical staff; Training for this group should teach these essential skills:

- Essential Staff Skills (www.zerosuicide.org)
- An approach that acknowledges the ambivalence of the person considering suicide and affirms that alternatives to alleviating the patient's pain do exist.
- The ability to gather patient information beyond suicide screening information that will inform a risk formulation.
- The ability to form and communicate to other clinicians, supervisors, and the patient a contextualized risk formulation to aid safety planning, counseling to reduce access to lethal means, crisis support, and treatment planning.
- The ability to write clear risk formulation for the patient record.
- A commitment to collaborating with the patient and others who are significant in the patient's life to create and record a safety plan and crisis support plan.
- Knowledge of the available treatment options and the ability to consider those options that are least restrictive to the patient whenever possible.
- Knowledge of the organization's suicide pathways and best practices.

While Washington State requires clinicians to receive ongoing training, it is best for organizations to take an active role in a clinician's training around suicide care best practices. This allows for greater understanding of clinic and local resources that are available to clients during suicide crisis and treatment.

Screening, Assessment, and Engagement

This phase of the care pathway involves using screening and assessment during clinical and community touchpoints to connect individual at risk to resources and clinicians to prevent a suicide. The Washington CRIS committee has identified that screening and engagement should be a major focus to help address crisis (Steering committee, 2021). All levels of care should be engaging in these activities on a regular basis and have procedures in place to make workflow more effective.

We know that these individuals at risk for suicidal behaviors are seen in health care settings for a wide variety of concerns. Of people who die by suicide, 77 percent of individuals had contact with their primary care provider in the year before death (Abed-Faghri, Boisvert, Faghri, 2010). Forty-five percent of individuals had contact with their primary care provider in the month before death. A meta-analysis concluded that screening increases treatment for suicide from 10%-50% depending on age group. (Mann, Bertolote, Beautrais, 2005).

As the Joint Commission notes in its 2016 alert, failure to assess suicide risk was the most common root cause of suicides (The Joint Commission 2016). Screening for suicide risk should be included in health and mental health care visits. The known risk factors that should trigger screening for suicide include mental health or substance use diagnoses, psychosocial trauma or conflict, recent loss (e.g., of a job or the death of a family member), family history of suicide, and personal history of suicide attempts (The Joint Commission, 2016). However, providing a screening for suicide in all initial contact and on an ongoing regular basis is the best way to identify risk. The basics of screening include:

- Short initial screening for every patient (medical, SUD, Mental Health). Examples include PHQ-3, PHQ-9, SAFE-T, ASQ, PSS-3, or first 2 Questions of C-SSRS.
    - Can be easily scaled to full assessment where needed.
    - Should be a standardized process within an agency, that is adjusted based on ongoing Quality Improvement.
    - What happens when a client says "Yes"?
- Hope based engagement, rooted in evidenced based practices.
    - The possibility of instilling hope is one reason that counseling is so important for people who are thinking about suicide. Professional counselors are experts at helping people see that suicide is a permanent solution to a temporary problem — and that there is hope for the future (Kaplan 2020).
- Caring contacts should be utilized for those who do not want to continue engagement with treatment.
    - Caring contacts are a non-demanding contact, from a provider to patient, that occurs after a missed appointment or the patient declining added services (Primary care recommending adding mental health but client declines).
- Provide referral to behavioral health care (Primary care and SUD providers).
- Provide 988 line information to patients.
- Train clinicians to identify and respond to suicidal ideation.
    - Training of all staff in Motivational Interviewing- an evidence-based treatment that addresses ambivalence to change (Case Western Reserve University, 2022).
    - Client-centered therapy that promotes hope for change.
    - Training in process/procedures allows clinicians to feel more comfortable providing care.
- Utilize EHR to track risk.

Safety Planning

Safety planning is an essential intervention with individuals at risk for suicide. It can be done in a variety of settings including emergency departments, primary care, and mental health and is a key component of an effective, evidence-based care management plan. It can be used with individuals who have made a suicide attempt, experience suicidal ideation, or are determined to be at risk for suicide (Stanley, Brown, 2012; Stanley, Brown, 2008). Safety planning is not to be confused with contracts for safety or no-suicide contracts, in which a client signs an agreement not to harm or kill themselves. There is no evidence that these contracts are effective, and they can provide a false sense of security for the provider (Stanley, Brown, 2012; Rudd, Mandrusiak, Joiner, 2006). Crisis response planning or safety planning have been found to be more effective than a contract for safety (Stanley, Brown, 2012; Bryan, Mintz, Clemans, etc, 2017).

Safety planning is a brief intervention involving a prioritized list of coping strategies and supports developed collaboratively between an individual and a clinician. Often, individuals at risk for suicide who are not admitted to treatment by emergency departments or crisis services are referred to outpatient mental health treatment. It is likely that the patient will continue to struggle with suicidal thoughts or emotional crises. The safety plan is an intervention to provide patients with a set of specific, concrete strategies tailored to their individual needs and circumstances that they can use to decrease the risk of

suicidal behavior and increase treatment motivation and compliance (Stanley, Brown, 2016; Stanley, 2013). Safety plans incorporate elements of several evidence-based suicide risk reduction strategies that are a part of the Zero Suicide approach, including means reduction, brief problem-solving and coping skills, social and emergency crisis support, and motivational enhancement for treatment (Stanley, Brown, 2016; Stanley, 2013).

- Safety planning should be an ongoing collaborative process with clients.
- Should be easy for clients to follow without assistance and when in crisis.
- Should include the 988 crisis line in addition to other supports.
- Should be evidence based (e.g. Collaborative safety planning intervention)
- Focus on what works, not what does not work.
- Should include effective supervision for the clinician (Ongoing monitoring of standards).
- Not a "No-suicide contract".
- Utilize quality improvement to improve efficacy within communities.

As with all parts of this pathway, there is no "one size fits all" safety plan for all settings. Be sure to utilize a plan that works well in your setting, for all clients and staff.

Evidence-Based Suicide Care

Clinicians have traditionally focused on treating mental health problems (e.g., Depression or anxiety), assuming suicidal ideation would decrease or go away once the mental health problem was treated. However, research supports the idea that we need to treat suicidal ideation and behaviors directly with independent diagnoses and treatment plans (Brown & Jager-Hyman, 2014). This treatment should also be carried out in the least restrictive setting possible and addressed in every session.

When looking to implement proper treatment, clinicians should have suicide care specific training that includes agency specific policies and treatment guides. All staff who may have direct contact with clients should receive suicide care specific training appropriate for their role. This will ensure proper suicide care for clients at all interactions with staff.

- Ongoing training in best practices, for suicide treatment, for all staff.
- Clear clinical protocols around suicide care, including protocols for ongoing care and acute care.
- Provide resources to clients based on their needs (BH/SUD/Community), maintaining up-to-date information as best as possible.
- Connection and discussion with client's other providers (treatment team), on a regular, ongoing basis.
- Regular, ongoing, engagement with client, about suicide.
- Track suicide risk in every appointment.
- Caring Contacts after all missed appointments. Caring contacts should be non-demanding and maintain non-judgmental, positive language.
- Help client maintain hope with calm and compassion, in a non-judgmental environment.
- Effective and consistent medication management.
- Suicide specific diagnosis and treatment path separate from other diagnoses.
- Clearly defined roles for all team members.

- Clear documentation of all information related to suicide, including information that may impact suicidality (ex. Housing instability, relapse, increased stress…).
- Effective protocols for support during transitions including but not limited to new providers, in/out of inpatient, and new medications.
- Clear protocols for follow-up with those affected by suicide, where appropriate (family members, friends, clinician working with the client…).
- Provide care in the least restrictive setting possible.
- Address lethal means for suicide as early as possible.
- Ongoing assessment of patient outcomes from evidence-based suicide modalities*. Should be completed on a regular basis.
- Evaluation of implementation of suicide care pathway and updating if needed, for the needs of the community.

This section is not meant to be a comprehensive list of all treatment possibilities but a roadmap for providers to determine what will best fit with their clients. Treatment for suicide should reflect the needs of the client and available resources.

Transitions of Care

Transitions of care are bridges of service between any two points. This can include transitions between levels of service, such as moving from inpatient to outpatient treatment or transitions between providers. Care transitions to any other level of care requires coordination between clinicians, families, staff, and the community. In any transition of care that involves connection with a new provider, the client should always be reminded of the 988 crisis line and provided information about how to access it in case of crisis.

Effective and Safe Transitions of Care Between Providers

Care transitions are a high-risk time for patients (Bickley et al., 2013). Bridging gaps in care at all levels should be a priority for clinicians, to decrease the risk of suicidal behaviors. Bridging this gap should also include a discussion between organizations about suicide ideation, behaviors, and risk assessments.

It is important that organizations develop written policies and procedures for safe and effective care transitions at all levels. Training should be provided to all employees who may have contact with clients, to ensure continuity of care across all interactions. When possible, warm handoffs should be provided to increase the likelihood of clients following up.

Care Transition Best Practices

- Clear clinical protocols for transitions, including specific guidelines for acute transitions (increase in care needs) and step-down transitions (includes transitions from direct suicide care to maintenance).
- Proper training for all staff, in transition guidelines.
- Clear communication between all transition partners, including the client. Communication should happen prior to transition beginning.
- Follow-up with client and/or care team following transition.
- Monitor to ensure that care transitions are documented and flagged for action in an electronic health record.

- Organizations should establish agreements or subcontracts between acute care settings and outpatient providers to ensure recently discharged high-risk patients have appointments within 24 hours.
- Provide a provider-to-provider warm hand-off, when possible, to provide additional support to the client when meeting their new provider.
- Be sure client has a copy of their updated safety plan, including numbers for the new provider and 988.
- Ensure that the client knows how they can access higher levels of care, when stepping down in care setting, including 988 crisis line.
- Ongoing quality improvement to be sure that all clinical guidelines work within your community.
- Ongoing updating of resources within the community (Minimum once per year).

Basic steps to ensure a safe transition between Providers

- Revise the patient's safety plan before discharge or referral.
- Ensure the patient has spoken by phone with the new provider.
- Send patient records several days in advance of the appointment to the new treatment provider.
- Be sure client has a copy of their updated safety plan.
- Call the new provider to go over patient information before the first appointment.
- Contact the patient within 24–48 hours after they have transitioned to the next care provider and document the contact.

Community Transitions

Integration into the community after a suicide attempt or treatment after suicidal ideation is the essential phase of maintenance. As a person transitions back into the community after a suicide attempt or treatment after suicidal ideation, it is essential to engage and promote mental health wellbeing among the patient and family and promote consistent and frequency communication.

The transition from the healthcare system to community care is often a vulnerable period of time for people with a history of suicide risk and for the health care systems and providers who serve them. In the month after patients leave inpatient psychiatric care, their suicide death rate is 300 times higher (in the first week) and 200 times higher (in the first month) than the general population's (Chung et al., 2019). Their suicide risk remains high for up to three months after discharge (Olfson et al., 2016; Walter et al., 2019) and for some, their elevated risk endures after discharge (Chung et al., 2017). In the United States, one out of seven people (14.2 percent) who died by suicide had contact with inpatient mental health services in the year before their death (Ahmedani et al., 2014). It is important for providers to develop relationships and build collaborative protocols and procedures with the family and community members while still in care and during discharge.

Integration from Inpatient

Ideally, clients would transition from inpatient care directly to a community mental health provider for ongoing care. When step-down care is not an option, the following best practices should be utilized.

- Update a client's safety plan the day before or day of discharge and go over how they can utilize this at home
- Attempt to connect with family, friends, or any other natural supports that may be available.
- Provide the client with community resources, highlighting those that will be important in the first few days. Remember to include community mental health clinics in case the client changes their mind or needs more support.
- Help the client schedule needed appointments following discharge (i.e., DSHS, PCP)
- Help the client plan activities for their first few days after discharge such as buying food, visiting friends/family, visiting a community center, obtaining needed social services, etc. Be sure to include time and address for any already scheduled appointments.
- Provide a caring contact to the client in the week/month after discharge, including options for the client to access care if needed.

Integration from Community Mental Health

- Discuss all aspects of this transition with the client prior to making the transition.
- Update Client's safety plan or wellness plan in the last session.
- Be sure that the client has strong community supports such as friends, family, or community groups (These should be established well before transition).
- Make sure the client has an updated list of resources they may need. This should be a collaborative effort over the final few sessions.
- Discuss transition with the client and have a plan for how they will access services again if needed.
- Be sure to update the client's diagnosis if they no longer meet the criteria.
- Make sure that the client has stable housing, income, and medication (if needed) prior to initiating transition.
- Provide a caring contact within the first month. Make sure the client understands what this is and knows they will be receiving it.

Maintenance

Maintenance of clients will vary in all settings. For many people, maintenance will occur outside of the treatment setting. For those who will require lifelong treatment, it is important to consider how maintenance differs from ongoing treatment. Maintenance should include structured care visits that leverage community supports and engagement to reduce the frequency of visits to a minimum for the client to maintain stability. In all cases, it is important to continue to monitor the need for increased contact, as needed, to support the client in staying in the maintenance stage. Community integration should be an ongoing process for all agencies. The need to keep up with ever changing resources is imperative as we work to provide a safe landing spot for clients. As agencies grow, they should consider providing more direct community engagement that is inclusive of all members of the community, not just

those suffering a diagnosable mental health disorder. Providing space for community activities or groups can help current clients transition out more easily but may also allow community members an easier access point for care, regardless of need.

988 Integration

On July 16, 2022, the U.S. transitioned the 10-digit National Suicide Prevention Lifeline to 9-8-8, an easy to remember three-digit number for 24/7 crisis care, similar to 911. The lifeline, which also links to the Veterans Crisis Line, follows a three-year joint effort by the U.S. Department of Health and Human Services (HHS), Federal Communications Commission (FCC), and the U.S. Department of Veterans Affairs (VA) to put crisis care more in reach for people in need. Washington State's House Bill 1477 establishes funding, through a tax on phone and voice over internal protocol lines, for crisis center that are fielding calls for 988 and focuses work on recruiting, hiring, and training additional crisis center staff.

In Washington State, when someone calls, texts, or chats to 988 they are redirected to one of three crisis center:

- Volunteers of America Western Washington
- Frontier Behavioral Health
- Crisis Connections

Figure 3: National Suicide Prevention Lifeline (NSPL) Crisis Center Service Areas in WA

What happens when you call 988?

- When you dial 988, you will be connected to an NSPL call center.
- You can call, text, or chat 988 on your cell phone, land line, or voice-over internet devices.
- The 10-digit number for the NSPL is still active. You can dial either 1-800-273-TALK (8255) or 988.
- People contacting 988 are not required to provide any personal data to receive services. Calls may be monitored or recorded for quality assurance or training purposes. The network system has several safeguards to address concerns about privacy.
- There are no changes to dispatch for Designated Crisis Responders and mobile crisis response teams or the functions of any other regional crisis service.

When calling 988, callers first hear a greeting message while their call is routed to a local NSPL crisis center (based on the caller's area code). A trained crisis counselor answers the phone, listens to the caller, understands how their problem is affecting them, provides support, and shares resources if needed. If the local crisis center is unable to take the call, the caller is automatically routed to a national backup crisis center. Live 988 services are available in English and Spanish and use Language Line Solutions to provide translation services in over 250 additional languages for people who call 988.

Many people have questions about the new system and interactions with law enforcements, but the primary goal of 988 is to provide support in suicidal crisis or mental health-related distress when they need it most. Fewer than 2% of calls are referred to 911 and are only activated when there is imminent risk to someone's life that cannot be reduced during the call. In these cases, the crisis counselor shares information with 911 that is crucial to saving the caller's life.

988 and Providers

The implementation of 988 is a culmination of multiple partners working together. If you are a mental health provider, you are an important bridge to the community by strengthening supports for the 988 system and providing education about the new system. Washington State Department of Health (WADOH) is leading the effort for 988 implementation and has developed a toolkit for partners in the field to and how to share information and understanding the new system. This toolkit can be here via this link.

Behavioral Health Administrative Service Organization (BH-ASO)

Another element that is vital to the successful implementation is mobile crisis response (MCR). The goal of 988 is to have mobile crisis teams respond to calls, which have been assessed by Behavioral Health Administrative Service Organization, as meeting the standards for risk assessment and engagement and reach any person in the service area in their home, workplace, or any other community-based location and provide crisis stabilization in a timely manner.

Currently, HCA is leading the crisis response expansion under proposed HB1134 to enhance training, fundings, outreach, and liability.

The following services may be provided by the BH-ASO to anyone in the region who is experiencing a mental health or SUD crisis:

- A 24/7/365 regional crisis hotline for mental health and SUD crises.
- Mental health crisis services, including the dispatch of mobile crisis outreach teams, staffed by mental health professionals and certified peer counselors.

- Short-term SUD crisis services for people intoxicated or incapacitated in public.
- Application of mental health and SUD involuntary commitment statutes, available 24/7/365, to conduct Involuntary Treatment Act assessments and file detention petition.

Adult Mobile Crisis Response

Mobile crisis response (MCR) services offer voluntary community-based interventions to individuals in need wherever they are including at home, work, school, courts, or anywhere else in the community where the person is experiencing a crisis. The caller, not the provider, defines the crisis. These services are provided by two-person teams that include a behavioral health clinician and a certified peer counselor.

Key components of quality MCR services include:

- Triage/screening, including explicit screening for suicidality and risk of harm to others
- Responding without law enforcement accompaniment, unless special circumstances warrant inclusion, to support true justice system diversion
- Reducing the use of emergency departments
- Assessing for risk and opportunities to resolve the crisis in the least restrictive setting
- Developmentally appropriate de-escalation/resolution
- Peer support; including family peers or youth peers
- Coordination with medical and behavioral health services
- Crisis planning and follow up

Mobile Crisis Response and Stabilization Services (MRSS) for youth and families

MRSS is a child and family specific intervention that recognizes the unique developmental needs of youth. Caregivers and youth are interconnected so when a youth is in crisis, the caregiver's ability to respond to the crisis can be impacted. Supporting the caregiver's response to the behavioral health need decreases the likelihood of calling 911, juvenile justice or child welfare involvement.

MRSS removes the word crisis, because in this comprehensive crisis continuum, youth can be screened during a crisis event and stabilized and connected to resources and supports after stabilization. This reduces barriers to ongoing clinical care, prevents return to the crisis phase, and improves outcomes.

In addition to the goals for all MCR services, MRSS is unique in the following areas:

- There is an initial response for 72 hours, and a separate stabilization phase for up to 14 days
- The crisis is defined by the youth, young adult, parent, or caregiver
- The team responds in person with peers within two hours and without law enforcement
- The team works with the youth and caregivers to reduce admissions to emergency departments (EDs) or adolescent inpatient units, and prevent unnecessary contact with law enforcement or child welfare
- Support and maintain youth in their living and community environment, reducing out of home placements
- Promote and support safe behavior in the home, schools, and community

- Ensure staff are trained in culturally responsive, developmentally appropriate trauma-informed care, de-escalation, safety planning for youth and families, and harm reduction
- Assist youth and families in identifying, accessing, and linking to natural and clinical supports
- Teams should provide robust outreach and engagement with youth system of care partners

HCA's crisis systems team (CST) is working to expand dedicated youth teams statewide and implement MRSS expansion through the ongoing work of HB 1477 and the CRIS committees.

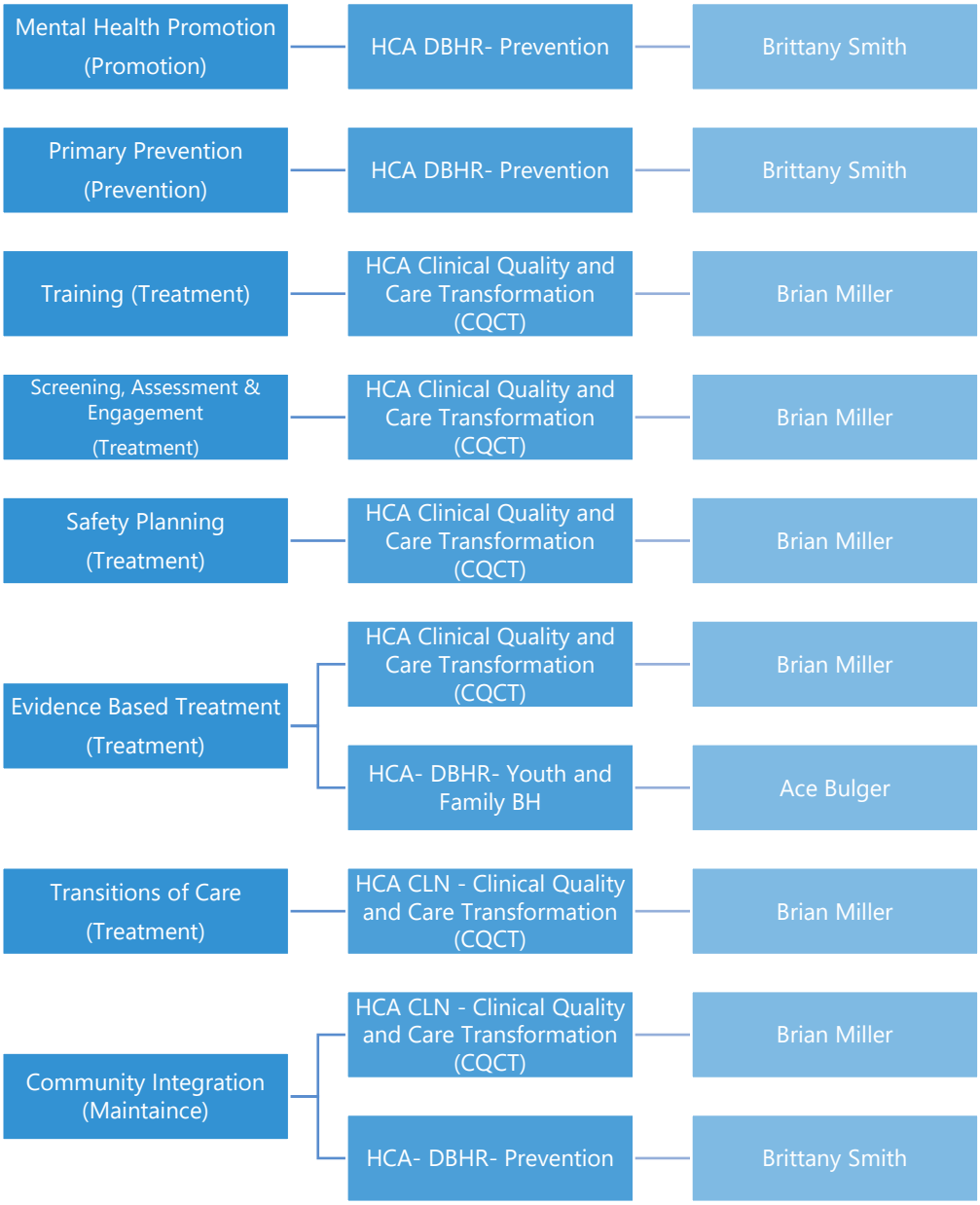
Future State of 988 Work

HCA continues to work with Behavioral health administrative service organizations (BH-ASOs), managed care organizations (MCOs), the Crisis Response Improvement (CRIS) committee, providers, and stakeholders on the crisis system expansion to ensure adequate coverage for an equitable response statewide as calls to 988 increases. The first Washington State Legislature bill to establish the Washington 988 system was House Bill 1477 and will be continued under House Bill 1134 to build mobile crisis response teams to capacity in alignment with SAMHSA's vision will reduce response times, reduce the likelihood of unnecessary contact with law enforcement or continued reliance on emergency responders like fire and EMS for behavioral health needs.

Conclusion

Suicide prevention rests on the success of our mental health infrastructure. As federal, state, and local partners implement the 988 system, the scope and scale of suicide prevention will change. The care pathway presented here is part of that changing landscape. The goal of this document is to serve both a research and practical purpose to address suicide prevention with a suicide care pathway from promotion to maintenance. Our system must be designed to serve all individuals and consider the collective and unique needs of individuals and the community. This document will continue to evolve, and we hope to expand on the best practices set out here and incorporate future research to improve services to all Washington State residents.

Health Care Authority Suicide Prevention Work



HCA Suicide Care Pathway Contracts:

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Brian Miller- Clinical Quality Care Transformation - brian.miller@hca.wa.gov

Ace Bulgar- Youth and Family Behavioral Health- ace.bulger@hca.wa.gov

Resources

https://developingchild.harvard.edu/science/key-concepts/resilience/\

https://www.sprc.org/about-suicide/risk-protective-factors

https://www.cdc.gov/suicide/factors/index.html

https://afsp.org/risk-factors-protective-factors-and-warning-signs

https://www.cdc.gov/suicide/factors/index.html

https://www.sprc.org/about-suicide/risk-protective-factors

https://www.hca.wa.gov/about-hca/behavioral-health-recovery/cybhwg-resources

https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/suicide-prevention-resources

https://www.theathenaforum.org/mentalhealth

https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention

https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/988-suicide-and-crisis-lifeline

https://www.hca.wa.gov/assets/program/988-background-and-implementation-DOH-971-053-988.pdf

Glossary

- **Acute Suicidal Ideation**- High risk for suicidal ideation and behavior includes patients with warning signs, serious thoughts of suicide, a plan or intent to engage in lethal self-directed violence, a recent suicide attempt, or those with prominent agitation, impulsivity, or psychosis
- **Assessment-** the evaluation or estimation of the nature, quality, or ability of someone or something.
- **Behavioral health organization (BHO)-** a county authority or group of county authorities or other entity that contracts for mental health services and substance use disorder treatment services within a defined Regional Service Area.
- **Behavioral health provider**- a licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions.
- **Behavioral healthcare-** the connection between your behavior and the health of your mind, body, and spirit. It is the way your habits affect your mental and physical health and wellness. Mental health and substance use treatment services.
- **Best Practice**- procedures that are accepted or prescribed as being correct or most effective.
- **Community**- a group of people living in the same place or having a particular characteristic in common.
- **Community Integration-** community integration refers to assimilating and welcoming people with disabilities into the larger community. Community integration enables persons with disabilities to fully participate in life at the same level as nondisabled individuals.
- **Comprehensive suicide prevention program**- A comprehensive approach to suicide prevention is characterized by: Strong leadership that convenes multi-sectoral partnerships. Prioritization of data to identify vulnerable populations and to better characterize risk and protective factors impacting suicide. Leveraging existing suicide prevention programs.
- **Connectedness**- a feeling of belonging to or having affinity with a particular person or group.
- **Continuity of care**- Continuity of care is an approach to ensure that the patient-centered care team is cooperatively involved in ongoing healthcare management toward a shared goal of high-quality medical care. Continuity of care promotes patient safety and assures quality of care over time.
- **Continuum of Care**- a concept involving an integrated system of care that guides and tracks patient over time through a comprehensive array of health services spanning all levels of intensity of care.
- **Crisis lines**- A *crisis hotline* is a phone number people can call to get immediate emergency telephone counseling, usually by trained volunteers.
- **Cultural competence**- in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including the tailoring of health care delivery to meet patients' social, cultural, and linguistic needs.
- **Death with Dignity**- Death with dignity is an end-of-life option, governed by state legislation, that allows certain people with terminal illness to request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified manner voluntarily and legally.
- **Evidence Based**- denoting an approach to medicine, education, and other disciplines that emphasizes the practical application of the findings of the best available current research.

- **Health home or patient centered medical home**- integrate physical and behavioral health (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations.
- **Hospitalization**- admission to a hospital for inpatient treatment.
- **Lethal means restriction**-assessing whether a person at risk for suicide has access to a firearm or other lethal means, and. working with them and their family and support system to limit their access until they are no longer at elevated risk.
- **Lethal means-** sufficient to cause death.
- **Maintenance**- the process of maintaining or preserving something.
- **Managed care organizations MCOs-** a health care company or a health plan that is focused on managed care as a model to limit costs, while keeping quality of care high.
- **Non-suicidal self-injury**- a self-inflicted act that causes pain or superficial damage and is not intended to cause death.
- **Out-patient-** a patient who receives medical treatment without being admitted to a hospital, community-based treatment.
- **Postvention or aftercare-** the support provided after the loss of a loved one from suicide. This can include therapy, support groups, support from family and friends (natural supports), and religious groups, etc.
- **Prevention-** action taken to decrease the chance of getting a disease or condition.
- **Promotion**- activity that supports or provides active encouragement for the furtherance of a cause, venture, or aim.
- **Recognition and referral training**- the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment.
- **Safety plan**- a prioritized written list of coping strategies and sources of support which can be use, especially when one has been deemed to be at high risk for suicide.
- **Screening**- the evaluation or investigation of something as part of a methodical survey.
- **Stigma**- a set of negative and often unfair beliefs that a society or group of people have about something.
- **Suicidal ideations**- *Suicidal* ideation means thinking about suicide or wanting to take your own life.
- **Suicide attempt**- when someone harms themselves with any intent to end their life, and they do not die because of their actions.
- **Suicide Care Pathway-** linking screening and assessment to brief intervention.
- **Suicide contagion or "copycat suicide"-** the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors.
- **Suicide threat-** Any interpersonal action, verbal or non-verbal, indicating a self-destructive desire, and stopping short of a direct self-harmful act.
- **Telemedicine telehealth-** the remote diagnosis and treatment by means of telecommunications technology.
- **Transition of care (warm hand off)-** The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
- **Treatment**- Behavioral health treatments are ways of helping people with mental illnesses or substance use disorders. For example, counseling and more specialized psychotherapies seek to change behaviors, thoughts, emotions, and how people see and understand situations.

Medications for mental and substance use disorders provide significant relief for many people and help manage symptoms to the point where people can use other strategies to pursue recovery.

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