Suicide Care Pathways

Recommendations for provider organizations

Washington State Health Care Authority

Ongoing issues

- 15.3 people per 100,000 commit suicide in Washington State every year. (CDC 2023)
- Suicide is the10th leading cause of death in the state (CDC 2023).
- Primary care providers see 60% of patients in the month before the patient attempts suicide.
  - Laanani et. al. Contacts with Health Services During the Year Prior to a suicide: A Nationwide Study. Journal of Affective Disorders. 2020;274:174-182. doi: 10.1016/j.jad.2020.05.071

Current suicide recommendations

Providers have tools to assess patients for thoughts of suicide:

- Use the Zero Suicide toolkit and care pathways.
- Implement the Bree Collaborative's Suicide Care Pathway.
- Use effective trainings such as All Patient's Safe.
- Screen all patients regularly.
- There is no "one size fits all" plan.
- Develop effective policies and train staff on carefully implementing them.

Screen patients at every visit

- Look for risk factors:
  - Social isolation
  - Changes in family dynamics
  - Job loss
  - Financial stress
  - Worries about personal health and health of loved ones
  - Increases in depression
  - Anxiety and/or fears
  - disruption of sleep and personal routines
  - Loss of support systems

    - Utilize tools such as the PHQ-9.

Engage all at-risk individuals

- Identify patients at risk and prioritize outreach.
- Increase phone check-ins.
- Send caring contact letters for patients who may not be engaging.
- Regularly review each patient's safety.

Treat suicidal thoughts and behaviors

- Continue to use suicide specific, evidence-based treatments.
- Increase utilization of caring contacts letters to patients.
- Document patient information related to suicide care and referrals.

Utilize warm handoffs and supportive contacts

- Identify where the responsibility for follow up and supportive contacts lies.
- Develop new or modify existing policies for follow ups after a missed appointment.
- Develop a clear protocol to provide support to friends, family, and providers involved in care of someone who has died by suicide.

Reach out to the 988 Crisis hotline

- Identify with patients if they need to contact the 988 hotline.
- Develop new or modify existing patient information materials, to include the 988 hotline.
- Help clients reach out if they need support.

Improve policies and procedures

- Focus on specific needs identified by your organization.
- Establish baseline data for organizations who are new to care. Review engagement, utilization, and follow up.
- Monitor screening, assessment, and care transitions, including:
  - Collaborative safety planning.
  - Lethal means safety.
  - Caring contacts.

Staff care and training

- Make sure all staff have access to and understand the process for managing suicide care.
- Prioritize staff care:
  - Make opportunities for teams to talk.
  - Provide mental health support for staff.
  - Do 1:1 check-ins with staff to assess their stress.
  - Encourage self-care plans.
- Celebrate successes! Share the positive, what is working and how tools and training are making a difference.

Promote effective training

- All Patients safe Training
- Zero Suicide Resources
- DOH identified Trainings

Key takeaways

- Theses are broad recommendations and not a one size fits all approach. Your organization's needs are most important.
- Effective screening and caring contacts are simple ways to increase engagement with patients.
- Be sure to promote crisis pathways such as the WA Listens hotline and the 988 hotline.

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