The Bree Collaborative
Suicide Prevention Workgroup Charter and Roster

Problem Statement

Suicide is the 10th leading cause of death nationally, resulting in approximately one death every twelve minutes.[1] Suicide rates show disparity based on race/ethnicity, age and other factors with the highest rates among those who are non-Hispanic American Indian/Alaska Native.[2] Other groups with higher rates include middle-aged adults, veterans and other military personal, and sexual minority youth (i.e., those who identify as lesbian, gay, bisexual, transgender, or queer).[2,3] 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.[4]

Aim

To develop implementable standards integrating suicide prevention into clinical care pathways.

Purpose

To propose evidence-based recommendations to the full Bree Collaborative on:

- Best practices for identifying depression and suicidal ideation within primary care.
- Interventions to prevent suicide.
- Implementation pathway(s) with metrics to monitor adoption and patient outcomes.
- 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.
- 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
(invited) Susan Bentley, DO	Assistant Professor	University of Washington Medical Center
Kate Comtois, PhD, MSW	Psychologist	Harborview Medical Center
Mary Pat Lancefield, MSW, LICSW	ED Social Worker	CHI Franciscan Health
Matthew E. 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
(invited) Greg Reger, PhD	Associate Investigator	VA Puget Sound Health Care System Seattle Division
Julie Richards, MPH	Research Associate	Kaiser Permanente Washington Health Research Institute
(invited) Julie Rickard, PhD	Program Director of Integrated Behavioral Services	Confluence Health
Jennifer Stuber, PhD	Associate Professor	University of Washington School of Social Work
Jeffrey Sung, MD	Member	Washington State Psychiatric Association

[1] 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

[2] Centers for Disease Control and Prevention. Deaths: Final Data for 2014. National Vital Statistics Reports. Volume 65, Number 4. June 30, 2016. Available: www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf.

[3] 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.

[4] 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.