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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 pioneer 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 minority groups at higher risk. The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from February 2018 to X.

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. The effect of a suicide on family members, friends, and clinical providers is long-lasting and profound.[1,2]

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.[3,4] Rates of suicide are higher among those who are non-Hispanic American Indian/Alaska Native, middle-aged adults, and veterans and other military personal and show great geographic variation.[4,5] 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.[6] 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.[7] Firearms account for almost half of all deaths by suicide with suffocation at 24% and poisoning at 19% followed by falls and jumps, cutting and piercing, drowning, and other all under 5%.[7]

Suicide is a response to multiple internal (e.g., depression, substance abuse) and external factors (e.g., lack of social support, financial stress).[8] Approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period.[9,10,11] Episodes of major depressive disorder typically last 16 weeks, almost all being clinically significant.[9] Economic recession appears to be associated with increases in behavioral health disorders, substance use disorders, and suicidal behavior.[12]

Within the last month prior to suicide, approximately 45% of suicide victims had contact with primary care.[13] Screening for and comprehensive access to treatment for depression have been shown to occur infrequently.[14] 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.[15] 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.[16,17] However, the patient health questionnaire-9 questions (PHQ-9) includes a one-item suicide screening question (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*) and the Joint Commission recommends screening for suicidal ideation.[18] High unmet need and siloed nature of behavioral health and physical health care were identified in the 2006 Institute of Medicine Crossing the Quality Chasm series as contributing to low-quality care.[19] On average, 80 million Americans visit an ambulatory care center with major depressive disorder as their primary diagnosis, indicating potential to impact patient outcomes through treatment within the context of primary care.[20]

The workgroup will work closely with and build 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 to develop implementable standards integrating suicide prevention, assessment, management, treatment, and supporting suicide loss survivors into clinical care pathways.

Recommendation Focus Areas

The workgroup developed recommendations for 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:

Screening for depression and suicide risk	• Screen all patients over 18 annually for:
	  o Depression (e.g., PHQ-2 or 3, followed by PHQ-9 if positive)
	  o Alcohol misuse (e.g., AUDIT-C, followed by full AUDIT)
	  o Anxiety (e.g., GAD-7)
	  o Drug use (e.g., one question, followed by DAST-10)
	  o Safe firearm storage

Patient risk formulation	• Columbia Suicide Severity Rating Scale (C-SSRS) for patients who:
	  o Answer 2 or 3 on PHQ question nine
	  o Screen positive for alcohol misuse, anxiety, substance misuse, or who have another mental illness diagnosis or have been prescribed psychiatric medication
	  o Life event (e.g., new diagnosis, family member death, job loss)
	  o Show clinician-identified red flags

Suicidal risk management and treatment to target	• If patient answers yes to C-SSRS questions 3-6 refer to same day in-person behavioral health (e.g., social work) for safety planning and lethal means reduction • Caring contact (?) within 48 hours of visit, second within seven days of visit • Appointment with behavioral health
Follow-up and support after a suicide attempt	

Element	Specifications	Patient Perspective	Operational Details for Integrating Behavioral Health Care into Primary Care
Screening for depression and suicidal risk	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.	*I am asked about depression and other behavioral health concerns at my first visit and at least annually thereafter.* *If my screening results suggest that I may have behavioral health concerns or screen positive I am introduced to someone on the team that is trained to help me. I receive the type of treatment that is best suited to me.*	**Usual Care:** Behavioral health needs are not assessed or are occasionally assessed. There is no way to systematically track patients who do screen positive or this is done by individual providers patient by patient. **Steps Toward Integration:** Screening for behavioral health needs is incorporated as a pilot for selected group(s) of patients. Follow-up is a normal part of care but patients are not contacted if they miss appointments or if they do not show improvement. **Optimal Care:** The integrated care team utilizes shared workflows to systematically screen for depression and suicidal risk using a validated tool (e.g., PHQ-2 or 3, PHQ-9, Columbia Suicide Severity Rating Scale (C-SSRS)). Individual patient progress is tracked toward treatment goals. Patient information is incorporated into a shared care plan whereby critical medical, behavioral, and social information is recorded and accessible. Access to psychiatric consultation services are available in a systematic manner so as assist the primary care provider and team to develop a treatment plan and adjust treatments for patients who are not improving as expected. Patients and the care team are partners in creating care plans that support patient needs and are informed by best practice. Patients are actively involved in their own care and they are asked about potential barriers to care. Shared-decision aids are used whenever possible.
Patient risk formulation			**Usual Care:** **Steps Toward Integration:** **Optimal Care:**

Suicidal risk management/ treatment to target			**Usual Care:** **Steps Toward Integration**: **Optimal Care:**
Follow-up and support after a suicide attempt			**Usual Care:** **Steps Toward Integration**: **Optimal Care:**

Example from Behavioral Health Integration

Patients and Family Members

- Talk to your primary care provider or other care team members about any concerns including feeling low or depressed, feeling anxious, concerns about drinking or drug use, or any other concerns about behavioral health.
- Ask to see your care plan if you would like.
- Talk to your providers about your concerns with accessing the type of care that you need.
- Track progress on treatment for behavioral health diagnosis in the same way that you would track something like blood pressure.
- Ask your care team about the reasons or evidence for the types of treatments that you receive.
- Give your feedback about your experience at the practice.

Primary Care Practices and Systems (including Primary Care and Behavioral Health Care Providers)

Review **Table 1: Roadmap to Integrated Care**. The following list includes key action items from the Roadmap.

- Screen all patients with the PHQ-3 (first two questions of the PHQ-9 and the ninth question).
- For patients who screen 2 or 3 on the ninth question, administer the Columbia Suicide Severity Rating Scale (C-SSRS).
-
- Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff.
- Structure typical practice activities to facilitate involvement by all members of the integrated care team (e.g., team meetings, daily huddles, pre-visit planning, and quality improvement meetings).
- Facilitate patient access to behavioral health and primary care services on the same day as much as feasible.
- 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.
- Ensure that the integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care.
- Ensure that clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.
- Facilitate access to psychiatric consultation services 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.
- Coordinate specialty behavioral health services for patients with more severe or complex symptoms and diagnoses.
- Proactively identify and stratify patients for targeted conditions.
- Use systematic clinical protocols based on screening results and other patient data, like ER use, that help to characterize patient risk and complexity of needs.

- 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.
- Use age-appropriate measurement-based interventions for physical and behavioral health interventions that are adapted to the specific needs of the practice setting.
- Use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether patients are improving.
- Include appropriate self-management support in care.
- Use patient goals to inform the care plan.
- Communicate effectively with the patient about treatment options and include patient goals, perspectives, and informed treatment decisions into treatment plans.
- Track system-level data regarding access to behavioral care, the patients' experience, and patient outcomes. If system goals are not met, use quality improvement efforts to achieve patient access goals and outcome standards.

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*[21]

- 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.
- Work with the Accountable Communities of Health to measure quality and outcomes including traditional clinical measures but also data beyond care delivery and claims: arrests/recidivism, housing status, employment, if possible.

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.
- 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).

Screening for Depression, Suicide Risk and Risk Formulation

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 is a one-item suicide screening question, *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*. A positive answer on this ninth question is associated with elevated risk of suicide over the subsequent two years, however 39% of suicide attempts within 30 days of answered "not at all."[22] Recent research suggests 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.[23]

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).[24] Other tools to screen and assess for suicide risk include:[25]

- Ask Suicide-Screening Questions (ASQ) National Institute of Mental Health
- 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[TM]
- Reasons for Living (RFL)

Suicidal Risk Management and Treatment to Target

Safety planning, a brief intervention in which the patient develops about a plan to remain safe, can be conducted in multiple settings (e.g., primary care, in- and out-patient behavioral health, emergency department).[25] Key components can include:[26]

- Recognition of warning signs
- Internal coping strategies
- Socialization strategies for distraction and support
- Social contacts for assistance in resolving suicidal crises
- Professional and agency contacts to help resolve suicidal crises
- Means restriction

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.[27] Many patients do not complete their referral for behavioral health.[28]

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.[29]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.[30]

Follow-up and support after a suicide attempt

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. Our workgroup found it important to define integrated behavioral health care in order to create a common vocabulary and focused on using 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

- o 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
  - o 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
  - o GOAL: Designated health professions are trained in suicide assessment, treatment and management.
  - o 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.
  - o 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
  - o 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.
  - o 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.
  - o 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.[31] 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[32]
- **MHMD-1: Reduce the suicide rate**
  - o Baseline: 11.3 suicides per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)
  - o Target: 10.2 suicides per 100,000 population
  - o Target-Setting Method: 10 percent improvement
- **MHMD-2: Reduce suicide attempts by adolescents**
  - o Baseline: 1.9 suicide attempts per 100 population occurred in 2009
  - o Target: 1.7 suicide attempts per 100 population
  - o Target-Setting Method: 10 percent improvement
- **MHMD-4: Reduce the proportion of persons who experience major depressive episodes (MDEs)**
  - o 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
  - o 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 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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