

Kaiser Permanente Research Roundup: Research Summaries for Policy Leaders

Integrating suicide prevention approaches into primary care

[Effectiveness of Integrating Suicide Care in Primary Care: Secondary Analysis of a Stepped-Wedge, Cluster Randomized Implementation Trial](#)

Annals of Internal Medicine / Angerhofer Richards et al. / October 1, 2024

Suicide is the 11th leading cause of death in the United States, and rates have risen 35% over 20 years.¹ Across the country, almost half (45%) of individuals who die by suicide see a primary care provider in the month before their death.² These visits offer critical opportunities to identify and support people at risk. Yet most clinics do not routinely assess suicide risk.³

[The Zero Suicide framework](#), developed by the National Action Alliance for Suicide Prevention, is a systems-level model that highlights opportunities for prevention and offers tangible supports across care settings and care providers. It embeds evidence-based practices that help identify people at risk of suicide and engages them in supportive care to reduce risk. Evaluations suggest the framework is associated with reductions in suicide attempts.⁴

To date, implementation and evaluation of the Zero Suicide framework has mostly occurred in behavioral health settings rather than in primary care. Many clinics lack the training, infrastructure, and clinical support needed to implement systematic screening and follow-up at scale.^{5,6} As a result, real-world evidence on whether suicide prevention strategies can be successfully implemented in primary care has been limited.⁷



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New research from Kaiser Permanente explores this issue, including questions of interest to policy audiences:

- Does adding suicide screening and safety planning during regular doctor visits improve care quality and patient outcomes?
- How can suicide prevention strategies be effectively implemented in primary care settings? What kinds of infrastructure and coordination supports are needed?

Study in *Annals of Internal Medicine*

Kaiser Permanente examined the effects of incorporating suicide prevention practices into regular primary care visits, among more than 300,000 patients who made over 1.5 million visits to participating primary care clinics in Washington. Primary care teams screened adult patients for suicide risk during routine visits, after being trained to conduct these assessments. They then conducted in-depth assessments when patients reported frequent suicidal thoughts, and created safety plans for those at elevated risk.

Safety plans are written lists of coping strategies and resources, including social and professional supports, that patients can use to decrease the risk of suicidal behavior. Clinics also used electronic health record tools, such as prompts to flag at-risk patients and checklists to guide next steps, to help providers identify and follow up with patients.



Key findings:

- Once suicide prevention screening was incorporated into primary care, patients were **25% less likely to attempt suicide** within 90 days of a visit (from 6.0 to 4.5 attempts per 10,000 visits).
- **Suicide safety plan use increased** (from 32.8 to 38.3 per 10,000 patients).

Policy opportunities

No single study can suggest the full range of policy needs and opportunities. Based on existing research and internal discussions among Kaiser Permanente behavioral health leaders, we recommend several avenues for improving suicide prevention:

Promote [access](#) to high-quality mental health care.

- **Standardize [quality](#) metrics** that evaluate mental health care. Promote measurement-based care by using standardized, no-cost mental health screeners that include screening for suicide risk.
- **Promote wider deployment of [evidence-based care](#)** across care settings, including primary care, based on high-quality scientific research showing better patient outcomes.

Expand high-quality, evidence-based [crisis services](#) for people experiencing serious mental health episodes and the acute effects of addiction.

- **Support sufficient federal and state funding for the continuum of crisis response services, including 988 suicide and crisis hotlines, and the development of national standards and definitions for crisis services.** Regional crisis call centers and centrally deployed mobile crisis teams provide critically needed services, and funding for state crisis-response teams and 24-7 crisis-support services can help patients and reduce the need for emergency department and medical inpatient holds
- **Support state funding for residential crisis stabilization programs.** These programs offer short-term, cost-effective “sub-acute” care for individuals who need support and observation, but not emergency department holds or medical inpatient care.

- **Promote high-quality crisis services.** Ensure quality through licensing guardrails, processes for transitioning patients back to appropriate in-network care when a crisis is resolved, and measurement of care and outcomes.

References

Full citations for this document can be found at: kpihp.org/references-ics.



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