# The Pennsylvania Model for Youth Suicide Prevention in Primary Care : Overview, Barriers, Solutions, Outcomes and Next Steps

The Pennsylvania Garrett Lee Smith Grant Team

## Why Screen For Suicide in Primary Care?

- 70% of adolescents seen once a year by a PCP
- Many at-risk subpopulations (e.g. HIV, chronic illness, family planning)
- 16% of adolescents in the last year were depressed, and 5% were at risk for suicide
- Over 70% of adolescents report a willingness to talk with a primary care physician about emotional distress
- 7-15% of adolescent attempters contacted a health provider in the month previous to an attempt and 20-25% in the previous year

## Screening Barriers

- Over 200 screening tools have been developed, However….
  - Most focus on a single domain (e.g., depression)
  - Most focus on psychiatric symptoms while PCPs think more in terms of risk behaviors
  - Most are paper-pencil administration and require hand scoring
  - Very few, not even the GAPS, map on to formal diagnostic categories
  - Few screening tools (less than five) have psychometric support

## Multiple Barriers to Implementation

- Provider Barriers
  - Lack of training, lack of time
- Organizational Barriers
  - Insurance, access to MH services
- MH Barriers
  - Long waiting lists, staff turnover
- Family and Patient Barriers
  - Low priority, treatment refusal or reluctance

## The Bottom Line…

- Primary care is an excellent context for early identification, prevention, and intervention
- While screening tools can help, they will not address the multi-systemic barriers to providing mental health in primary care by themselves

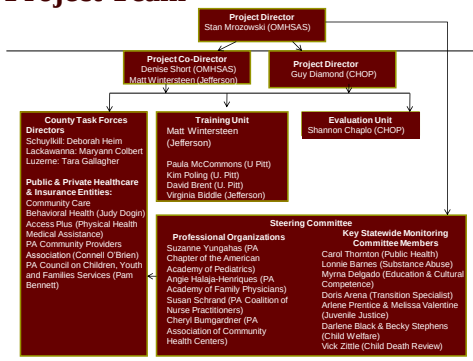
# Youth Suicide Prevention in Primary Care (YSP-PC)

(ages 14-24)

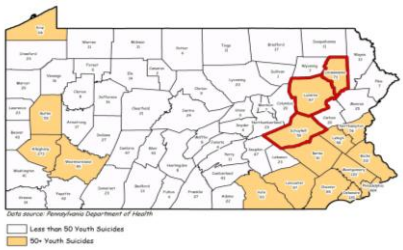
Office of Mental Health and Substance Abuse Services
Pennsylvania Department of Public Welfare

Funded by SAMHSA through the Garrett Lee Smith Memorial Act

## Project Team




## # Youth Suicides (15 to 24 years old), by Pennsylvania County, 1990-2005




Targeted Counties: Lackawanna, Luzerne, Schuylkill

## Five Central Aims

**# 1:** Create state and local stake holder groups

**# 2:** Increase coordination between medical and behavioral health services

**# 3:** Provide youth suicide "gatekeeper" training

**# 4**: Introduce empirically supported therapies to local behavioral health providers

**# 5**: Provide web-based screening tool

## Aim # 1: Stakeholder Involvement

**Stakeholder Involvement**

*State-Level*

*Community-Level*

## State Level Stakeholders

**State Agencies**:

- Dept. of Welfare
- Dept. of Health

**Medical Associations**:

- PA Chapter of the American Academy of Pediatrics
- PA Association of Family Physicians
- PA Coalition of Nurse Practitioner
- PA Association of Community Health Centers

**Behavioral Health:**

- Pennsylvania Community Providers Associations

**Payers**:

- Access Plus, Community Care

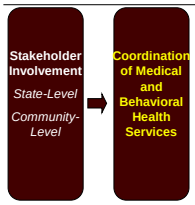
## State Level: Suicide Prevention Task Forces

- Hosted four regional suicide prevention task force meetings
  - Over 35 counties represented by 137 participants
- Needs assessment, resource development, increased communication
- Activated their interest in the YSP-PC project

## Other State Level Strategies

- State survey (N= 667) of PCPs regarding behavioral health needs and challenges
- Produced a series of training webinars
- Presentations at numerous state medical and behavioral health meetings
- Bi-monthly call with *Pennsylvania Office of Medical Assistance* to explore sustainability
- Participated in Start-up of the Pennsylvania Physical Health/Behavioral Health Learning Community
- Sponsored a state suicide prevention conference

## Aim # 2: Coordination of Behavioral Health & Medical Services




## State Survey Results (N=667 PCPs)

- Most practices do not have an on-site behavioral health (BH) worker
- 45% reported that they cannot quickly get BH appointments for suicidal patients and encounter long waiting lists for non-urgent patients
- Only 24% reported that the BH provider always or often let them know if a patient attends services

## Other Challenges

- PCPs cannot get reimbursed for identifying and treating BH problems
  - Nearly 50% report submitting a medical diagnosis in order to provide reimbursable behavioral health services
- Limited personal relationships between providers
- Overly restricted interpretation of HIPAA
- PCPs have a poor understanding of available resources

## Coordination of Services

- Screen and refer patients, but also improve the relationship and exchange of information between PCPs and behavioral health providers and agencies

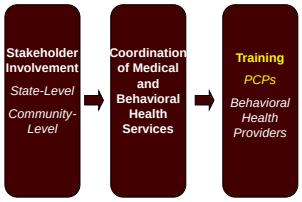
## Liaison/Navigator Role: Within Practices

- Collaboration with County MH/MR Directors.
  - Funded part time liaison/navigator between PCPs and the behavioral health community.
- Identified interested PC practices to participate in the project
- Educated PCPs on how to access services
- Created support material for accessing behavioral health services (phone numbers, office posters, wallet cards)
- Offered educational services about suicide and behavioral health assessment

## Primary Mechanisms of Success

- Relationship development
- Behavioral health community reaching out to PCPs
- PCPs screening enough patients to make it financially viable for the behavioral health providers to consider collocating services.

## Aim # 3: PCP Gatekeeper Training




## Why Training?

- PCPs get very little training on suicide and mental health
  - Less than 50% of PCPs feel competent in diagnosing depression
- Physician education increases PCPs feelings of capability and competency which leads to increased identification rates of high risk youth
- Physician education is one of only two suicide prevention strategies shown to reduce the suicide rate (Mann et al., 2005)

## Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC-Y)

- Developed by the American Association of Suicidology
- Covers material pertinent to PCPs
- Designed as a 90-minute presentation
- Includes lecture, video demonstrations of techniques, and printed resources

## Content of RRSR-PC-Y

- Suicide risk assessment
- Triage decision making
- Crisis Response Planning
- Interventions for Primary Care
- Documentation

## Suicide Prevention Toolkit for Rural Primary Care

**Suicide Prevention Resource Center (SPRC)**

## Toolkit: Overall Layout

- The Toolkit is available in 2 forms
  - Hard copy, spiral bound ordered through WICHE
  - Electronic copy (www.sprc.org)
- Includes 6 sections:
  - Getting started
  - Educating clinicians and office staff
  - Developing mental health partnerships
  - Patient management tools
  - Patient education tools
  - Resources
- New content on billing for services in PC setting

## Online Training

**Developed by Virginia Biddle, PhD, CRNP, RN**

- Geared to primary care providers, including nurse practitioners, physician assistants, as well as school nurses, nurse midwives, and other clinicians
- Program focuses on the assessment of background and subjective risk factors using the well known *HEADSS* (*H*ome, *E*ducation, *A*ctivities, *D*rug use and abuse, *S*exual behavior, and *S*uicidality) interview
- Pretest and post-test including videotaped vignettes

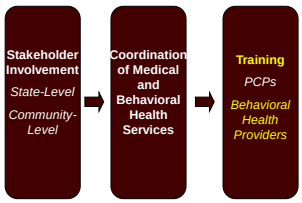
## Online Training

- Specific topics include the following:
  - Importance of suicide risk assessment
  - Prevalence/epidemiology of suicide
  - National efforts for suicide prevention
  - Reasons why suicide becomes an option
  - Performing an adolescent assessment (background and subjective factors)
  - Levels of suicide risk
  - Referral
  - Treatment
  - Assessment tools
  - Family assessment

## Online Training

- Available on website of National Association of Pediatric Nurse Practitioners
- Continuing education available for nurses and nurse practitioners
- Also available on www.payspi.org
  - Click on News & Events
  - Under "Adolescent Suicide Risk Assessment"

## Aim #4: Training Behavioral Health Providers



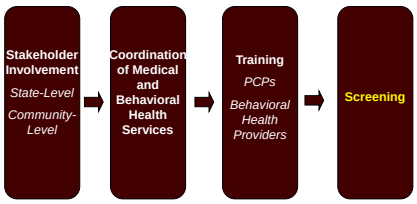

## Behavioral Health Trainings

- Provided 2 CBT trainings in the region
- Provided 2 family therapy trainings in the region
  - Offered ongoing supervision to attendees
- Coordinated a co-occurring training with the Bureau of Drug & Alcohol Programs

## Continued Barriers

- Little time for additional supervision and training
- Unclear level of support coming from agency administrators and directors
- No mandate to learn new skills
- High staff turn over
- Bottom line: Agenda was too vast for this grant; implementing smaller goals:
  - Safety Planning Training
  - Crisis Management Training

## Aim # 5: Web-based Screening




## Why is Screening Helpful?

- Standardizes screening questions across patients and providers
- Adolescents as likely or more likely to report psychosocial problems
- Summary reports maximize efficiency of medical staff time
- Facilitates patient-doctor conversations
- Increases early detection of risk behaviors
- Patients are more likely to receive care after being screened

## Why Web-Based Screening?

- Greater dissemination and accessibility
- Instant scoring of results, automated skip outs, preferred by adolescents
- Interface with electronic medical records
- Track patient status over time
- Capacity for aggregate reports within a practice
- Support quality assurance projects and license renewal
- Capacity for tracking county- and state-level trends

## Behavioral Health Screen – Primary Care (BHS-PC)

- Screens for risk behavior and psychiatric symptoms
- Covers areas recommended by the American Academy of Pediatrics as best practice guidelines for a well-visit interview
- Takes 9 - 15 minutes
- Generates summary report and follow-up recommendations in real time
- Promising psychometric properties

## Key Domains of BHS-PC

- Medical
- School
- Family
- Safety
- Substance Use
- Sexuality
- Nutrition and Eating
- Anxiety
- Depression
- Suicide and Self-Harm
- Psychosis
- Trauma
- Independence

## Implementation Challenges

- Consent
- Confidentiality
- Technology
- Workflow

## Progress & Outcomes


## Screening Progress To Date

- Approached 17 practices, 11 participated
- 1,208 youth screened
- 187 (15.5%) endorsed having thoughts of killing themselves at some point in their life
- 54 (4.5%) had current ideation (function of indicated screening)
- Of those identified at risk for suicide:
  - 8% were already in treatment
  - 21% refused services
  - 44% accepted their referral and went to services

## Other Behavioral Health Concerns

| | Total # Screened | Suicide | Depression | Anxiety | Trauma | Eating Disorder | Substance Abuse |
|---|---|---|---|---|---|---|---|
| Total | 1,042 | 169 (16.2%) | 223 (21.4%) | 343 (32.9%) | 240 (23.0%) | 29 (2.8%) | 39 (3.7%) |

• 303 youth (28.4% of sample) met the clinical cut-off for at least one behavioral health concern other than suicide

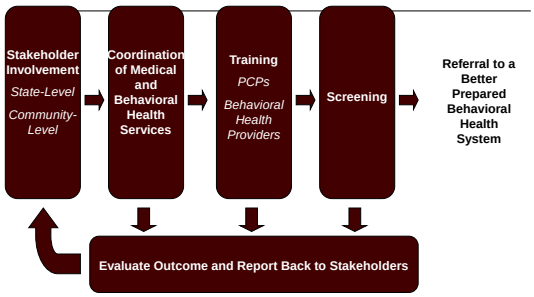
## Sustainability

1. Find practices that are more project-ready and willing to integrate innovative models into their practice (e.g., medical home practices)
2. Build a comprehensive web-site with our multiple resources
3. The more the PCP screens, the more cases there will be for behavioral health assessments and treatment; therefore, creating a viable business plan
4. Continue to lobby for PCP reimbursement for screening

## Summary and Main Findings

- Systems change model is needed
- Picking a screening tool is easy; getting PCPs to use it is much harder
- Need a point person to help implement changes and screening
- PCPs will continue to be reluctant to screen unless:
  - Reimbursement for screening
  - Increased availability of behavioral health referral sources

## The Pennsylvania Model for Youth Suicide Prevention in Primary Care (YSP-PC)

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