PA Garret Lee Smith Project:
Effective Suicide Screening and Prevention in Primary Care

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Wilkes-Barre Task Force Workshop

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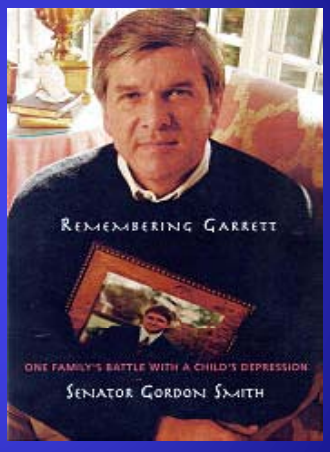
Garrett Lee Smith Memorial Act

- Passed by Congress in 2004
- Named after Senator Gordon Smith's (OR) son who died by suicide at age 21
- Provides funding for community based suicide prevention



GLS Team

Project Director
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County Task Forces
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Access Plus (Physical Health Medical Assistance)
PA Community Providers Association (Connell O'Brien)
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Steering Committee

Professional Organizations
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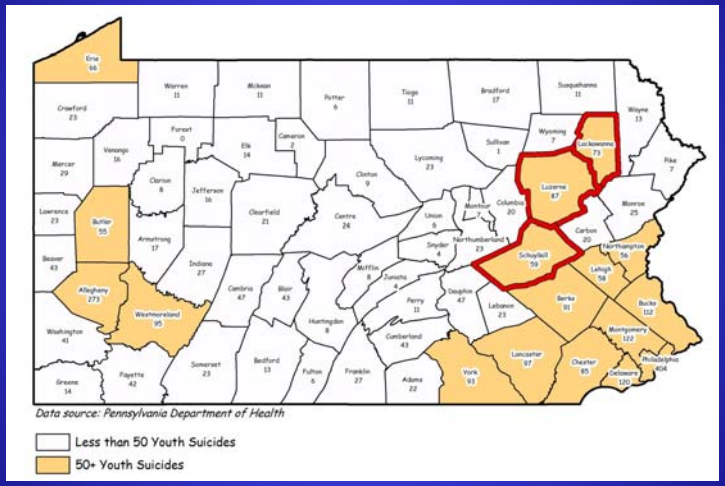
Angie Halaja-Henriques (PA Academy of Family Physicians)
Susan Schrand (PA Coalition of Nurse Practitioners)

Key Statewide Monitoring Committee Members
Carol Thornton (Public Health)
Lonnie Barnes (Substance Abuse)
Myran Delgado (Education & Cultural Competence)
Doris Arena (Transition Specialist)
Arlene Prentice & Melissa Valentine (Juvenile Justice)
Darlene Black & Becky Stephens (Child Welfare)
Vick Zittle (Child Death Review)

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



Targeted Counties: Lackawanna, Luzerne, Schuylkill

Central Aims

- **Objective 1:** Create a task force of a broad range of stakeholders
- **Objective 2**: Provide a youth suicide "gatekeeper" training program
- **Objective 3:** Provide medical practitioners in the 3 counties free access to a web-based self report suicide screening tool
- **Objective 4:** Increase the integration of behavioral health services with medical services
- **Objective 5**:Enhancing clinical services for suicidal youth

National Perspectives:

Mental Health in Children

- AAP: Task Force on Mental Health & COPACFH
- AAP: New Bright Futures Guidelines
- AAP: New priority in strategic plan-early brain development
- NC Chapter of the AAP, Mental Health Committee: changes in Medicaid Policy, PEDIATRICS, 110 (6), December 2002, pp. 1232-1237.
- AACAP: Collaborative Mental Health Care Partnerships in Pediatric Primary Care
- ABCD (Assuring Better Child Health & Development) Projects: early childhood social-emotional development and mental health

Objective 1:

Create a task force of a broad range of stakeholders.

Objective 1: Stakeholders

Successes

State level

- Multiple state agencies collaborating – Dept. of Welfare, Dept. of Health
- Engagement of the:
  - PA Chapter of the American Academy of Pediatrics
- PA Association of Family Physicians
- PA Coalition of Nurse Practitioners
- Linked with Pennsylvania Association of Community Health Centers
- Access Plus collaboration
- Website Development – www.payspi.org
- Monitoring Committee Foundation

Statewide
Suicide Prevention Monitoring Committee

- Office of Mental Health and Substance Abuse Services
- Children's Hospital Of Philadelphia
- Jefferson Medical College
- Department of Health – Bureau of Drug and Alcohol Programs and Bureau of Injury Prevention
- Pennsylvania Council for Children, Youth, and Family Services
- Community Care Behavioral Health
- Office of Children, Youth & Families
- Delaware County Juvenile Probation Department
- Department of Education
- University of Pittsburgh – STAR Center
- Office of Mental Retardation
- MH/MR Administrators Association
- Juvenile Court Judges' Commission
- Juvenile Detention Centers Association of Pennsylvania
- Pennsylvania Community Providers Association
- Pennsylvania Network for Student Assistance Services
- Pennsylvania Chapter, American Academy of Pediatrics, Child Death Review
- National Alliance for Mental Illness of Pennsylvania
- Commonwealth Approved Trainer – Compass Mark
- Feeling Blue Suicide Prevention Council

Objective 2:

Provide a youth suicide "gatekeeper" training program to participating primary care providers in the designated counties.

Objective 2: Gatekeeper Training
Survey Results

- 27% of PCPs report adequate training in suicide risk assessment.
- 35% of PCPs report adequate knowledge about suicide risk assessment.
- 66% of PCPs feel comfortable talking to adolescent patients about suicide.

Why Training?

- Data suggest 16% of adolescents in the last year were depressed and 5% were at risk for suicide.
- PCPs get very little, if any, training on suicide and mental health.
  - Less than 50% of PCPs feel competent in diagnosing depression
- Studies show that physician education increases PCP's feelings of capability, competency, and identification rates of depression, suicide, and other mental health concerns.

Primary Care Physician Training

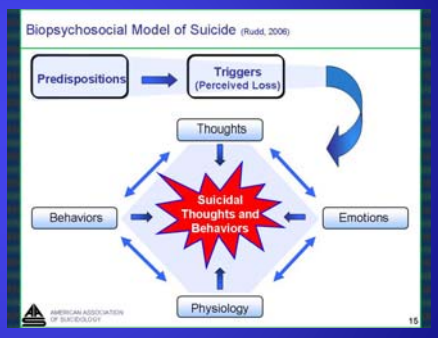
1. Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC-Y)
2. Suicide Toolkit for Rural Primary Care
3. Web-based Training for Nurses

Key features of Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC-Y)

- Developed for PCPs by PCPs and suicide experts who work within primary care
- Covers material most pertinent to PCPs
- Designed as a 90-minute presentation
- Includes lecture, video demonstrations of techniques, and printed resources

Content of RRSR-PC-Y

- Suicide epidemiology and statistics
- Suicide and primary care
- The language of suicide
- Biopsychosocial model of suicide



Content of RRSR-PC-Y

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

Other Trainings

- Suicide Prevention Toolkit for Rural Primary Care by SPRC
  - Self-guided training
  - Numerous resources for setting up practices to engage in suicide prevention activities
- Web-based Training for Nurses
  - To be completed in near future
  - Will be available on national nurse practitioner website

Objective 3:

Provide medical practitioners in three counties free access to a web-based, patient self-report screening tool to assess for suicide and related risk factors.

Objective 3: Screening
Survey Results

- Majority (65%) of PCPs rarely screen for suicide or only screen when they suspect it.
- 14% report using a standardized screening tool to assess suicide risk.
- 83% would consider using a reliable suicide screening tool.
- 74% do not think that a screening tool would disrupt the patient-provider relationship.

Why Screening in Primary Care?

- 70% of adolescents seen once a year
- 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

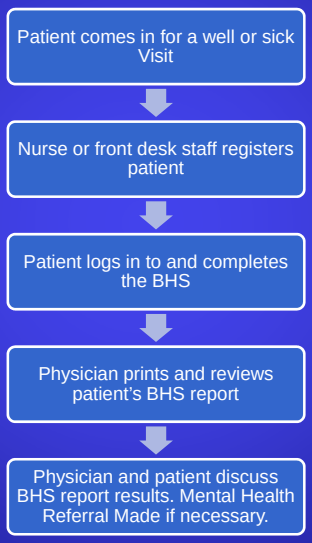
Behavioral Health Screening- Primary Care (PC)

- Screens for risk behaviors and psychiatric symptoms
- Covers areas recommended by best practice guidelines for a well-visit interview
- Takes less than 15 minutes
- Generates summary report and follow-up recommendations in real time
- Promising psychometric properties

Benefits of a Web-based Screening Tool

- Greater dissemination and accessibility
- Instant scoring of results
- Interface with electronic medical records
- Track patient status and service use over time
- Aggregate reports within a practice
- County and state level reports

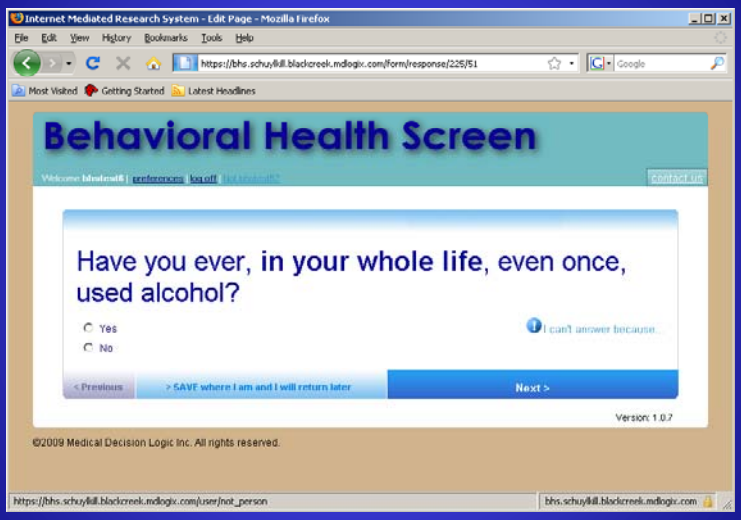
How Does It Work?



Domains of the BHS-PC

SHADESS Categories	Domain	Number of Items	Time Frame	Descriptor
School Activities	**School**	6 and 5	Current; past year	Grades, attendance, enrollment status
Home	**Family**	4 and 1	Current	Conflict, cohesion, monitoring
Drugs and Substances	**Substance Use**	4 and 5	Whole life; past 30 days Past year	Use of tobacco, alcohol, other drugs and abuse of drugs
Emotions	**Anxiety**	16 and 2	Past year; past 2 weeks	Generalized anxiety, OCD symptoms, panic, social phobia, and impairment
	Depression	4 and 7	Past year past 2 weeks	Feeling sad, loss of interest in things, and impairment
	Trauma	8 and 1	Past year; whole life	Exposure to difficult or upsetting things and symptoms of avoidance
	Suicide and Self-Harm	5 and 5	Ever; past week	Suicidal thoughts, plan, attempt, self-harm
	Psychosis	2	Past year	Seeing or hearing things that aren't there
Sexuality	**Sexuality**	6 and 9	Whole life; current	Unprotected sex, number of partners, orientation
Safety	**Safety**	11 and 1	Current; past 30 days; past year	Personal safety
Other	**Independence**	5	Past year; current	Taking responsibility for one's medical care, transition to adulthood
	Demographics	6	Current	Age, race, gender
	Medical	4 and 1	Past year	Health over past year
	Nutrition and Eating	7	Current	Eating and exercise habits, and weight control

Sample Patient Screen



Sample Report for PC provider

Patient Name:_____ DOB:_____

MRN:_____ Date:_____

BEHAVIORAL HEALTH SCREENING RESULTS
CONFIDENTIAL

INSTRUCTIONS
Review report before meeting with the patient. Review results with patient and follow standard care procedures, including referral, if necessary. Place results report in medical chart.

CRITICAL ITEMS

SCALES (All scales are 0 – 4. 0 = no risk and 4 = highest risk)

	Score	Clinical Significance
Depression		
Anxiety		
Suicide – Lifetime		
Suicide – Current		
Traumatic Distress		
Eating Disorder		
Substance Abuse		

RISK BEHAVIORS

PATIENT STRENGTHS

Validity of the BHS-PC

(Diamond et al., 2010)

- The psychiatric scales are valid and predictive of risk behaviors
- Strong Internal Consistency
  Range: 0.75-0.87, *a* ≥ 0.75
- Strong Convergent Validity
  BHS suicide risk and SSI, r = .72, P < .0001
- Strong Divergent Validity
- More than adequate specificity and sensitivity

Objective 4:

Increase the integration, if not collocation, of behavioral health services with medical services.

Objective 4: Integration
Survey Results

- 78% have referred at least 1 adolescent patient to MH services for suicidal ideation or attempts in the past year.
- The majority do not have a MH worker in their office to help with triage (73%) or treatment (81%).
- 45% report that they never or rarely can quickly get MH appointments for suicidal patients.
- 24% report that the MH provider always or often lets them know if a patient attends services.

Objective 4: Integration
Challenges

- Lack of faith in the mental health providers
- Lack of communication between systems
- Inability to change practice behavior
- Many barriers to collocation

Objective 4: Integration
Successes

- Behavioral health partners for each PC site identified
- Successful meetings between medical and behavioral health providers facilitated
- Partnership with Access Plus
- Engagement of D&A providers
- Resource sheets developed in each county

Objective 4: Integration
Discussion

- How do we better bridge the communication gap between systems?
- What is the motivation of each side to engage the other? What's in it for the mental health providers? And how do we tap into this?
- What are the benefits and drawbacks to telepsychiatry?

Objective 5:

Provide clinical training in best practice therapy models for suicidal youth to behavioral health providers.

Objective 5: Clinical Trainings

Successes

- Provided 2 CBT trainings in the region
- Provided 2 family therapy trainings in the region
- Coordinated a co-occurring training with the Bureau of D&A Programs
- Safety Planning Training
- Crisis Management Training

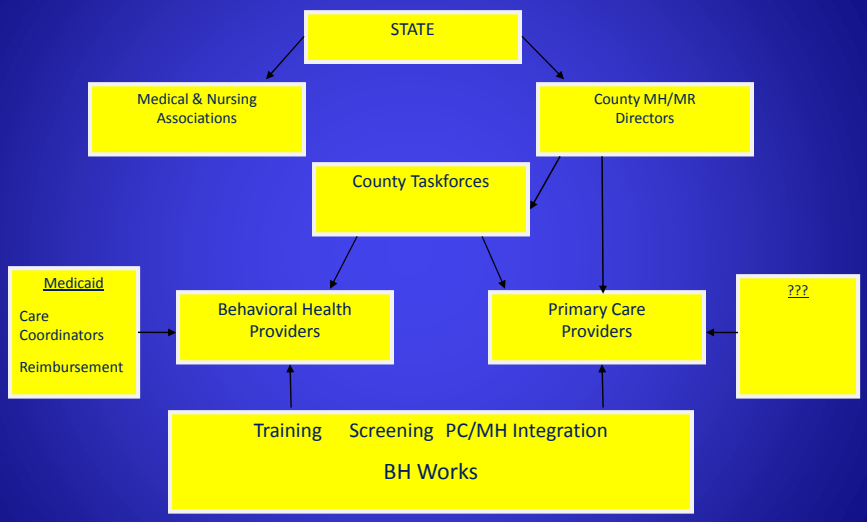
Success Recap

- Broad range of stake holders involved
- Task forces in each county
- 10 primary care practices participating
- Over 400 youth screened
- 48 youth identified as at risk for suicide
- 13% identification rate

Future Directions:
Grant Renewal

- Technical Assistance Model
  - Statewide dissemination of the BHS
  - Task Forces
  - Technical Assistance center, website, and resources

Envisioned Organization of Partnerships & Support:



Role of Task Forces

- Training (2 Day Workshop):
  - Familiarity with resources and the BH Works
  - Understanding of the rationale for suicide prevention in Primary Care
- Ongoing Responsibilities:
  - Attend 2-3 follow up training discussions
  - Reach out to and identify PCP
  - Identify and collaborate with a “champion” in each PCP
  - Facilitate PCP training in BH works, resources, and suicide prevention
  - Reach out to local mental health agencies to create partnerships
  - Work with local MH/MR director to enhance collaboration across the county

Role of GLS Grant Team

- What kind of support can the grant team and funds provide to task forces to implement this model???
- Possibilities:
  - Enhance state website capacity
  - Provide free QPR training around the state
  - Provide yellow ribbon training in schools

BHWorks Website Resources

- Education & Training for PCPs:
  - Practice Readiness Evaluation System
  - SPRC Tool Kit for PC
  - AAP Tool Kit for PC
  - AAS Training
  - Provide CME and CEU credits for web-based trainings
  - Mental Health Lecture Series
  - Motivational Interviewing
  - How to talk to parents and their children about suicide, mental health, and seeking services

BHWorks Website Resources

- Screening System
  - BHS-PC
  - Training Manual & Video
- Training for Mental Health Providers
  - Suicide Crisis Management
  - Safety Planning
  - Additional training materials on assessing and treating suicidal youth

To Learn More…

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