Bringing Suicide Prevention into Primary Care

Matthew Wintersteent, PhD
Thomas Jefferson University
Department of Psychiatry & Human Behavior
Philadelphia, PA
Disclosures

- The presenter receives research funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and consulting funds from the American Association of Suicidology (AAS)
- However, the content of this presentation does not relate to any product of a commercial interest.
Learning Objectives

1. Understand the rationale for suicide prevention in primary care
2. Be familiar with the Youth Suicide Prevention in Primary Care project and its objectives
3. Learn strategies to help implement suicide prevention programs in primary care practices
Health Care Reform 2.0

• Full implementation of Affordable Care Act in 2019
  • What will it look like?
    • 32 million uninsured Americans will have insurance
    • Extended Medicaid coverage to 16 million Americans
• Emphasis on integration of behavioral and primary health care (and other specialties)
• Payment mechanisms will move away from fee-for-service for behavioral health
Why Should Mental Health Professionals Focus on Health Care?

- 24% of GNP by 2020 on Medicaid and Medicare
  - Psychologists and psychiatrists will be left out if they stay in their silo

Most Expensive Disorders in the US (over $10b each/yr):
- Ischemic heart disease
- Motor vehicle accidents
- Acute respiratory infection
- Athropathies
- Hypertension
- Back problems
- Mood disorders
- Diabetes

Top 5 Risk Factors for Death:
- Smoking
- High Blood Pressure
- Obesity
- Physical inactivity
- High blood glucose

With everything else going on in primary care, why focus on suicide prevention?
<table>
<thead>
<tr>
<th>Rank</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>All Ages</th>
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<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Short Gestation 4,148</td>
<td>Congenital Anomalies 507</td>
<td>Malignant Neoplasms 439</td>
<td>Malignant Neoplasms 477</td>
<td>Homicide 4,678</td>
<td>Suicide 5,735</td>
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<td></td>
<td></td>
<td></td>
<td>SIDS 2,063</td>
<td>Homicide 385</td>
<td>Congenital Anomalies 163</td>
<td>Suicide 267</td>
<td>Suicide 4,600</td>
<td>Homicide 4,258</td>
<td>Heart Disease 10,594</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Maternal Pregnancy Comp. 1,561</td>
<td>Malignant Neoplasms 346</td>
<td>Homicide 111</td>
<td>Homicide 150</td>
<td>Malignant Neoplasms 1,604</td>
<td>Malignant Neoplasms 3,619</td>
<td>Suicide 6,571</td>
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<td>Unintentional Injury 1,110</td>
<td>Heart Disease 159</td>
<td>Heart Disease 68</td>
<td>Congenital Anomalies 135</td>
<td>Heart Disease 1,028</td>
<td>Heart Disease 3,222</td>
<td>Homicide 2,473</td>
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<tr>
<td>6</td>
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<td>Placenta Cord Membranes 1,030</td>
<td>Influenza &amp; Pneumonia 91</td>
<td>Chronic Low. Respiratory Disease 60</td>
<td>Heart Disease 117</td>
<td>Congenital Anomalies 412</td>
<td>Heart Disease 741</td>
<td>Liver Disease 2,423</td>
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<td>Bacterial Sepsis 583</td>
<td>Septicemia 62</td>
<td>Cerebrovascular 47</td>
<td>Chronic Low. Respiratory Disease 73</td>
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<td>Diabetes Mellitus 6,510</td>
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<td>Respiratory Distress 514</td>
<td>Benign Neoplasms 59</td>
<td>Benign Neoplasms 37</td>
<td>Benign Neoplasms 45</td>
<td>Influenza &amp; Pneumonia 181</td>
<td>Cerebrovascular 517</td>
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<td></td>
<td></td>
<td>Circulatory System Disease 507</td>
<td>Perinatal Period 52</td>
<td>Influenza &amp; Pneumonia 37</td>
<td>Cerebrovascular 43</td>
<td>Diabetes Mellitus 165</td>
<td>Liver Disease 487</td>
<td>Diabetes Mellitus 1,789</td>
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<td></td>
<td></td>
<td>Necrotizing Enterocolitis 472</td>
<td>Chronic Low. Respiratory Disease 51</td>
<td>Septicemia 32</td>
<td>Septicemia 35</td>
<td>Complicated Pregnancy 163</td>
<td>Congenital Anomalies 397</td>
<td>Influenza &amp; Pneumonia 773</td>
</tr>
</tbody>
</table>
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 Director
(OMHSAS)

Project Co-Director
(OMHSAS)

Project Director
(Academia)

Evaluation Unit
(Housed in Academia)

Training Unit
(Housed in Academia)

County Task Forces

County MH/MR Directors

Public & Private Healthcare & Insurance Entities:
Community Care
Behavioral Health Access Plus
PA Community Providers Association
PA Council on Children, Youth and Families Services

Steering Committee

Professional Organizations
PA Chapter of the American Academy of Pediatrics
PA Academy of Family Physicians
PA Coalition of Nurse Practitioners
PA Association of Community Health Centers (FQHCs)

Key Statewide Monitoring Committee Members
Department of Health (public health)
Substance Abuse Division
Education & Cultural Competence
Transition Specialist
Juvenile Justice
Child Welfare
Child Death Review
Where We Are in Pennsylvania

- Philadelphia
- Pittsburgh
- Scranton

[Map of Pennsylvania with highlighted regions and major cities]
Five Central Aims

# 1: Create state and local stakeholder 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

- State-Level
- Community-Level
State Level Stakeholders

State Agencies:
• Department of Public Welfare (Behavioral Health)
• Department 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
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
- Worked with county suicide prevention task forces
Aim # 2: Coordination of Behavioral Health & Medical Services

Stakeholder Involvement

State-Level
Community-Level

Coordination of Medical and Behavioral Health 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 MH appointments for suicidal patients and encounter long waiting lists for non-urgent patients

• Only 24% reported that the MH provider always or often let them know if a patient attends services

Other Challenges

• PCPs cannot get reimbursed for identifying and treating MH 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
Aim # 3: PCP Gatekeeper Training

- Stakeholder Involvement
  - State-Level
  - Community-Level
- Coordination of Medical and Behavioral Health Services
- Training
  - PCPs
  - Behavioral Health Providers
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 can directly impact a reduction in the suicide rate (Mann et al., 2005)
Training Options

• Live in-person trainings
  • Pros: Positive doctor – doctor experience, address practice-specific concerns
  • Cons: Scheduling and cost

• Toolkit
  • Pros: Scheduling and cost, printed resources
  • Cons: Must be self-motivated, hard to engage full practice, lack of demonstration and practice, unable to interact with trainer

• Online trainings
  • Pros: Scheduling and cost
  • Cons: Unable to interact with trainer
Aim #4: Training Behavioral Health Providers

- Stakeholder Involvement
  - State-Level
  - Community-Level

- Coordination of Medical and Behavioral Health Services

- Training
  - PCPs
  - 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 turnover

• Bottom line: Agenda was too vast for this grant; implementing smaller goals:
  • Safety Planning Training
  • Crisis Management Training
Aim # 5: Web-based Screening

Stakeholder Involvement
- State-Level
- Community-Level

Coordination of Medical and Behavioral Health Services

Training
- PCPs
- Behavioral Health Providers

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 6-10 minutes to complete
- 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
Progress & Outcomes

- **Stakeholder Involvement**
  - State-Level
  - Community-Level

- Coordination of Medical and Behavioral Health Services

- Training
  - PCPs
  - Behavioral Health Providers

- Screening

Evaluate Outcome and Report Back to Stakeholders
# Demographics

<table>
<thead>
<tr>
<th>Sex n(%)</th>
<th>All Screened (N=1561)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>964 (62.7)</td>
</tr>
<tr>
<td>Male</td>
<td>574 (37.3)</td>
</tr>
</tbody>
</table>

| Age Mean (Range, SD) | 17.70 (14-24, ±2.94) |

<table>
<thead>
<tr>
<th>Race n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black/African American</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
</tr>
<tr>
<td>More than one race</td>
</tr>
<tr>
<td>Not Sure</td>
</tr>
</tbody>
</table>
# Mental Health

<table>
<thead>
<tr>
<th></th>
<th>All Screened (N=1561)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression n(%)</strong></td>
<td></td>
</tr>
<tr>
<td>Minimal</td>
<td>683 (45.9)</td>
</tr>
<tr>
<td>Mild</td>
<td>406 (27.3)</td>
</tr>
<tr>
<td>Moderate</td>
<td>104 (7.0)</td>
</tr>
<tr>
<td>Severe</td>
<td>295 (19.8)</td>
</tr>
<tr>
<td><strong>Anxiety n(%)</strong></td>
<td></td>
</tr>
<tr>
<td>Not Significant</td>
<td>881 (59.0)</td>
</tr>
<tr>
<td>Significant</td>
<td>613 (41.0)</td>
</tr>
<tr>
<td><strong>Suicide n(%)</strong></td>
<td></td>
</tr>
<tr>
<td>No History</td>
<td>1223 (82.9)</td>
</tr>
<tr>
<td>Hx Suicidal Ideation or attempt, but not current</td>
<td>186 (12.6)</td>
</tr>
<tr>
<td>Current Suicidal Ideation or Past Week Attempt</td>
<td>66 (4.5)</td>
</tr>
<tr>
<td><strong>Traumatic Distress n(%)</strong></td>
<td></td>
</tr>
<tr>
<td>Not Significant</td>
<td>1090 (74.2)</td>
</tr>
<tr>
<td>At risk for PTSD</td>
<td>379 (25.8)</td>
</tr>
<tr>
<td><strong>Substance Abuse n(%)</strong></td>
<td></td>
</tr>
<tr>
<td>Not Significant</td>
<td>1452 (93.0)</td>
</tr>
<tr>
<td>At risk for Substance Abuse Problem</td>
<td>58 (3.7)</td>
</tr>
<tr>
<td><strong>Eating Disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Not Significant</td>
<td>1450 (96.7)</td>
</tr>
<tr>
<td>At risk for an Eating Disorder</td>
<td>49 (3.3)</td>
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## Risk Factors

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<tr>
<td><strong>Access to a gun</strong></td>
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<tr>
<td>Yes</td>
<td>185 (12.2)</td>
</tr>
<tr>
<td>No</td>
<td>1334 (87.8)</td>
</tr>
<tr>
<td><strong>Exposure to Violence</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>886 (58.4)</td>
</tr>
<tr>
<td>Some</td>
<td>630 (41.6)</td>
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## Satisfaction

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td><strong>Comfortable answering these questions?</strong></td>
<td></td>
</tr>
<tr>
<td>Very uncomfortable</td>
<td>105(7.2)</td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>108(7.4)</td>
</tr>
<tr>
<td>Neutral</td>
<td>548(37.4)</td>
</tr>
<tr>
<td>Comfortable</td>
<td>464(31.7)</td>
</tr>
<tr>
<td>Very comfortable</td>
<td>240(16.4)</td>
</tr>
<tr>
<td><strong>A good idea for medical providers to ask these kinds of questions?</strong></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>144(9.9)</td>
</tr>
<tr>
<td>Yes</td>
<td>1308(90.1)</td>
</tr>
<tr>
<td><strong>Comfortable discussing answers with medical provider?</strong></td>
<td></td>
</tr>
<tr>
<td>Very uncomfortable</td>
<td>148(10.1)</td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>213(14.5)</td>
</tr>
<tr>
<td>Neutral</td>
<td>553(37.8)</td>
</tr>
<tr>
<td>Comfortable</td>
<td>394(26.9)</td>
</tr>
<tr>
<td>Very comfortable</td>
<td>156(10.7)</td>
</tr>
<tr>
<td><strong>Medical provider asks about feelings (sadness, anxiety, or suicidal feelings)?</strong></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>460(31.8)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>747(51.7)</td>
</tr>
<tr>
<td>Often</td>
<td>239(16.5)</td>
</tr>
<tr>
<td><strong>Medical provider asks about experiences (violence-home or neighborhood, substance use, and sexual activity)?</strong></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>628(43.3)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>640(44.1)</td>
</tr>
<tr>
<td>Often</td>
<td>184(12.7)</td>
</tr>
</tbody>
</table>
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 website with our multiple resources
   • Many of the training pieces are on www.payspi.org

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 – see Massachusetts
  • Increased availability of behavioral health referral sources
The Pennsylvania Model for Youth Suicide Prevention in Primary Care (YSP-PC)

Stakeholder Involvement
State-Level
Community-Level

Coordination of Medical and Behavioral Health Services

Training PCPs Behavioral Health Providers

Screening

Referral to a Better Prepared Behavioral Health System

Evaluate Outcome and Report Back to Stakeholders
Correspondence Regarding This Presentation May be Directed to:

Matthew B. Wintersteen, Ph.D.
Assistant Professor, Director of Research
Thomas Jefferson University/Jefferson Medical College
Department of Psychiatry & Human Behavior
Division of Child & Adolescent Psychiatry
833 Chestnut Street, Suite 210
Philadelphia, PA 19107

(215) 503-2824 – phone
(215) 503-2852 – fax

matthew.wintersteen@jefferson.edu