Tools for Implementing Suicide Prevention in Primary Care

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Disclosure

- 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)

Learning Objectives

1. Understand the rationale for suicide prevention in primary care
2. Be familiar with tools used to implement staff training and patient screening for suicide risk in primary care

Why Screen For Suicide in Primary Care?

- 70% of adolescents seen once a year by a physician
- 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

What are the Barriers to Screening?

- 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 need hand scoring
  - Very few, not even the GAPS, map on to formal diagnostic categories
  - Few screening tools (less than five) have psychometric support.

Provider Based (PCPs) Barriers

- Clash of medical and behavioral health paradigms
- Lack of training in MH assessment
- Discomfort with MH problems
- Lack of time in a busy practice
- Resistance toward change in work flow
- Fear of increased liability

Organizational Barriers

- Lack of psychiatrists for assessments
- Difficult to access care
- No assistance with triage and case management
- Too many restrictions from insurance
- Lack of available services
- No reimbursement for screening, assessment, or treatment

Behavioral Health System Based Barriers

- Few providers outside the larger, urban areas
- Long waiting lists
- Low reimbursement
- Staff turn-over
- Lack of well defined, empirically supported clinical treatment models
- No systematic focus on engagement

Family and Patient Based Barriers

- Concerns about stigma
- Low trust that the “system will be helpful.”
- Low perceived need (e.g., “He will grow out of this.”)
- Other challenges take priority (e.g., money, medical health, school)
- Parental stress (e.g., depression, substance use)
- Family chaos and conflict
- Patient refusal

Bottom Line…

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

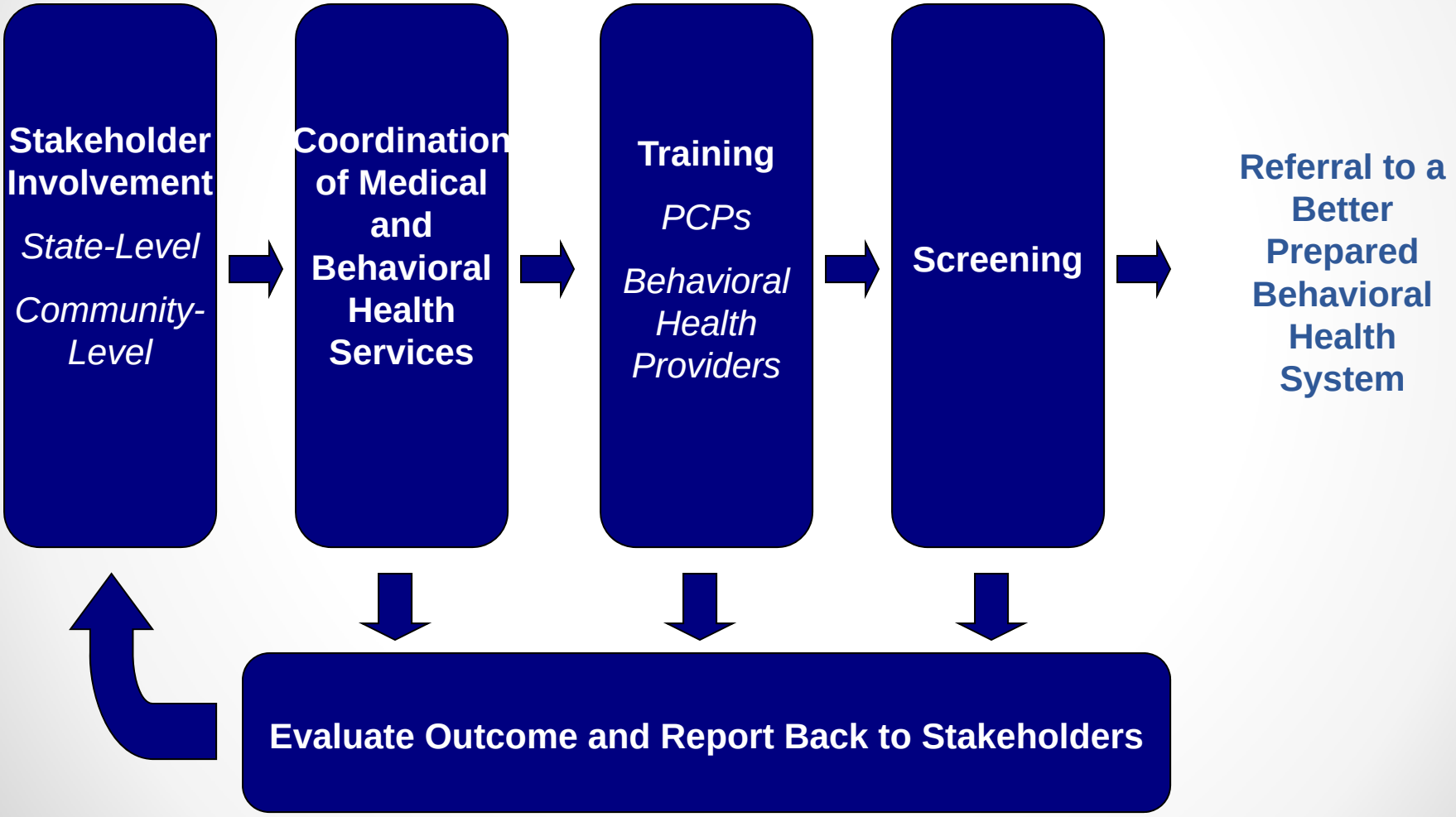
Youth Suicide Prevention in Primary Care (YSP-PC)

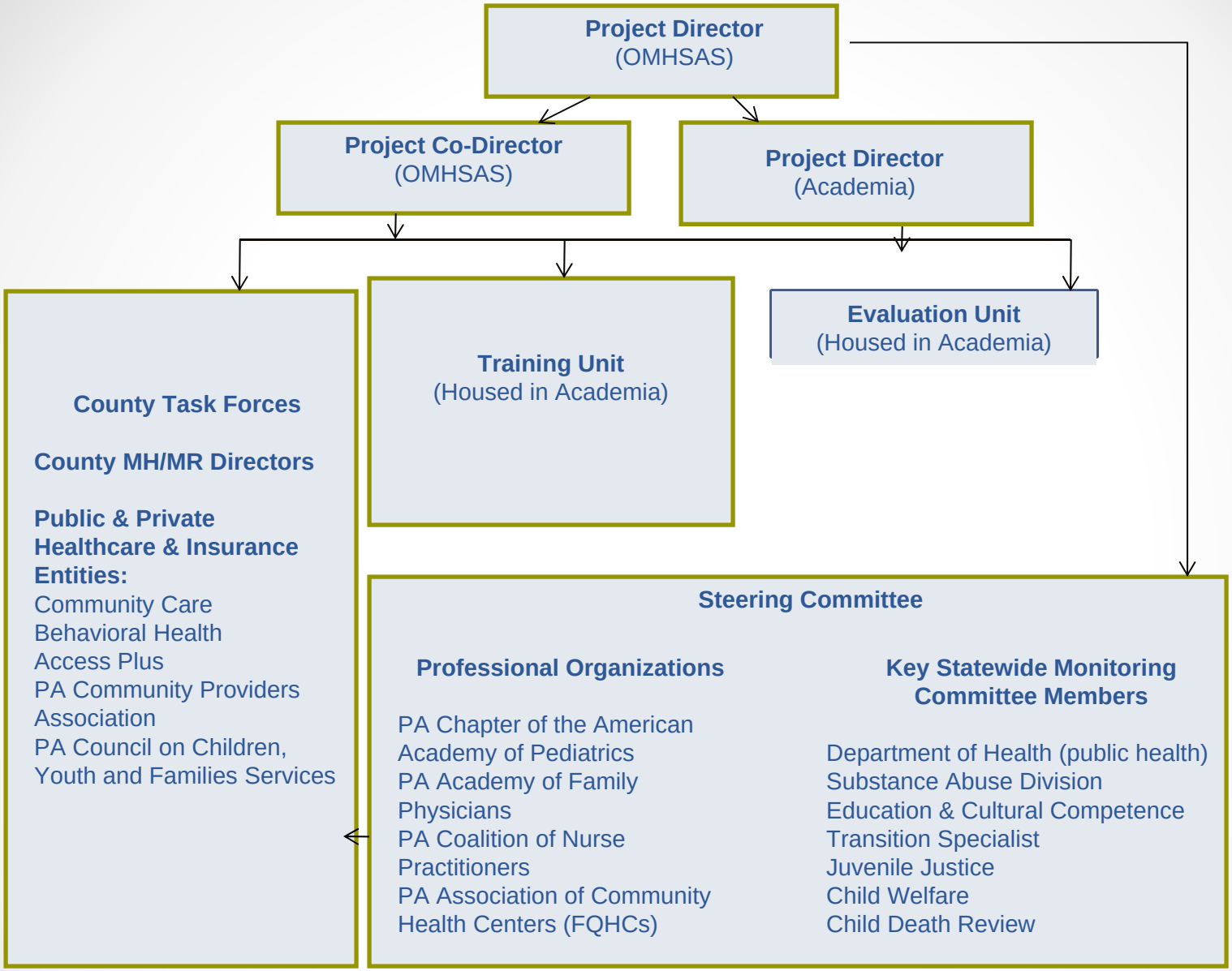
(ages 14-24)

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

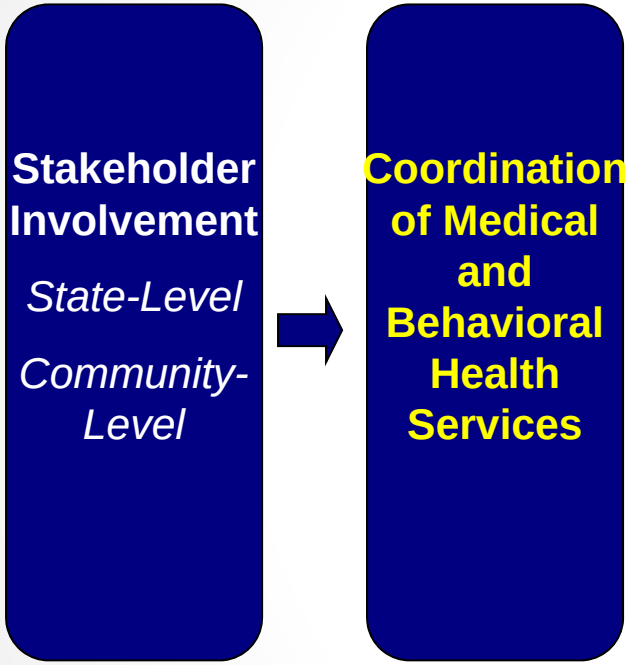
Funded by SAMHSA through the Garrett Lee Smith Memorial Act

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




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

Aim # 2: Coordination of Behavioral Health & Medical Services



Models of Collaborative Care

- Coordinated
- Co-Located
- Integrated

- Example:
  - Youth Suicide Prevention in Primary Care

Coordinated Care

- Routine screening for behavioral health problems conducted in primary care setting
- Referral relationship between behavioral health and primary care
- Routine exchange of information between both treatment settings to bridge cultural differences
- PCPs to deliver brief behavioral health interventions using algorithms
- Connections made between patients and community resources

Blount, 1998, 2003.

Issues Related to Behavioral Health Screening in Primary Care

- Screen for one disorder or range of psychosocial problems and risk factors?
- Who will conduct the screening?
- Will it increase time of appointment?
  - Indicated screening – overall more time attributed to screening
  - Universal screening – no additional time attributed to screening when spread over all patients
- Reimbursement – traditionally not covered
  - Medicare to now cover costs of screening for depression and substance abuse
  - Massachusetts found court-ordered screening resulted in increase from 16.6% to 53.6% ($10 per screen, $25 if follow up needed)

Telepsychiatry

Pros

- Rapid follow-up/consult
- Underserved areas
- Cost effective (more pts in less time, no travel)
- Pts satisfied, even with rapport
- Promotes team dynamic
- Effective for many pts and dxs

Cons

- Possibly impersonal, loss of sensory info
- Not suitable for violent pts
- Difficult to obtain licensure
- Reimbursement
- Technical difficulties
- Sustainability problems

Co-Located Care

- Medical and behavioral health services in same facility
- Referral process between medical and behavioral health services
- Enhanced informal communication between providers
- Consultation to increase skills of both groups
- Increase in level of quality of behavioral health services offered
- Significant reduction of no-shows for behavioral health treatment

Blount, 1998, 2003.

Integrated Care

- Medical and behavioral health services either in same facility or separate locations
- One treatment plan with both medical and behavioral health components
- Team works together to deliver care based on prearranged protocol
- Teams composed of physician plus one or more of: PA, NP, nurse, case manager, family advocate, behavioral health therapist
- Use database to track care of patients referred to behavioral health

Blount, 1998, 2003.

Liaison/Navigator Role: Within Practices

- Identified interested PC practices to participate in the project
- Educated PCP about how to access services
- Created support material for accessing mental health services (phone numbers, office posters, wallet cards)
- Offered educational services about suicide and behavioral health assessment

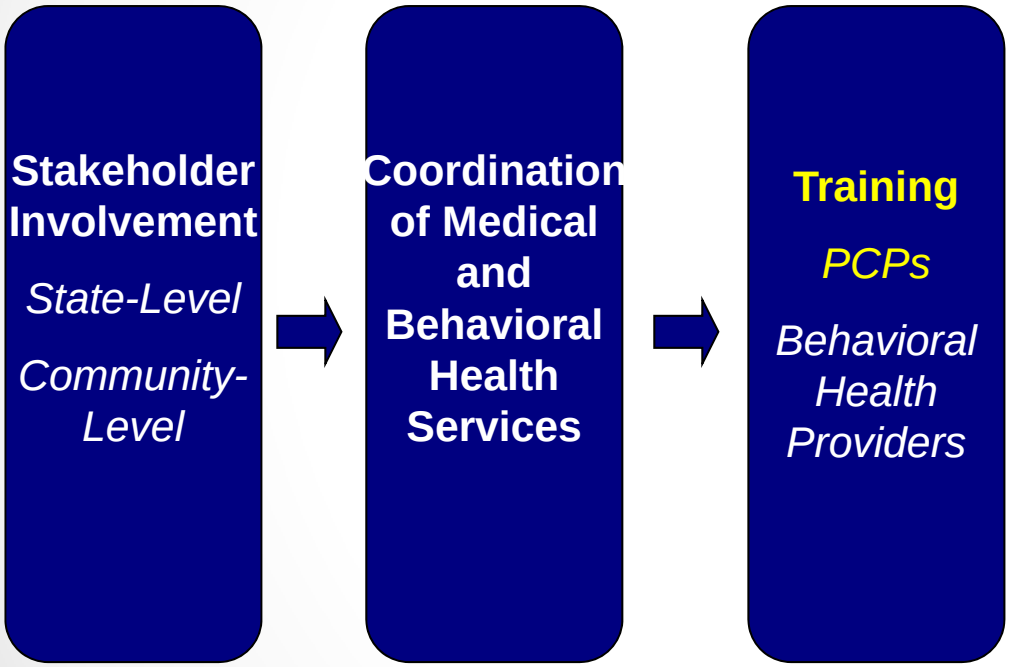
Liaison/Navigator Role: Between Services

- Identified current and new behavioral health providers for partnership
- Set-up face to face meetings to discuss barriers and improved communication
- Invited behavioral health staff to suicide risk assessment trainings
- Left behavioral health release of information forms at the PCP office
- Behavioral health offices created a single point of contact or single contact person (PCP specialist) for PCP's
- Assisted in patient referrals
  - Decreased over time as relationships between PCP's and behavioral health providers improved

Resources

- Integrated Care Resource Center
- SAMHSA-HRSA Integrated Care Models
- Milbank Report (2010) – Evolving Models of Behavioral Health Integration in Primary Care
- Center for Studying Health System Change
- ACP Internist – April 2009: Pennsylvania Medical Home Model

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 PCP's feelings of capability and competenty which leads to increased identification rates of high risk youth
- Physician education has been shown to reduce the suicide rate (Mann et al., 2005)

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

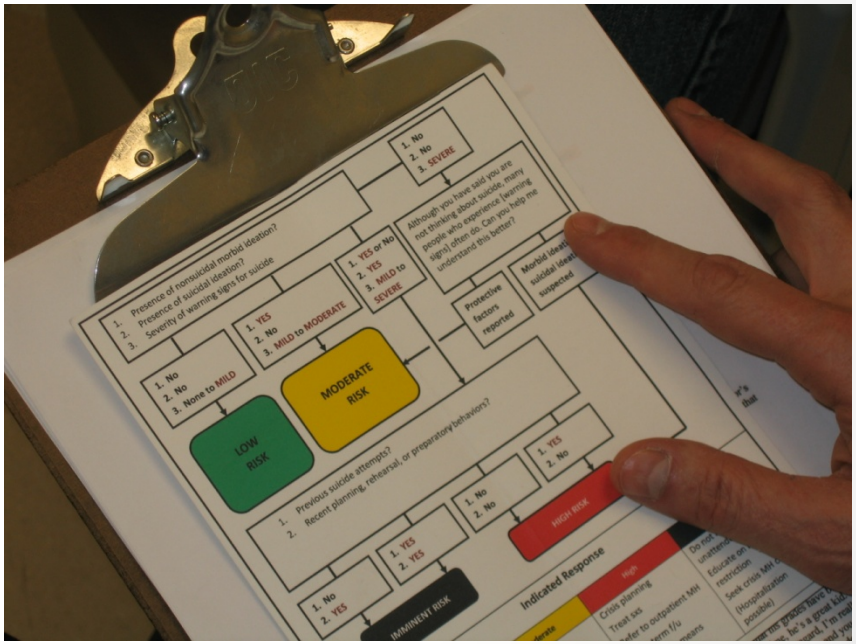
American Association of Suicidology

(RRSR-PC-Y) 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

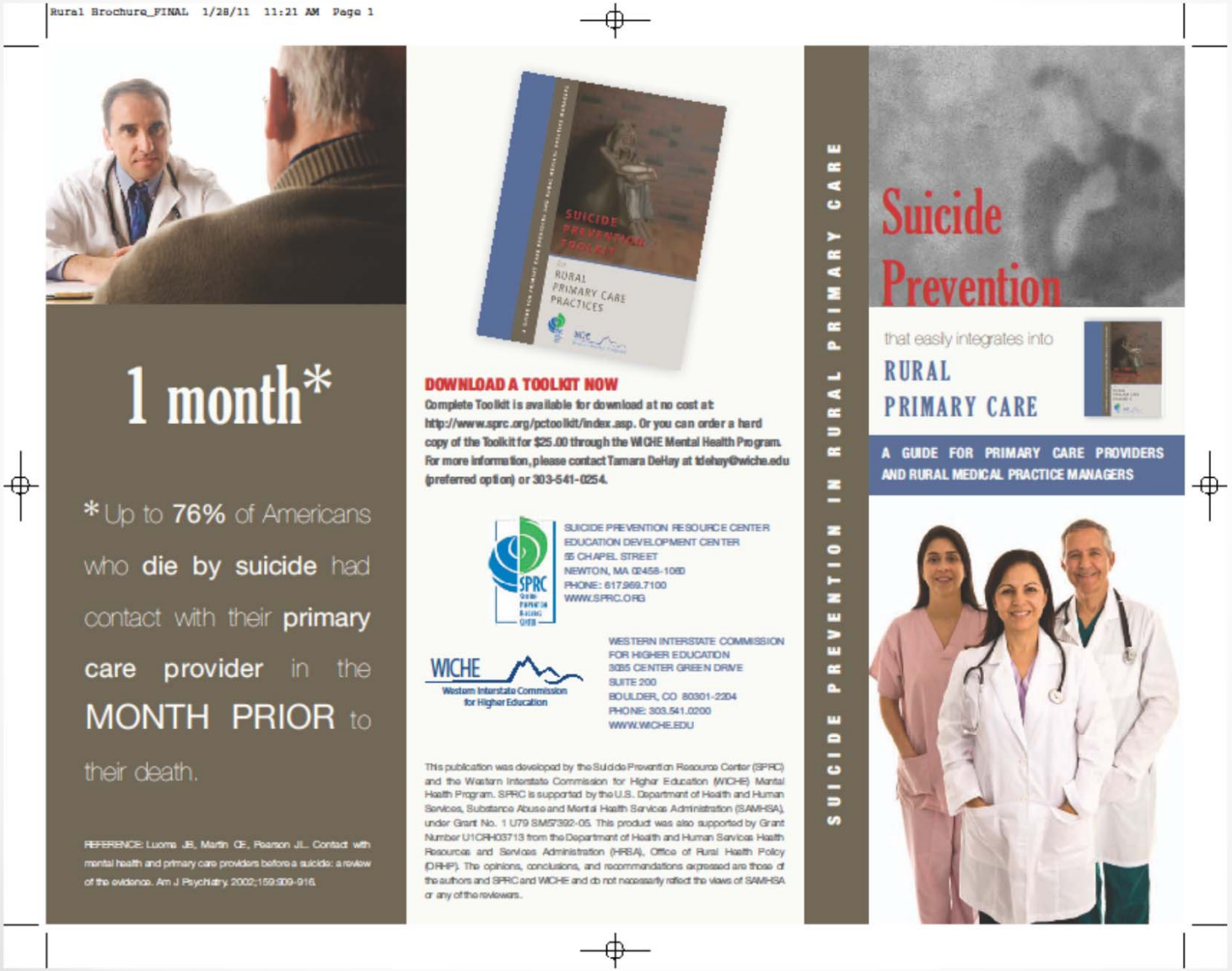
- Suicide risk assessment
- Triage decision making
- Crisis Response Planning
- Interventions for Primary Care
- Documentation



Suicide Prevention Toolkit for Rural Primary Care

SPRC and WICHE

SPRC Suicide Prevention for Rural Primary Care Toolkit



Toolkit: Overall Layout

- The Toolkit is available in 2 forms
  - Hard copy, spiral bound ordered through WICHE
  - Electronic copy (www.sprc.org)

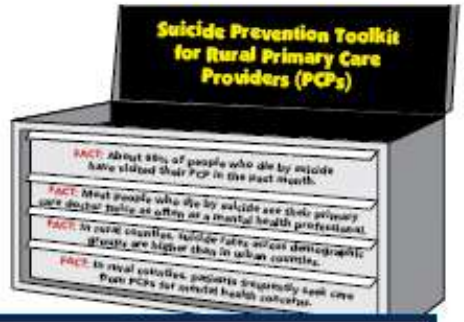
- Includes 6 sections:
  - Getting started
  - Educating clinicians and office staff
  - Developing mental health partnerships
  - Patient management tools
  - Patient education tools
  - Resources

- New content on billing for services in PC setting

1. Getting Started

QUICK START GUIDE

How to use the Suicide Prevention Toolkit



STEP 1 Communicate with staff about the new Suicide Prevention Initiative in your office. Determine who will be the lead coordinator in your office. That individual should familiarize himself/herself with the entire contents of the Toolkit.

STEP 2 Meet to develop the "Office Protocol" for potentially suicidal patients. See the "Office Protocol Development Guide" instruction sheet in the Toolkit.

STEP 3 Schedule necessary trainings for staff members according to the individual suicide prevention responsibilities determined in Step 2.

STEP Develop a referral network to facilitate the collaborative care of suicidal

1. Getting Started

To be used with instruction sheet to create an office protocol that may be referred to when a potentially suicidal patient presents

Protocol for Suicidal Patients - Office Template
Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected…

- ✓ _____ **should be called/paged to assist with evaluation of risk (e.g., physician, mental health professional, telemedicine consult etc.).**
- ✓ **Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).**

If a patient requires hospitalization…

- ✓ **Our nearest Emergency Department or psychiatric emergency center is _____. Phone #_____.**
- ✓ **_____ will call _____to arrange transport.**
  (Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)

  Backup transportation plan: Call_____.
- ✓ **_____will wait with patient for transport.**

Documentation and Follow-Up…

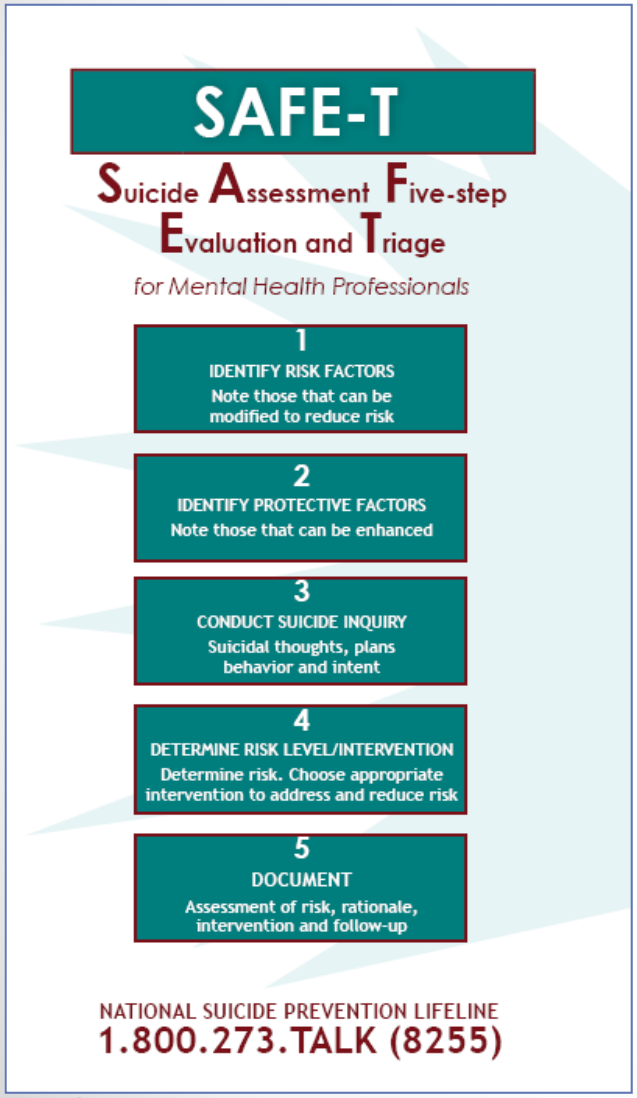
_____will call ED to provide patient information.

- ✓ **_____will document incident in_____.**
  (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)
- ✓ **Necessary forms are located _____.**
- ✓ **_____will follow-up with ED to determine disposition of patient.**
  (Name of individual or job title)
- ✓ **_____ will follow up with patient within_____.**
  (Name of individual or job title) (Time frame)

2. Educating Clinicians and Office Staff

- Primer with 5 brief learning modules:
  - Module 1- Prevalence & Comorbidity
  - Module 2- Epidemiology
  - Module 3- Effective Prevention Strategies
  - Module 4- Suicide Risk Assessment
    - Warning Signs, Risk Factors, Suicide Inquiry, Protective Factors
  - Module 5- Intervention
    - Referral, PCP Intervention, Documentation & Follow-up

3. Developing Mental Health Partners



- Letter of introduction to potential referral resources--template
  - Increasing vigilance for patients at risk for suicide
  - Referring more patients
  - SAFE-T card for Mental Health Providers
  - Invitation to meet to discuss collaborative management of patients
  - NSSP recommends training for health care professionals
  - Nationally disseminated trainings for MHPs

4. Patient Management

- "Safety Plan"
  - Collaboratively developed with patient
  - Template that is filled out and posted
  - Includes lists of warning sings, coping strategies, distracting people/places, support network with phone numbers
- "Crisis Support Plan"
  - Provider collaborates with Pt and support person
  - Contract to help- includes reminders for ensuring a safe environment & contacting professionals when needed

5. Patient Education

Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

How to Get a Copy of the Toolkit…

- Order a Toolkit: Hard copies of the toolkit are available for $25.00 through WICHE Mental Health Program. For more information, please contact Tamara DeHay at tdehay@wiche.edu (preferred option) or 303-541-0254

- View Online: http://www.sprc.org/pctoolkit/index.asp

Online Adolescent Suicide Risk Assessment Training

Virginia Biddle, PhD, CRNP, RN

Online Training

- 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

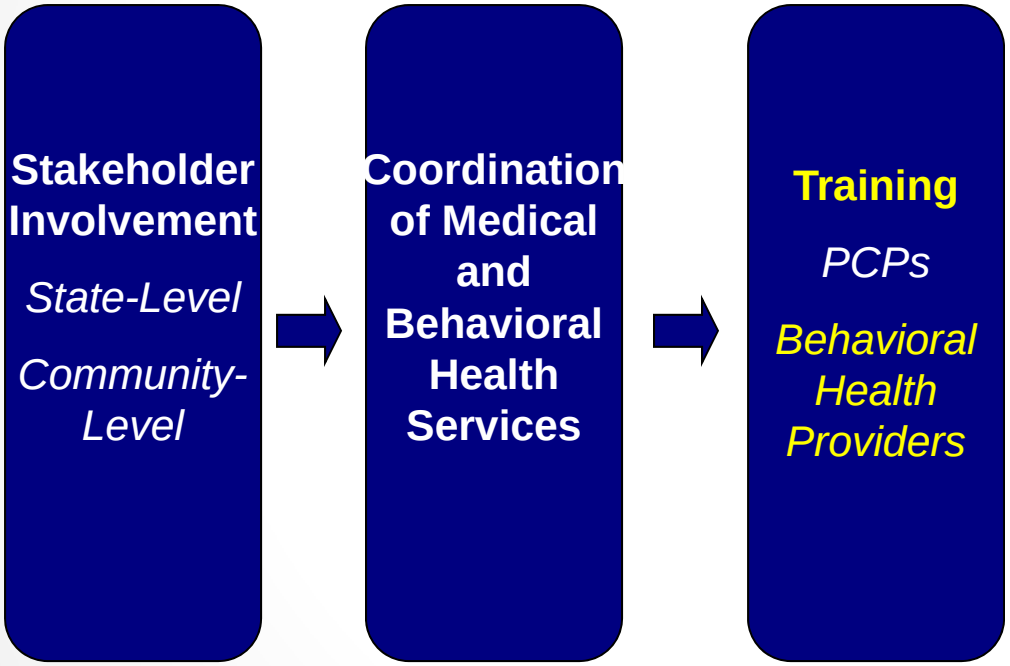
Online Training

- 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”

Webinars Offered to PCPs through State Medical and Nursing Associations

- Suicide Risk Assessment
- Safety Planning
- Motivational Interviewing
- Interviewing and Managing Suicidal Patients and their Families
- Psychopharmacology for the PCP
- Using the AAP Toolkit

Aim #4: Training Behavioral Health Providers



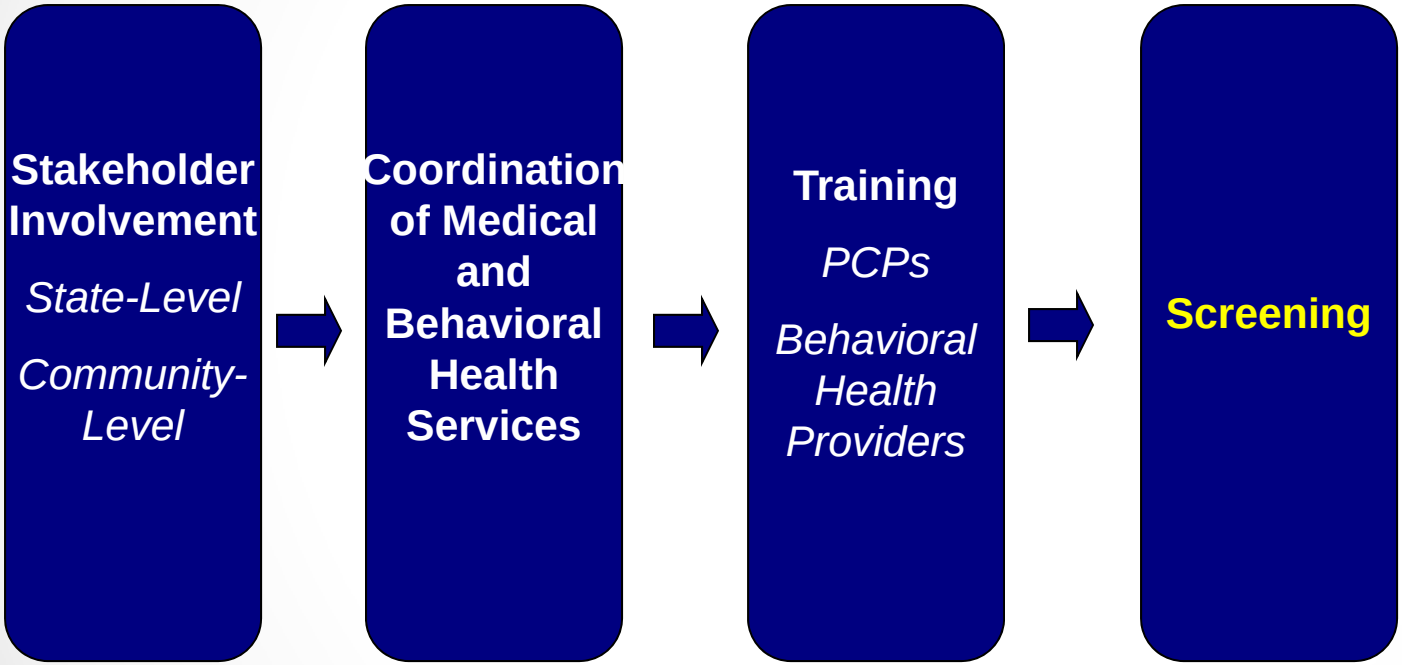
Behavioral Health Trainings

- 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 turnover
- 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 MH problems
- Summary reports maximize efficiency of medical staff's time
- Facilitates patient-doctor conversations
- Increases early detection of risk behaviors
- Patients are more likely to receive care after being screened

Why a web-based screening tool?

- 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 with-in a practice
- Support QA projects and license renewal
- Capacity for tracking county and state level trends

The BHS-PC

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

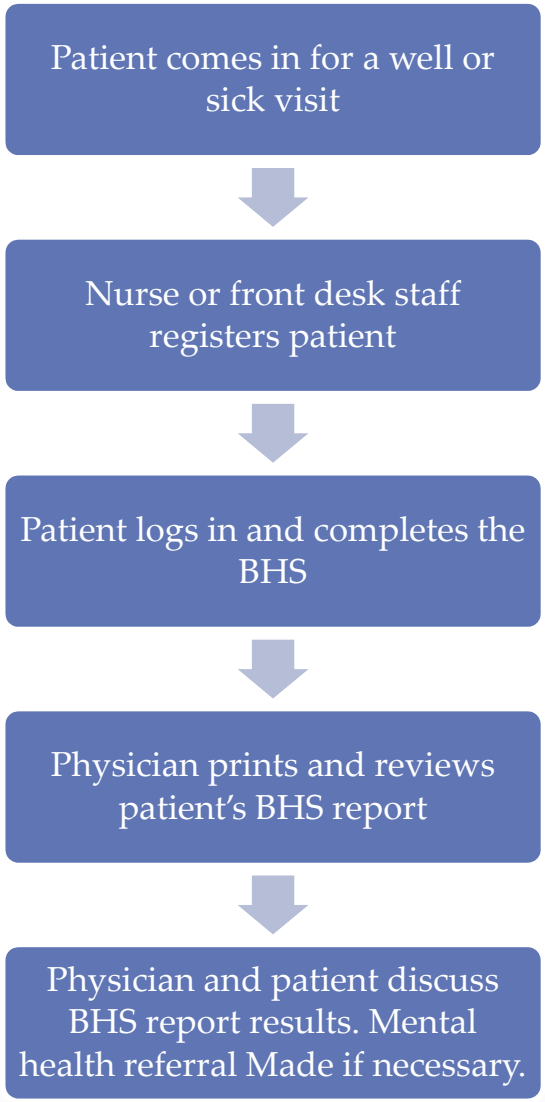
Key Domains of BHS-PC

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

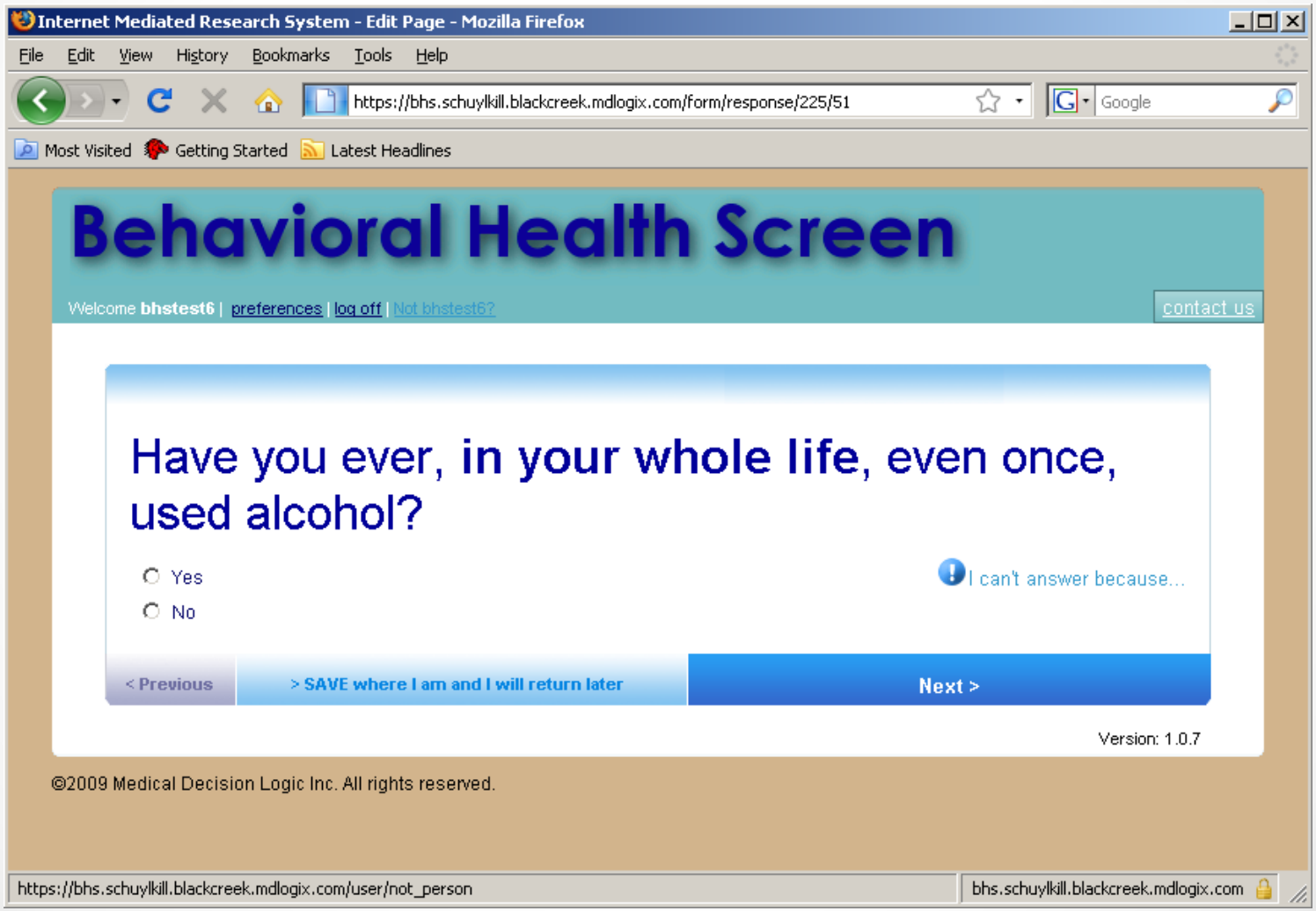
Key Domains of BHS-PC

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

How Does It Work?



Sample Patient Screen



Sample Report for the PCP

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

Feasibility Study

- 24 adolescents were consented and administered the BHS before a medical appointment

- Satisfaction Questionnaire Results
  - 75% liked the software
  - Adolescents completed the tool on average within 12.4 minutes (sd= 5.04)
  - 92% reported honestly
  - 92% thought it should be used in future appointments
  - Of those patients whose doctors used the printout during the appointment, 94% found it helpful during their appointment

Validation Study

- Sample recruited from primary care clinics

- Completed the BHS and a validation battery that included:
  - Beck Depression Inventory-II (BDI-II)
  - Scale for Suicidal Ideation (SSI)
  - Trauma Symptoms Checklist for Children (TSCC)

Validation Study

Sample:

- 415 adolescents aged 12-21 (M = 15.8, SD = 2.2)
- 66.5% female
- 77.5% African American, 10.7% Caucasian, 9.7% mixed race, 2.1% of another race

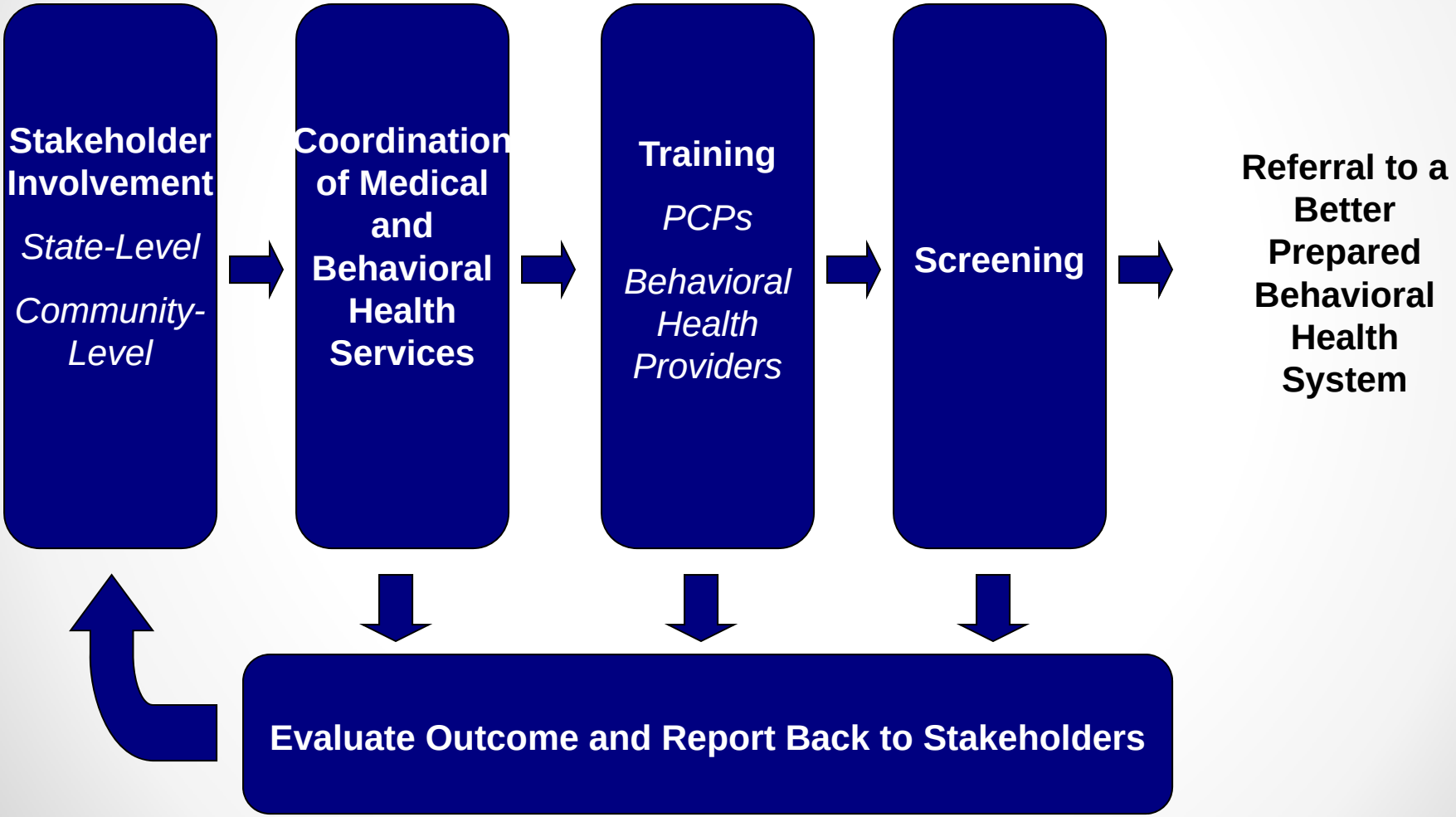
Scales:

- Single-factor confirmatory factor model fit statistics support the unidimensionality of the four scales (depression, suicide, trauma, anxiety)
- All scales had adequate internal consistency reliability (range: .75 - .87)

Validity of the BHS-PC

- The psychiatric scales are valid and predictive of risk behaviors (Diamond et al., 2010)
- Strong Internal Consistency
  - Range: 0.75-0.87, $\alpha \geq 0.75$
- Strong Convergent Validity
  - BHS suicide risk and SSI, r = .72, P < .0001
- Strong Divergent Validity
- More than adequate specificity and sensitivity (see table)

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



Questions?

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