Suicide Prevention in Primary Care: Applications, Challenges, and Solutions

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Objectives

1. Emphasize the importance of primary care as a clinical setting for suicide prevention
2. Describe methods of engaging primary care practitioners in suicide prevention
3. Discuss training, screening, and intervention barriers and solutions in the primary care setting
4. Discuss methods of coordinating care between primary care and behavioral healthcare
5. Review Youth Suicide Prevention in Primary Care (YSP-PC): The Pennsylvania Project
Importance of Suicide Prevention in Primary Care

• National Strategy for Suicide Prevention (2001)
• IOM report (2002)
• Frankenfield et al. (2002)
  – Despite the fact that many PCPs encounter suicidal adolescent patients (47% in past year with at least 1 pt), very few routinely screen for suicidal ideation or related risk factors
Importance of Suicide Prevention in Primary Care

• In 15-24 year old age group, suicide deaths exceed the TOP 7 non-injury based medical conditions combined

• Suicide is 2\textsuperscript{nd} leading cause of death from ages 1-40 (CDC, 2009)

• 20\% of adults who died by suicide visited their PCP within 24 hours of their death (Pirkis & Burgess, 1998)
Engaging Primary Care Providers in Suicide Prevention

• 2006 SAMHSA GLS State/Tribal Technical Assistance Meeting

• Where to start?
  – Providers you know
  – Local suicide prevention task forces
  – State or regional medical associations

• **Relationship building**
  – Go to them
  – Offer to consult or help them in other ways
  – Demonstrate an established program – let them put your experience to the test
Youth Suicide Prevention in Primary Care (YSP-PC)

The Pennsylvania Project
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
Objective 1:

Create a task force of a broad range of stakeholders
Objective 2:
Provide a youth suicide “gatekeeper” training program to participating primary care providers in the designated counties.
Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC-Y)
American Association of Suicide Prevention

- Covers material pertinent to PCPs
- Designed as a 90-minute presentation
- Includes lecture, video demonstrations of techniques, and printed resources
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
Training Challenges

• What do they really want to know?
  – Everything in 15 minutes
  – Risk assessment, intervention, referral

• Challenges:
  – Time
  – “I need more than just knowledge – give me the tools”
Objective 3:
Provide free access to a web-based, self-report screening tool to assess suicide and related risk factors.
Screening Challenges

• Ask and they will tell (Bryan et al., 2008; Wintersteen, 2010)
• What do you use?
  – No clear measures for primary care
• Major challenges:
  – Time
  – Workflow
  – Reimbursement
    • “But we get paid to screen for autism, maternal depression, etc.” – (soon to be substance abuse)
    – “So I identify someone, then what?”
Challenges to Screening Lead to...

1. PCPs avoiding screening
2. Referral of non-imminent risk adolescents to EDs and CRCs

These lead to:

- Decreased patient safety (no screening)
- Unnecessary burden on families, ED, and Psychiatry staff
- Threats to doctor-patient relationship
Web-based Behavioral Health Screen

Diamond, Fein, Levy, Wintersteen

- 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
Key Domains of BHS-PC

- Medical
- School
- Family
- Safety
- Substance Use
- Sexuality
- Nutrition and Eating
- Anxiety
- Depression
- Suicidality
- Psychosis
- Trauma
- Independence
BHS-PC Demo
Objective 4:

Increase the integration, if not collocation, of behavioral health services with medical services.
Objective 4: Integration
State Survey Results (N=700 PCPs)

• 78% have referred at least 1 adolescent patient to MH services for suicidal ideation or attempts in the past year.

• Most practices have no in house MH worker

• 45% report they can not get quick MH appointments for suicidal patients.

• 24% report that the MH provider always or often lets them know if a patient attends services.
Intervention in Primary Care

• “I see a lot of mental health problems in my practice, but it’s someone else’s job to deal with that.”
• Primary care is the sole source of mental health treatment for most Americans
• What can be accomplished in primary care?
• Implications of the black box warning
• Challenges:
  – Time
  – Lack of training
  – “…then what?”
Collaboration with the Behavioral Health World

• “And who are you again?”
• Major challenges:
  – Evolution along parallel tracks such that reality often interferes with desire
  – Perceived or real lack of services
    • Absolutely must have local resources available
  – Behavioral health hides behind HIPAA
  – Lack of faith in behavioral health system
  – PCP poor understanding of available resources
Barriers to Collocation

• Policy barriers related to licensure and billing
  – Need to establish a satellite office
  – Who bills for screening?
  – How to bill for assessments?
  – How to bill for prevention work?

• Collocation is not cost effective if the PCP does not identify enough MH problems. (Increased screening might solve this)
Objective 5: Provide clinical training in best practice therapy models for suicidal youth to behavioral health providers.
Objective 5: Clinical Trainings

- 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
- Crisis Management Training
Overarching Challenges (and Possible Solutions)

- Challenges
  - Time
  - Workflow
  - Investment – “why would I do this again?”
  - Availability of the behavioral health world to help *their* patients

- Possible Solutions:
  - Approachability
  - Flexibility
  - Persistence – remember that most PCPs deal with suicidal patients and really do what to do more to help them
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