Bringing Suicide Prevention into Primary Care

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Disclosures

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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

Danaei et al. *PLoS Med*. 2009; 6.
Druss. *Gen Hosp Psychiatry*. 2002; 24.
Puente. *Amer Psychologist*. 2011; 66.

With everything else going on in primary care, why focus on suicide prevention?

10 Leading Causes of Death, United States

2010, All Races, Both Sexes

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 5,107	Unintentional Injury 1,394	Unintentional Injury 758	Unintentional Injury 885	Unintentional Injury 12,341	Unintentional Injury 14,573	Unintentional Injury 14,792	Malignant Neoplasms 50,211	Malignant Neoplasms 109,501	Heart Disease 477,338	Heart Disease 597,689
2	Short Gestation 4,148	Congenital Anomalies 507	Malignant Neoplasms 439	Malignant Neoplasms 477	Homicide 4,678	Suicide 5,735	Malignant Neoplasms 11,809	Heart Disease 36,729	Heart Disease 68,077	Malignant Neoplasms 396,670	Malignant Neoplasms 574,743
3	SIDS 2,063	Homicide 385	Congenital Anomalies 163	Suicide 267	Suicide 4,600	Homicide 4,258	Heart Disease 10,594	Unintentional Injury 19,667	Chronic Low. Respiratory Disease 14,242	Chronic Low. Respiratory Disease 118,031	Chronic Low. Respiratory Disease 138,080
4	Maternal Pregnancy Comp. 1,561	Malignant Neoplasms 346	Homicide 111	Homicide 150	Malignant Neoplasms 1,604	Malignant Neoplasms 3,619	Suicide 6,571	Suicide 8,799	Unintentional Injury 14,023	Cerebro-vascular 109,990	Cerebro-vascular 129,476
5	Unintentional Injury 1,110	Heart Disease 159	Heart Disease 68	Congenital Anomalies 135	Heart Disease 1,028	Heart Disease 3,222	Homicide 2,473	Liver Disease 8,651	Diabetes Mellitus 11,677	Alzheimer's Disease 82,616	Unintentional Injury 120,859
6	Placenta Cord Membranes 1,030	Influenza & Pneumonia 91	Chronic Low. Respiratory Disease 60	Heart Disease 117	Congenital Anomalies 412	HIV 741	Liver Disease 2,423	Cerebro-vascular 5,910	Cerebro-vascular 10,693	Diabetes Mellitus 49,191	Alzheimer's Disease 83,494
7	Bacterial Sepsis 583	Septicemia 62	Cerebro-vascular 47	Chronic Low. Respiratory Disease 73	Cerebro-vascular 190	Diabetes Mellitus 606	Cerebro-vascular 1,904	Diabetes Mellitus 5,610	Liver Disease 9,764	Influenza & Pneumonia 42,846	Diabetes Mellitus 69,071
8	Respiratory Distress 514	Benign Neoplasms 59	Benign Neoplasms 37	Benign Neoplasms 45	Influenza & Pneumonia 181	Cerebro-vascular 517	HIV 1,898	Chronic Low. Respiratory Disease 4,452	Suicide 6,384	Nephritis 41,994	Nephritis 50,476
9	Circulatory System Disease 507	Perinatal Period 52	Influenza & Pneumonia 37	Cerebro-vascular 43	Diabetes Mellitus 165	Liver Disease 487	Diabetes Mellitus 1,789	HIV 3,123	Nephritis 5,082	Unintentional Injury 41,300	Influenza & Pneumonia 50,097
10	Necrotizing Enterocolitis 472	Chronic Low. Respiratory Disease 51	Septicemia 32	Septicemia 35	Complicated Pregnancy 163	Congenital Anomalies 397	Influenza & Pneumonia 773	Viral Hepatitis 2,376	Septicemia 4,604	Septicemia 26,310	Suicide 38,364

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

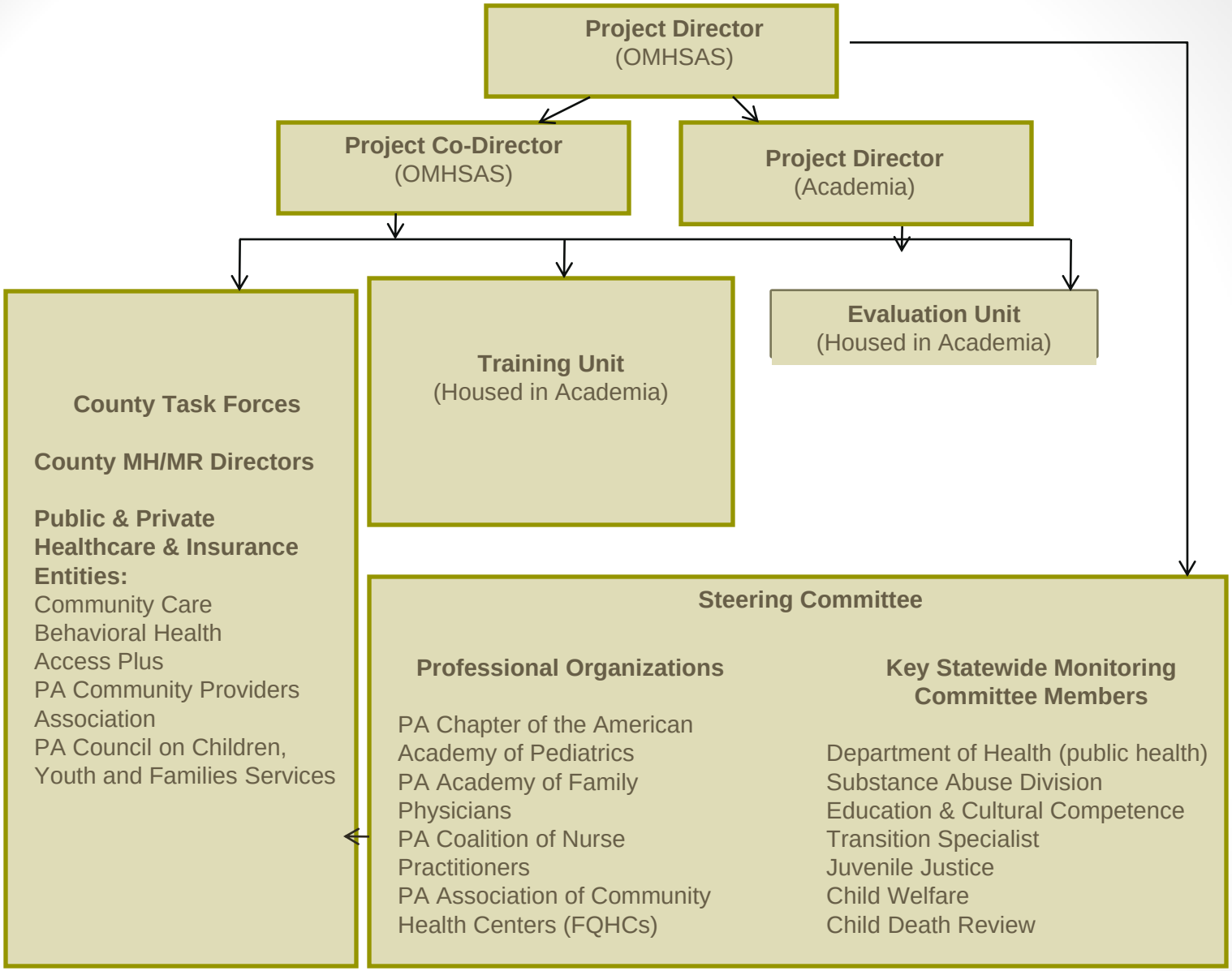
- While screening tools can help, they will not address the multi-systemic barriers to providing mental health in primary care by themselves

Youth Suicide Prevention in Primary Care (YSP-PC)

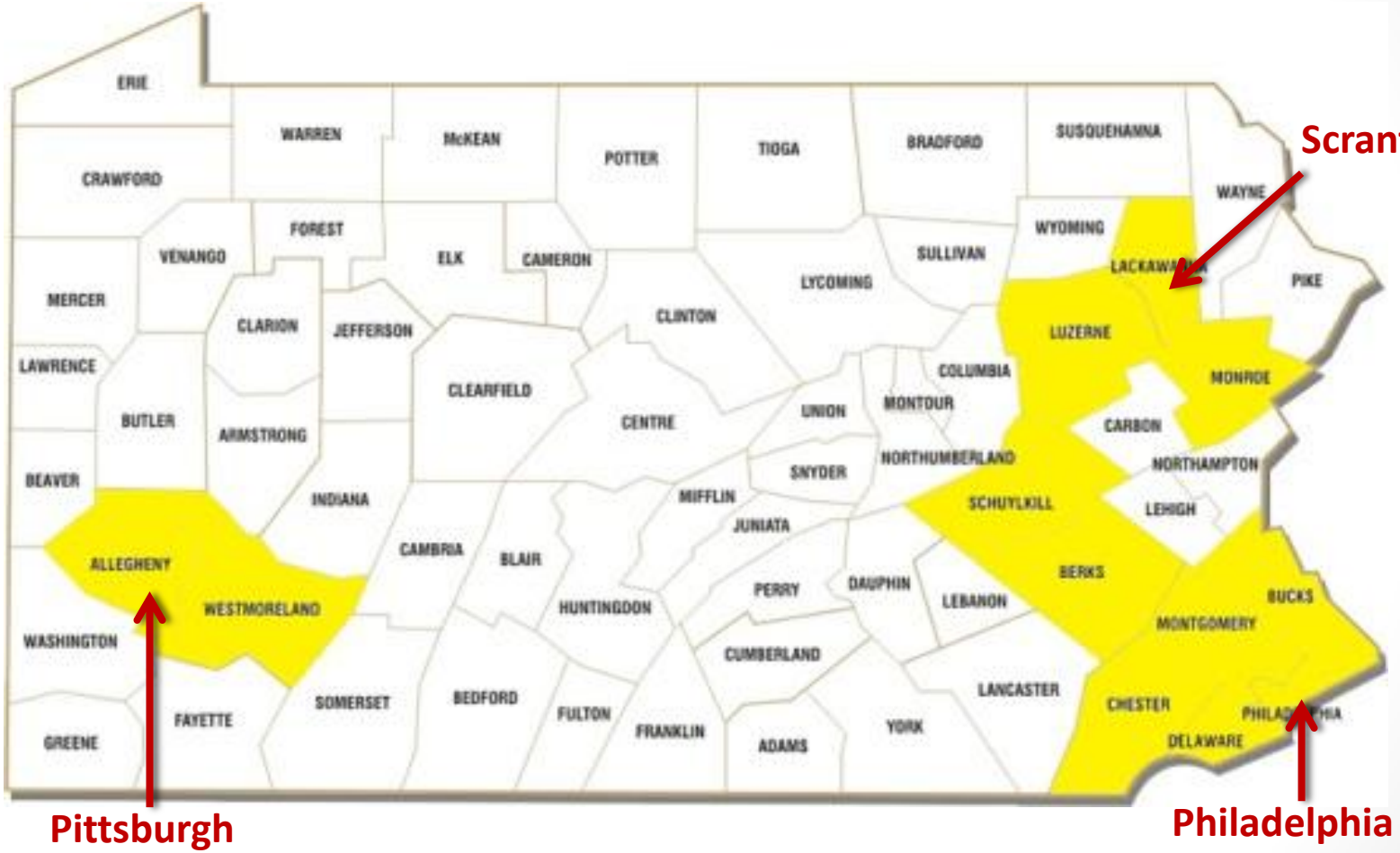
(ages 14-24)

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



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

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

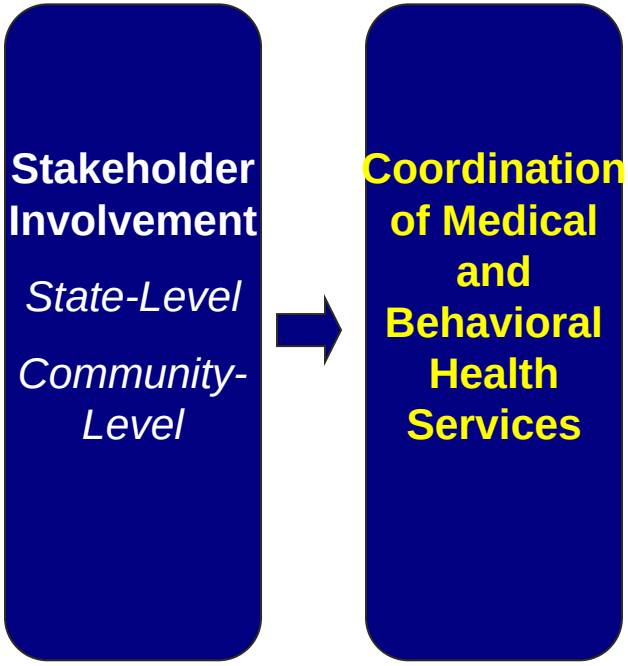
Payers:

- 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



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

Diamond GS, O'Malley AC, Wintersteen MB, Peters S, Yunghans SC, Biddle V, O'Brien C, Schrand S. Attitudes, practices, and barriers to adolescent suicide and mental health screening: A survey of Pennsylvania primary care providers. Journal of Primary Care and Community Health. 2012; 3:29-35.

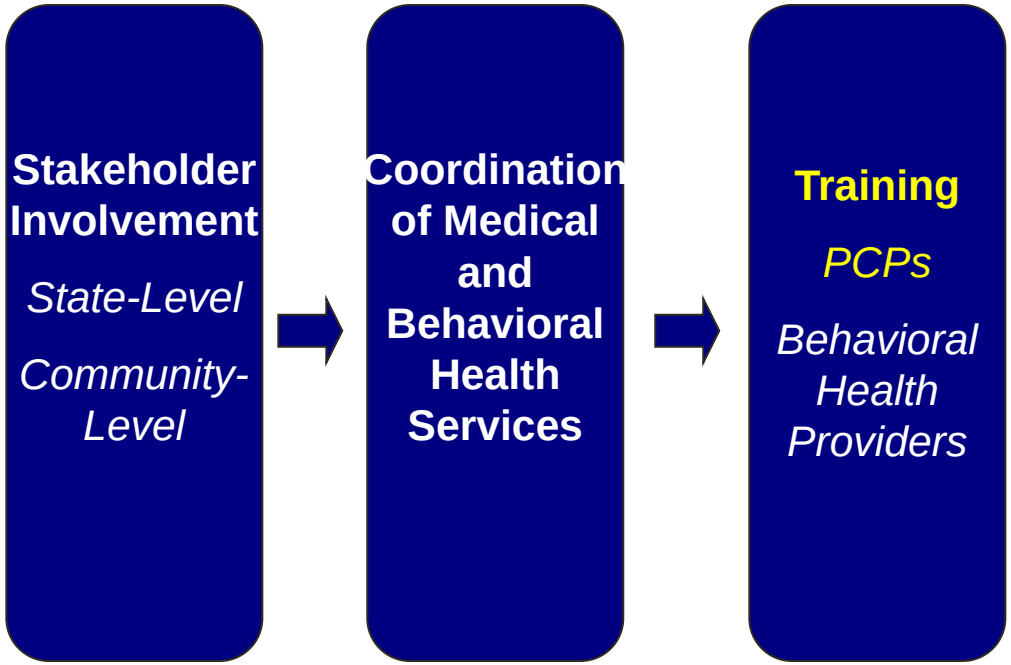
Other Challenges

- 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



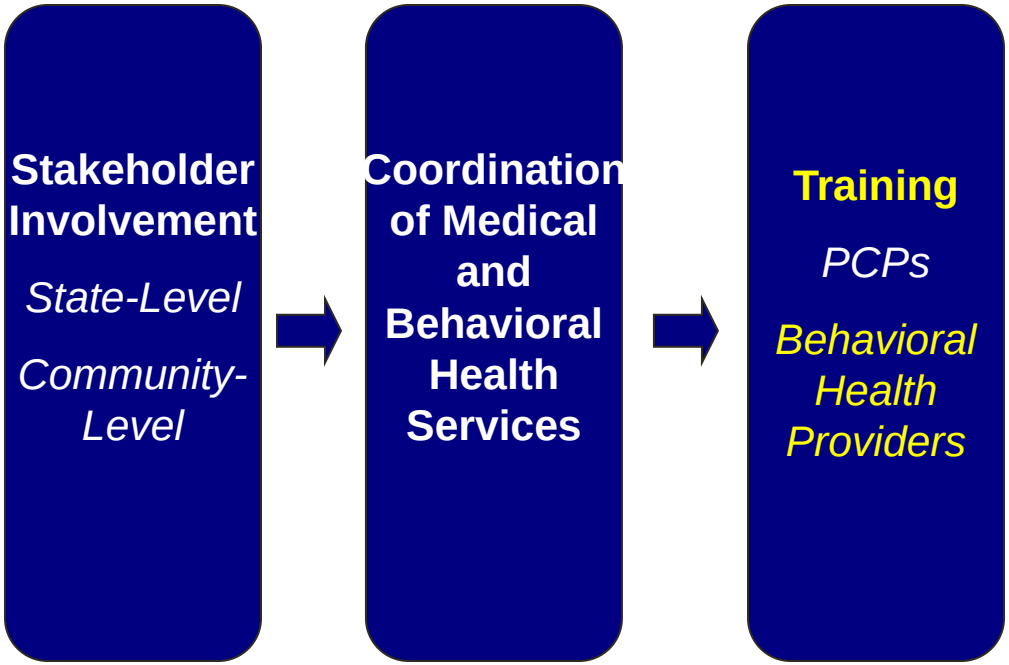
Why Training?

- 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



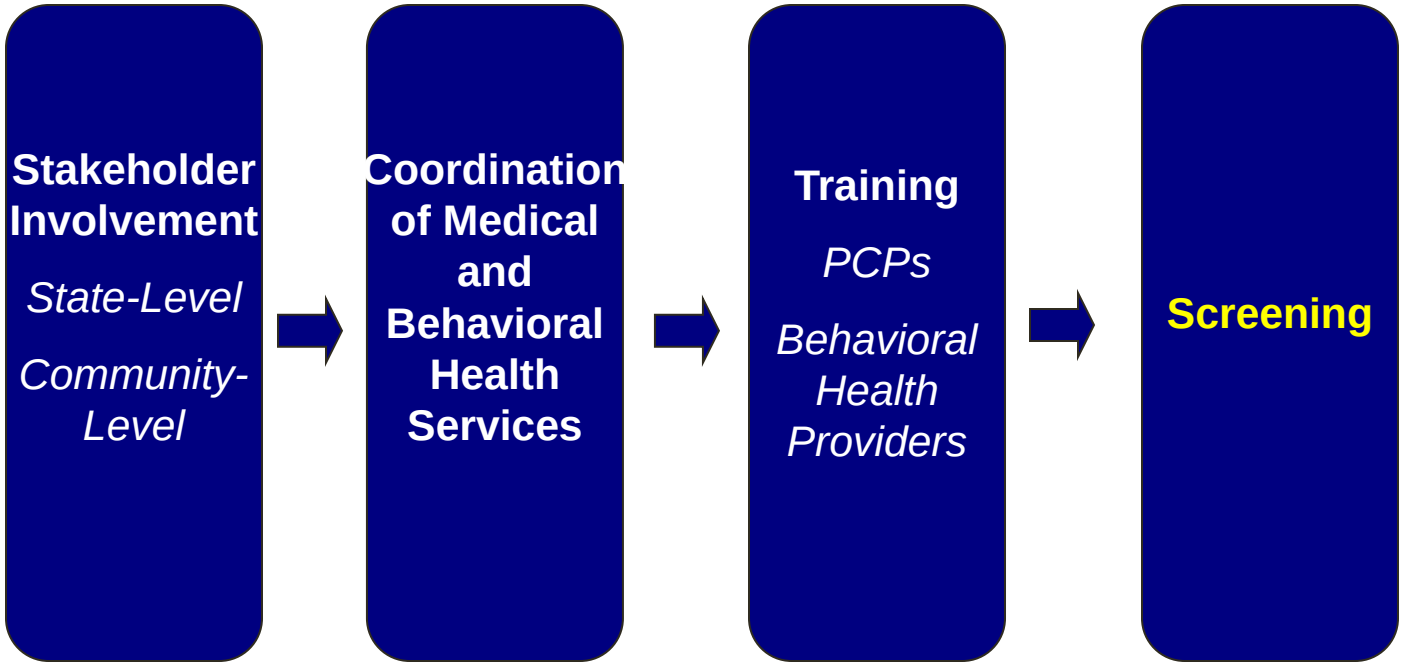
Behavioral Health Trainings

- 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 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

Demographics

	All Screened (N=1561)
Sex n(%)	
Female	964(62.7)
Male	574(37.3)
Age Mean(Range, SD)	17.70 (14-24, ±2.94)
Race n(%)	
White	1240(81.5)
Black/African American	59(3.9)
American Indian/Alaskan Native	13(0.9)
Asian	28(1.8)
Native Hawaiian/Other Pacific Islander	10(0.7)
More than one race	85(5.6)
Not Sure	87(5.7)

Mental Health

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

Risk Factors

	All Screened (N=1561)
Access to a gun	
Yes	185(12.2)
No	1334(87.8)
Exposure to Violence	
None	886(58.4)
Some	630(41.6)

Satisfaction

	All Screened (N=1561)	
Comfortable answering these questions?		
Very uncomfortable	105(7.2)	**Only 14.6% uncomfortable**
Uncomfortable	108(7.4)	
Neutral	548(37.4)	
Comfortable	464(31.7)	
Very comfortable	240(16.4)	
A good idea for medical providers to ask these kinds of questions?		
No	144(9.9)	
Yes	1308(**90.1**)	
Comfortable discussing answers with medical provider?		
Very uncomfortable	148(10.1)	**Only 24.6% uncomfortable**
Uncomfortable	213(14.5)	
Neutral	553(37.8)	
Comfortable	394(26.9)	
Very comfortable	156(10.7	
Medical provider asks about feelings (sadness, anxiety, or suicidal feelings)?		
Never	460(**31.8**)	
Sometimes	747(51.7)	
Often	239(16.5)	
Medical provider asks about experiences (violence-home or neighborhood, substance use, and sexual activity)?		
Never	628(**43.3**)	
Sometimes	640(44.1)	
Often	184(12.7)	

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

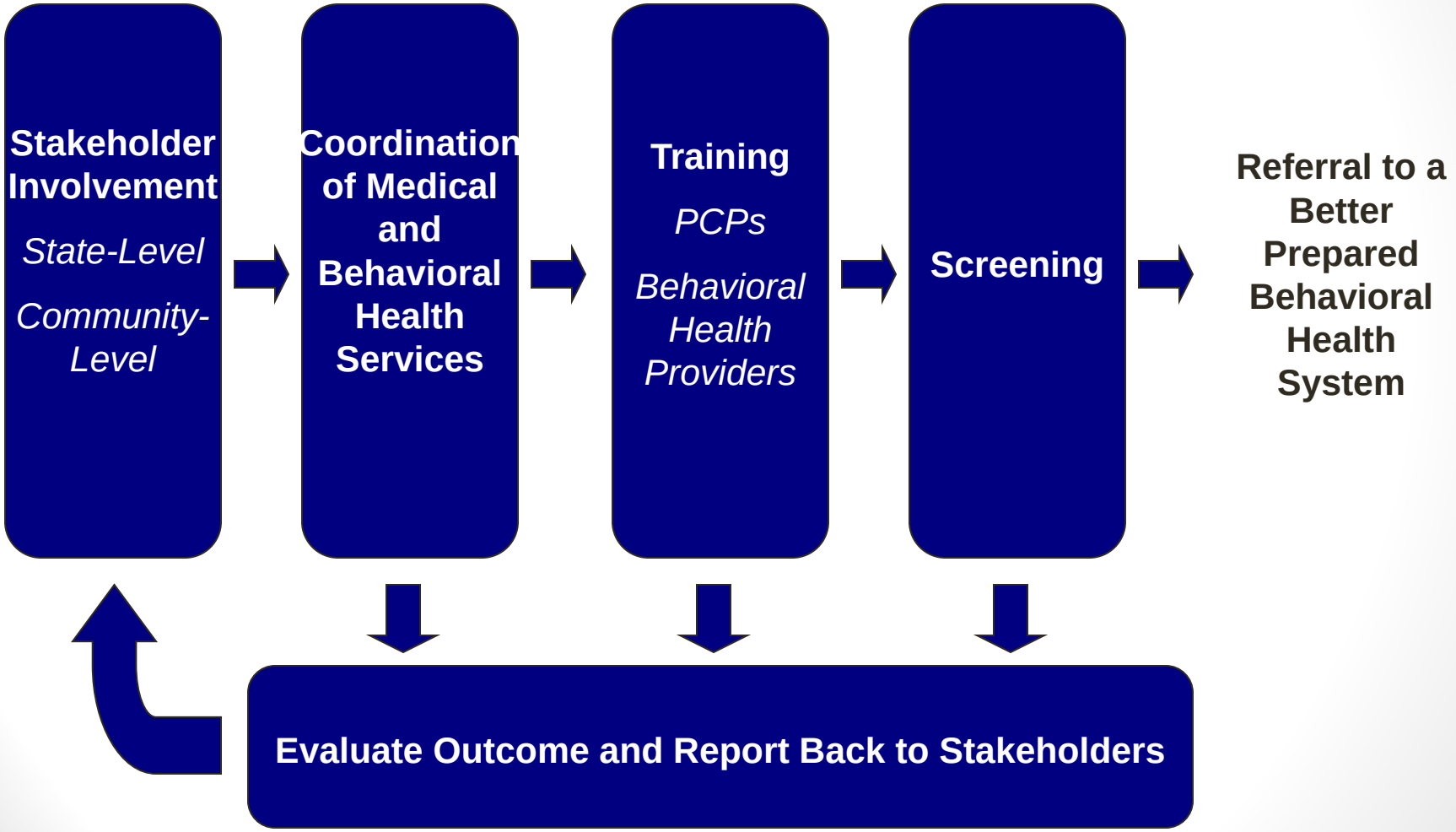
3. The more the PCP screens, the more cases there will be for behavioral health assessments and treatment; therefore, creating a viable business plan

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)



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