Methods for Training Primary Care Providers in Youth Suicide Prevention

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Why Primary Care?

- Primary care is a potential source for identification, triage, and brief intervention (IOM, 2002)
- 70% of adolescents see their primary care provider (PCP) at least once pre year (U.S. DHHS, 2001)
- Many at-risk subpopulations served (e.g., HIV, chronic illness, family planning)
- 77% of adolescents with mental health problems go see their PCP (Schurman et al., 1985)
- PCPs prescribe over 75% of all anti-depressants (Hylan et al., 1998), although this has declined since FDA warning

Why Primary Care?

- According to a sample of pediatricians, 16% of adolescents in the last year were depressed and 5% were at risk for a serious suicide attempt (Annenberg Adolescent Mental Health Project, 2003)
- Over 70% of adolescents report a willingness to talk with a primary care physician about emotional distress (Good et al., 1987)
- 7-15% of adolescent suicide attempters contacted a health provider in the month previous to an attempt and 20-25% in the previous year (Groholt et al., 1997)

Why Primary Care?

- In the United States health care system, primary care is the #1 source for mental health treatment.
- Primary care is many times a patient's *only* source for MH treatment of any kind.
- The majority of visits to a primary care clinic have at least some psychosocial or behavioral component contributing to the problem (Gatchel & Oordt, 2003)
- Less than 50% of PCPs feel competent in managing suicide (Annenberg Adolescent Mental Health Project, 2003)
- Mental health was 1 of 6 research areas primary care providers felt were important (AAP, 2002)

Psychosocial Problems in Primary Care

- Approximately 70% of primary care medical visits are for psychosocial issues. (Gatchel & Oordt, 2003)
- Comorbid psychiatric-physical disorders are more impairing than either "pure" psychiatric or "pure" physical disorders alone. (Kessler, Ormel, Demler, & Stang, 2003)
- Depressive symptoms are more debilitating than diabetes, arthritis, GI disorders, back problems, and hypertension. (Wells et al, 1989)

Physical Illness and Suicide

- More than 25 medical illnesses have been identified with significantly elevated risks for suicidality (Berman & Pompili, *in preparation*).
- Medically ill patients were 50% more likely to have suicidal ideation and 67% more likely to have made a suicide attempt than those without medical illness. Co-morbid Axis II disorders doubled the risk for ideation or attempt (Druss & Pincus, 2000).

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Suicide in Primary Care

- Suicidal ideation is present in 2-7% of all primary care patients (Olfson et al, 1996; 2003).
- PCPs have low rates of inquiry and detection of suicidal ideation (Schulberg et al, 2004; Bartels et al, 2002; Williams et al, 2002).
- Actors portrayed standardized patients with symptoms of major depression and sought help in PCP offices. *PCPs inquired about suicide in less than half (42%) of these patient encounters* (Feldman et al, 2007).
- 20% of adults who die by suicide visit their PCP *within 24 hours of their death.* (Pirkis & Burgess, 1998)
- Less than 20% of adolescent suicide attempters are asked about suicidal behavior by a physician at a medical visit (Slap et al., 1992)
- Often times, the PCP is the last medical professional to see the patient alive.

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

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Developing the RRSR-PC

- Phase I of project funded by Irving and Barbara C. Gutin Charitable Fund of the New Hampshire Charitable Foundation in December 2007
- Phase I included focus group interviews with 32 individuals during March and April 2008
- Phase II of project funded by Irving and Barbara C. Gutin Charitable Fund of the New Hampshire Charitable Foundation in August 2008
- Phase II included convening a Task Force charged to review the results of Phase I and develop a training curriculum that meets the needs of the primary care community

Focus Group Findings

- *N* = 32 (50% physicians, 41% nurses, 9% physician assistants)
- Medical/Graduate School Training in Suicide Assessment?:
  - *None – 44%*
- Continuing Education in Suicide Assessment?:
  - *None - 56%*

Focus Group Findings

- In your practice, is there a protocol for assessing:

	% No
• Suicide Ideation	56%
• Past Suicide Attempt	66%

- How competent do you think you are to work with patients at risk for suicide?
  - *Not competent or slightly competent*: 44%
  - *Somewhat competent*: 26%

How likely would you be to sign up and complete a training in each mode below?

Top 4 Modalities:

1. In-service on-site at provider's practice
2. 1-day workshop at hotel or conference center
3. Workshop scheduled at professional conference provider already attends
4. Workshop as part of state association meeting provider already attends

What topics are most important for a training?

1. Conducting a risk assessment (72%**)
2. Determining a patient's suicide lethality (55%)
3. When to refer a depressed patient (52%)
4. Information on suicidal ideation, thoughts, and plans (48%)
5. Information on suicidal behaviors such as rehearsals, attempts, interrupted attempts (48%)
6. Distinguishing acute risk factors (45%)
7. Formulating judgments about suicide risk (45%)
8. Documentation (45%)

**Percent responding "very important"

What factors would influence your decision to attend a suicide prevention training?

1. How much time spent away from office (75%**)
2. Increased knowledge and skill (75%)
3. Better clinical outcomes (71%)
4. Convenience (64%)
5. Greater confidence in working with suicidal individuals (64%)
6. Location (54%)
7. Keeping up to date (50%)

**Percent responding "very important"

What PCPs are saying…

"It has to be practical, dynamic, "hands-on." Give us the nuts and bolts, do it in 15-20 minutes modules, with lots of handouts and tools. Speak it, model, have us practice it."

"We are nuts and bolts people; we are protocol-driven. Our tools drive our behavior; we don't need a lot of training, just teach us how to use the tools."

AAS Primary Care Providers Training Project Task Force

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RRSR-PC – What Does It Look Like?

- Brief (Face-to-Face or Webinar)
- Adult (75-minute) or Youth and Young Adult (90-minute)
- Skill-Modeled
- Tool Focused:
  - Pocket Card/Algorithm
  - Resources

Training Content of RRSR-PC

- Suicide epidemiology and statistics
- Suicide and primary care
- The language of suicide
- Biopsychosocial model of suicide
- Suicide risk assessment
- Triage decision making
- Developing a crisis response plan
- Interventions for primary care
- FDA black box warning
- Documentation

Video Vignette Demonstration

Where is the RRSR-PC Being Used?

- Adult Version (RRSR-PC):
  - Presented at DoD/VA Annual Suicide Prevention Conference
  - Contracted to complete Training-of-Trainers model for VA Suicide Prevention Coordinators who will then go on to train several hundred providers
- Youth and Young Adolescent Version (RRSR-PC-Y):
  - Pennsylvania SAMHSA Garrett Lee Smith Project

Questions?

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