# Final Report (excerpted from final report to SAMHSA)

**Garrett Lee Smith Youth Suicide Prevention in Primary Care Grant, 2008-2011**

### Objective #1: Create a task force of a broad range of stakeholders.

First, we convened a leadership summit to make sure that efforts of this project are in line with the state goals of health care reform. This state leadership group will help to position this project as a sustainable product that can go to scale. Second, we held a statewide set of meetings with local county task forces facilitated by the Star Center (a grant partner). Twenty-six counties have active task forces. We want to assist them in developing internal infrastructure, improving communication with each other, and explore using them as a possible resource to help support the expansion of this project across the Commonwealth. Third, we will continue to explore reimbursement options for the screening tool. This is likely the single biggest barrier to broader dissemination of this screening system. We are working with the state Medicaid agency to explore this possibility. Finally, we will continue to be active members of the Pennsylvania Youth Suicide Prevention Initiative Monitoring Committee. In this role, we will work with state and community members to revise the existing structure of suicide prevention efforts. One focus will continue to remain on prevention efforts in primary care medicine. A second focus relevant to the grant will be on the continuation of the Statewide Suicide Prevention Conference. Initially held annually, this statewide conference will now be held every two years with a focus on education and training on the opposite years. In previous years, members of our project team have led focus groups and presentations on engaging PCPs in suicide prevention and our aim is to continue with that goal.

### Objective #2: Provide a youth suicide “gatekeeper” training program

We provided the RRSR-PC-Y training to all PCPs who join the project. We also worked to make Dr. Biddle’s web-based nurse practitioner training available with CEU credits. We sponsored more webinars through the medical associations and increased our utilization of SPRC’s resources, particularly the Suicide Prevention Toolkit for Rural Primary Care.

Based on feedback from PCPs, we will aim to develop a new set of trainings that will focus on behavioral health problems more broadly than suicide alone (e.g. depression, trauma, substance use, etc). We also understand from the providers that they need more training in basic intervention skills: how to talk to patients about behavioral health problems, how to talk to parents about this, and how to motivate parents to take their children to services when indicated. We are aiming to develop video versions of these new training areas so they can be posted on the web-site.

### Objective #3: Provide medical practitioners in the three counties free access to a web-based, patient self-report suicide screening tool

We made modifications to the current BHS websites in order to enhance ease of use and decrease time burdens on PCP staff. We tested with the intent to eventually implement procedures where reports of identified suicidal adolescents are automatically sent to research staff and county coordinators. This would improve the likelihood of the local research evaluation team reaching youth for follow-up. We worked with the practices to ensure that this process was not only seamless but also conforms to all

federal and local privacy regulations. We collected information from the PCP through a provider satisfaction survey about the feasibility and acceptability of the screening and triage services provided throughout this project.

## Objective #4: Increase the integration of behavioral health services with medical services through TRIAGE (Teen Risk Identification and Guided Evaluation system)

The County Task Forces continued in Year 3 to use the two TRIAGE models outlined below to find solutions for specific communities within each county. The general types of TRIAGE goals include: a) assess patient's need for behavioral health services; b) work with the adolescent and the family to develop a service plan; c) link the adolescent/family with appropriate treatment and support services; d) facilitate access to services or provide time-limited treatment; e) facilitate an emergency evaluation, if warranted; and f) conduct short term follow-up and monitoring.

**Triage Model #1: Collocation of services.** The ideal solution is to co-locate behavioral health professionals in the same building or within close proximity to the PCP practice. This model was being considered by at least one of the initial practices in Year 1 and will most likely involve behavioral health facilities setting up a satellite structure within the medical office. This structure allows a unified collaboration between the medical and behavioral health provider, reduces stigma by providing behavioral health services in a medical setting with which the patient is already familiar, and streamlines access to care by providing dedicated behavioral health services for these patients.

We are continuing to identify behavioral health agencies and medical facilities that want this level of collaboration and have the space to accommodate it. We are working with insurance companies to assure that these behavioral health services are billable. One of our primary care sites is currently considering the possibility of hiring psychologists/psychiatrists and a social worker to enhance their behavioral health services. We will work with them to achieve the goal of co-location.

**Triage Model #2: Intensify collaboration between the two systems**. In many settings, co-location will not be possible. One alternative is to strengthen the relationship between the medical and behavioral health facilities. This may involve setting up a behavioral health clinic one afternoon a week when a behavioral health worker can be on-site for assessment. This may also involve an agreement with the behavioral health agency to be available for consultation and triage when a suicidal youth is identified. The provider can call the agency, and the agency will provide an immediate response, whether it is assisting in decision making over the phone or sending someone for a face-to-face assessment. Some variation of this model will be used in many of the practices. We will also continue to consult with agencies across the state of Pennsylvania who have succeeded in co-locating services.

## Objective #5: Enhancing clinical services for suicidal youth

This year we cut back on our efforts to provide training to the behavioral health community. Our impression is that, while an admirable goal, it is a grant in and of itself. Further, there are additional barriers to conducting these trainings, such as limited participation due to the amount of non reimbursable time away from the office. We continued to utilize webinars for family therapy and some local supervision of CBT. However, our efforts for training were more focused on the PCPs and local crisis workers. We worked with the local providers to supply trainings that are most helpful and relevant

to them related to youth suicide. We also looked to develop training tools for the PCP so they can acquire the appropriate level of clinical skills to manage specific behavioral health problems and work with families on engagement and treatment. Specifically, we hope to develop video training modules in the future for PCPs on depression, family conflict, trauma, and substance use and abuse that could be posted on our state website.

## Quantitative Summary of Activities and Accomplishments Throughout Grant Period

| **Activity/Accomplishment** | **Number** |
|---|---|
| Children served | 1,242 |
| People trained as gatekeepers | 424 |
| Behavioral health providers trained | 787 |
| Task forces established | 3 |
| Active primary care sites | 10 |