Youth Suicide Prevention in Primary Care
Summary of Garrett Lee Smith Suicide Prevention Grant

The Commonwealth of Pennsylvania needs a better system of early identification, assessment, triage and treatment of adolescents ages 14 to 25 at risk for suicide, in order to reduce the number of deaths and hospitalization for self-injury in the Commonwealth. To address this statewide need, we aim to use Garrett Lee Smith funding as a demonstration project to develop and test an intervention program that, if successful, could be disseminated across the state. We will test the program in three of the counties with the most serious suicide problems: Schuylkill, Lackawanna and Luzerne.

These three counties are among the top 10 in terms of rates of death from suicide (23.4, 20.1, and 12.1, respectively), and rates of hospitalization for self-injury (342.6, 142.7, and 90.2, respectively). In addition, all three counties are physically contiguous in northeastern Pennsylvania, share the same Medicaid Behavioral Health Managed Care Organization (Community Care), Medicaid physical health care system (Access Plus), and regional monitoring units under the Commonwealth's Office of Mental Health and Substance Abuse Services (OMHSAS) as well as the Office of Children, Youth, and Families. Based on county data, we estimate approximately 94,000 adolescents live in the three counties. We aim to screen between 15 percent of these adolescents each year, or 14,100 youth. National data suggest that 20 percent of youth might express suicidal ideation (2,820 per year) and 5-8 percent might attempt suicide (705-1,128 per year; AACAP, 2001; Gould et al., 2003).

Current Systems that Treat Suicidal Youth and Will Collaborate on Project

RESOURCES	Schuylkill	Luzerne	Lackawanna
PCP offices	Group practices, but mostly spread out	Group practices, but mostly spread out	Scranton Primary Health Center
Medical Health Systems	Geisinger Health Integrated Med. Group.	Geisinger Health	Geisinger Health
Mental Health Facilities	Individual providers	3 larger programs, individual providers	14 other providers
Psychiatric Emergency Services	One hospital emergency room	4 hospitals	2 hospitals, 24-hour psych emergency
Psychiatric Inpatient	10 beds	36 beds	32 beds
Behavioral Health Medicaid Managed Care	Community Care Behavioral Health	Community Care Behavioral Health	Community Care Behavioral Health
Physical Health Medicaid Health Care System	Access Plus	Access Plus	Access Plus
Existing Suicide Task Force	Large and active group	No active group	Advocacy Alliance

Project Aims

The general goal of this project is to implement an early identification system for youth at high risk for suicide (ages 14-24 years) within primary care medical settings. We anticipate that this will increase their access to outpatient behavioral health services, reduce hospital admission for suicide, and prevent suicidal behaviors. To this end, the project will focus on five objectives:

Objective 1: Create a task force of a broad range of stakeholders. These stakeholder groups will guide the initial needs assessments and help identify and address system and policy changes necessary to implement and sustain this suicide prevention system in these three counties. In Year 3, they will assist in plans for dissemination across the Commonwealth.

Objective 2: Provide a youth suicide "gatekeeper" training program to participating pediatricians, family physicians, nurse practitioners, and emergency room physicians in the designated counties. For this, we will use the Question, Persuade, and Refer program (QPR; Quinett, 1995), a highly-recognized gatekeeper training program that has demonstrated effectiveness in multiple settings. In addition, we will use many materials developed for primary care providers from the Suicide Prevention Resource Center (SPRC).

Objective 3: Provide medical practitioners in the three counties free access to a web-based, patient self-report screening tool to assess for suicide and related risk factors. This tool will generate a brief report for the provider to review at the time of the visit.

Objective 4: Increase the integration, if not co-location, of behavioral health services with medical services. This collaboration will decrease access barriers, reduce delays in assessment and treatment, and provide necessary behavioral health support to medical providers and their patients.

Objective 5: Provide clinical training to behavioral health providers who receive referrals and treat those at risk for suicide. Specifically, nationally renowned experts in cognitive behavioral therapy, family therapy, and suicide crisis intervention and assessment will provide several workshops throughout the funding period to help local behavioral health providers improve their therapeutic skill set for working with suicidal youth.

Specific Tasks, Year One

Create Local Task Force. Form a Primary Care Suicide Prevention Task Force (PCSP), consisting of a Steering Committee of public and private partners, professional organizations, and statewide monitoring committee members, that will help develop prevention efforts across counties. Each county will also have its own County Task Force. Each County Task Force will meet monthly in person and weekly on the phone for at least the first six months. Several PCSP meetings will also occur. The PCSP will have broad representation. At the county level, we will have representation from local government, the primary care systems, Emergency Departments, behavioral health facilities, Medicaid, and private insurance carriers as well as parents and adolescents.

Conduct a Needs Assessments. The initial focus of the County Task Forces will be to carry out a needs assessment of their respective counties. These projects will help us understand the culture of the local community and the medical and behavioral programs that serve them. In addition, these projects will heighten awareness in the communities of the local problem of suicide and the project strategy for addressing it. To assist in this task, the Center for Family Intervention Science (CFIS) will lead three projects: a) a countywide survey of medical practitioners about their need and readiness for incorporating more behavioral health assessment and intervention into their practice, b) a countywide survey of behavioral health administrators

regarding barriers to better integration within the primary care system, and c) an analysis of county data descriptive of the population that attempt and complete suicide. This will include looking at different sources of data such as Child Death Review, hospital admissions, emergency room records, child abuse reporting records, and drug and alcohol records.

Develop a Resource Guide. The County Task Force will work with the local county MH/MR Care Coordinators and Case Management Units to develop a comprehensive referral guide for the PCPs. They will catalog all local/county resources and visit many of them to assess their capacity to treat high-risk youth. We will explore putting these resources onto the web-based screening program as a resource for medical staff when youth present with suicidal thinking or behavior that needs professional attention.

Select Local Program Sites. The ideal primary care sites will be large, centralized organizations with high patient loads and several medical staff. However, we are committed to developing a system that fits the needs of the more remote parts of the counties as well. Therefore, we will initially focus on centralized service locations, but evolve and expand to smaller practices as the system gets up and running.

Implement Gate Keeper Training (GKT). The GKT training will teach medical staff to identify warning signs and symptoms, to discuss suicide with patients, to engage parents and guardians, and to initiate an effective referral process. The training will be open to other health care professionals, public health departments, juvenile detention centers, foster care agencies, and schools of nursing. We will also disseminate many of the materials developed by the Suicide Prevention Resource Center (SPRC) specifically for the primary care setting. The SPRC has developed excellent resources that have immediate applicability to medical and behavioral health practitioners in rural regions. Several of these resources will be used.

Use Web-Based Behavioral Health Screening Tool. All participating primary care offices will receive free access to the web-based behavioral health screening tool. The aim is to administer the screening tool before a well visit or at the provider's discretion. The tool will generate a report to be reviewed by medical staff before the appointment. If an adolescent endorses suicidal thinking, the physician will evaluate the need for further assessment. If further attention is needed, medical staff will activate one of the TRIAGE options listed below. Assistance for some practices without computer or internet connection will be provided.

Increase the Integration of Behavioral Health and Medical Services, through TRIAGE (Teen Risk Identification And Guided Evaluation system). This project will develop and implement several solutions to increasing a suicidal patient's access to behavioral health services This will 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.This will be achieved by a) intensifying collaboration between the medical and behavioral systems, b) increasing collocation of services, c) using telemedicine, d) promoting family involvement.

Enhance Clinical Services for Suicidal Youth. The final component of the prevention program will be to "upgrade" the skill set of the behavioral health providers who engage, refer and or treat this population. STAR-Center and CFIS will prepare annual continuing education workshops to expose local mental health practitioners to best practice interventions. Three skills sets will be promoted: Cognitive-Behavioral Therapy for suicidal youth; Family Therapy for suicidal youth, and assessment and crisis intervention with suicidal youth. These trainings will be offered free to behavioral health providers at least twice a year.