FINAL PROGRESS REPORT

Grant No.: 1U79 SM060387
Grantee Name: Preventing Youth Suicide in Primary Care
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Dates of funding cycle: August 1, 2011 – September 30, 2014

Project Description, Implementation, and Results

I. Executive Summary

The goal of this project was to increase identification of youth (ages 14-24 years) at risk for suicide and to improve their access to mental health services. The primary means to this goal was through implementation of an early identification system initially within primary care medical settings in three Pennsylvania counties (Lackawanna, Luzerne, Schuylkill) with high rates of adolescent suicide. With the renewal grant, this goal was expanded to include additional Pennsylvania counties (Allegheny, Berks, Bucks, Chester, Delaware, Monroe, Montgomery, Philadelphia, and Westmoreland). This directly met the aim of the RFA for this project: to develop and implement early intervention and prevention programs for suicidal youth.

There are four objectives:

Objective #1: Create a state level and county level advisory group consisting 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 twelve counties. Additionally, they will assist in plans for dissemination across the Commonwealth.

Objective #2: Provide medical practices in the designated counties with educational materials and training that will improve the PCP's ability to identify and refer youth at risk for suicide.

Objective #3: Provide medical practitioners in all participating 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 collocation, 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.

This project meets the needs of Pennsylvania's Youth Suicide Prevention Plan and the National Strategy. The Pennsylvania Youth Suicide Prevention Plan is modeled after the *National Strategy,* and the GLS project meets numerous needs across both suicide prevention plans. Specifically, the following goals are met by this project: Goal #1: promoting awareness of suicide as a public health problem; Goal #2: developing broad-based support for suicide prevention; Goal #3: develop and implement strategies

to reduce stigma; Goal #4: identify, develop, and implement suicide prevention programs; Goal #6: training to recognize risk factors for suicide; Goal #7: promote effective clinical and professional practices; Goal #8: improve access to community linkages with mental health services; Goal #10: promote and support suicide research efforts; and Goal #11: improve and expand surveillance systems.

Total Number of Participants Eligible and Served:

Total Number of Adolescents Screened through Grant (S1) – 10137 – (Grant goal was 6500).
Total Number of Positive Screens Identified through Screening during Grant – 1911
Total Number of Referrals during Grant – 863 – (Grant goal was 1040).
Total Percentage of Individuals receiving mental health or related services after referral (AC1) – 40% – (Grant goal was 33%).
Total number of individuals trained in prevention or mental health promotion (TR1) - 1355 – (Grant goal was 400).
Total number of individuals exposed to mental health awareness messages (AW1) – 5868 – (Grant goal was 3000).
Total number of people in the mental health and related workforce trained in mental health related practices/activities that are consistent with the goals of the grant (WD2) – 90 – (Grant goal was 300).

Description of service areas:

We continued to implement our primary care youth suicide prevention program in three, primarily rural, north-eastern counties (Lackawanna, Luzerne, and Schuylkill). We also expanded this project to two new regions: the southeast, a predominately urban and suburban area, and the western end of the state, including Pittsburgh (Allegheny) and one of its neighboring rural counties (Westmoreland). These new sites had appeal for several reasons. First, although the suicide rates were slightly lower than in our initial counties, there were significantly more suicide deaths because the population is so much larger. In fact, our initial three counties as well as the new eight counties in the southeast and west (16.4% of the total number of counties) accounted for 50.6% of all suicide deaths in PA in 2008. Second, systems of care in urban and suburban areas are bigger, more complex and have more resources. Third, these counties have a number of other risk factors such as high poverty, a large percentage of families on medical assistance, high rates of adults with disabilities, high levels of alcohol use, high rates of domestic violence with fatalities, and high rates of reported child abuse. Access to firearms was also high within these counties. Fourth, we had a new opportunity to specially target some high-risk populations: low income, urban minority youth and identified LGBT youth.

Description of challenges encountered and lessons learned through local evaluation:

A. Barriers to Accomplishments
   i. **Length of time to set up a site.** Challenge. One major challenge has been the amount of time needed to get the project up and running in each county. While we built on the success from the first grant in the three pilot counties, we learned there are new challenges in each new county we entered. Each site can take a varying amount of time depending on a number of issues including the size of the practice, internet access/ IT support issues, IRB issues, implementation/workflow issues, and how comfortable the staff is with identifying, assessing, and triaging mental health problems. Solution. We have developed many tools that help facilitate the implementation process. For example, we now have a project readiness questionnaire that assessed many of these potential workflow issues prior to implementation. We have also put many of our

training and resources on the web so sites can more easily access these tools and trainings. We have also streamlined the screening tool so it more easily creates new sites for easier implementation.

ii. **IRB issues**. Challenge: Many of the new sites are part of larger hospital or academic institutions. These centers have much more attention to issues related to patient confidentiality and the IRB. These IRB's had different views on issues relating to patient privacy, age of consent, etc. Thus, we had to return to our IRB and make changes and then go back to the institutions' IRB for approval. This turnaround time can take months. Solutions. We now have a 12 page document that addresses most of the IRB issue that have come up in this project over the six years. This document is given to new IRBs who are reviewing the project. This also helps new sites prepare for the kinds of issues that IRB will want them to address.

iii. **Integration of medical and behavioral health**. Challenge. This emerged as one of our biggest challenges. One major complaint by the PCP was the difficulty getting access to behavioral health services for their patients. While a severely suicidal patient would more easily enter the system, urgent but not critical patients would often linger on waiting lists, often for weeks or months. Solutions. Several steps have been taken to address this. Meeting with the directors of the medical and behavioral care systems can lead to new agreements to increase cooperation. For example, some behavioral health centers set up a single intake person assigned to serve the PCP offices and a commitment was made by the behavioral health provider to either bring any PCP referral in for crisis services (which would allow for immediate access) or to give some level of priority to the case. This flexibility on the part of the behavioral health providers is partially because of the local attention that the grant has generated and partially because the behavioral health providers feel that these cases were already partially assessed by a medical professional, had the BHS report, and therefore, the referrals came with a clear need for services. Our biggest success has been to create meet and greets between the PCP provides and local behavioral health providers. We do a mailing to all local BH providers and invite them to a meeting at the PCP office. This face to face contact and personal relationship building has been critical to expanding the behavioral health neighborhood.

iv. **Insurance.** Challenge. Possibly the biggest barrier to screening is still the lack of reimbursement available for this process. Insurance companies do not currently reimburse the PCP for the screening. Clearly the PCPs that we worked with are strong patient advocates and looking to do the right thing for their patients. However, they are cognizant of the business aspect to their practice and to implement an activity that does not generate income can raise concern. Solutions. We worked closely with state Medicaid Authorities to explore reimbursement for these services. We also engaged commercial insurers to pay for screening. We scheduled several meeting with the key entities to further discuss this issue. The poor national and regional economic climate has thwarted these efforts, but we feel health care reform may revive possibilities.

B. Lessons learned from project implementation:

Adoption of the program has been the most interesting challenge, teaching us a variety of lessons:

i. The strongest predictor of success is the leadership of the practice. If the primary care practice leadership truly embraces this project, then the staff seems more likely to comply. When leadership has been more ambivalent about the program, then staff's resistance is permitted to persist. Related to this, we have found greater success with implementation in practices where the administrator or "owner" of the practice is also a physician in the practice.
ii. Some practices have patients complete the screening in the waiting room while others have patients complete it in the exam room. When completed in the waiting room, it is dependent on administrative staff to introduce the screen. The majority of our sites utilizes the screening tool as a clinical tool and has fully integrated it into their workflow. In these sites, the screening numbers have been much more substantial.
iii. Workflow issues are not inconsequential. Issues such as who will administer the screening, where it will take place, who will log patients on, where the report prints out, and who enters the report into the patient's medical record seem like minor problems, but they become enormous barriers when they are not clearly addressed or mandated from the practice's leadership.
iv. Larger institutions need more time to set up the system. It is difficult to get all the providers and staff together for training. There is also difficulty in having PCPs retain the information they received from the trainings because of the long gap between the training and screening launch dates. Additionally, it is difficult to get the IT department to configure the web site within the practice's network, especially if the clinic was going to use a new computer purchased by the project. These delays often lead to a three month start up phase, which in turn, may result in poor retention of information by the providers once screening has finally begun. In contrast, smaller agencies, private practices with one or two PCPs, were able to move more quickly to establish the infrastructure of the program.

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

In Year 3, we held a statewide set of calls with local county task forces facilitated by the Star Center (a grant partner). Most recently, we had two statewide conference calls in February 2014 with over 20 counties represented. Prior to that, we had two conference calls in 2013 with nearly 30 counties represented. Over the course of the second grant, we sought to formally establish collaborations with the CDR and APSF chapters. These collaborations will continue to develop beyond this grant. Our across the lifespan efforts have also continued to develop as OMHSAS seeks to bring together the PAYSPI and Older/Adult groups under one statewide coalition. The new interactive county task force calendar of events will certainly facilitate these efforts both locally, regionally and statewide. The updated PAYSPI website was unveiled at the 2014 statewide conference is which over 30 counties were represented. A second focus relevant to the grant was the continuation of the Statewide Suicide Prevention Conference. This statewide conference is now held yearly with a focus on education and training. 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 even beyond this grant.

Objective #2: Provide a youth suicide "gatekeeper" training program

Summary of Training Activities

We had a number of training goals for the program. Overall, we were successful in achieving most goals, and we exceeded expectations in a number of ways. Year 1 began with a one-day Youth Suicide Prevention Symposium in Harrisburg. While this event was supported from carryover funding from our Cohort IV efforts, the symposium served as a statewide kickoff for the new project. With nearly 300 participants in attendance, representing primary care, behavioral health, schools, and other areas, the event offered morning plenaries and afternoon breakout sessions targeting different venues by which suicide prevention efforts occur: schools, behavioral health, and primary care. Overall, the symposium was very well received by attendees, who provided feedback about future trainings.

With the expansion of the project away from just northeastern PA, it became necessary to develop new methods of disseminating training information. Consequently, Dr. Matthew Wintersteen worked with Jefferson Medical Media and the American Association of Suicidology (AAS) to transform Recognizing and Responding to Suicide Risk in Primary Care for Providers of Youth and Young Adults (RRSR-PC-Y) to an archived web-based version that could be accessed on the web. Participating practices were given password access to the training, arranged for a time for the practice to view it, and Dr. Wintersteen participated in a question and answer session immediately following the training. Feedback remained as positive as many of the live trainings.

Practices received copies of the Suicide Prevention Resource Center (SPRC) and WICHE Toolkit for Suicide Prevention in Rural Primary Care. Highlights to these materials and how they best augment the AAS training were discussed with providers.

Additional highlights of Year 1 included:

- Coordinating a training of Assessing and Managing Suicide Risk (AMSR) in Nanticoke, PA, for behavioral health providers in northeastern PA.

- Developing Effective Safety Plans for Suicidal Youth. This training uniquely spans both primary care and behavioral health settings and focuses on the development and implementation of safety plans in clinical practice and is based on the work of Drs. Greg Brown and Barbara Stanley.

- Updating the Pennsylvania Youth Suicide Prevention Initiative (PAYSPI) website (www.payspi.org) to include a specific training page, where primary care and behavioral health providers are able to view free, archived trainings focused on suicide prevention.

Year 2 concluded with a major conference at The Children's Hospital of Philadelphia, whereby we partnered with SPRC and the STAR Center in Pittsburgh, to present a program focused on behavioral health integration in primary care. SPRC assisted us in advertising this event and eventually archived the conference recorded web talks on their website. Over 400 participants from across the globe viewed the event live, and SPRC has reported to us that it is one of the most frequently viewed archived trainings on their site.

As was the case each year, project staff participated in a number of trainings and conferences over the course of Year 2. Drs. Diamond and Wintersteen presented at the state Medical Home conference in April to over 200 attendees of the medical community. Dr. Wintersteen was invited to attend an integration conference in Maine and discuss our efforts in Pennsylvania, as well as also talking about suicide risk assessment in youth. He also spoke at a behavioral health workshop for the Pennsylvania Coalition of Nurse Practitioners. The scope of presentations increased dramatically during Year 2, with an expansion to broader communities of healthcare providers.

Year 3 included many similar trainings. Dr. Wintersteen spoke at two CME conferences for the Pennsylvania Academy of Family Physicians. The first conference included a complete morning plenary with three unique talks focused on working with suicidal youth in primary care, assessment, and general behavioral health integration issues. Our work was also featured at the 2013 Pennsylvania Suicide Prevention Conference in State College. The RRSR-PC-Y trainings decreased in Year 3, as the number of new practices participating in the project deceased dramatically. This decrease was due to our desire to complete the work with the existing practices but also due to our need to avoid bringing on new practices without a firm understanding of how future funding could support their initial startup. In fact, the only practitioners to complete the online training in Year 3 were new practitioners at existing, participating practices.

In January 2014, Dr. Wintersteen assisted the American Association of Suicidology in convening a number of national experts to discuss challenges associated with training behavioral health professionals on suicide assessment and intervention. In part, his involved stemmed from his training efforts on the current and previous GLS grants.

Our project was highlighted to Special Operations Command at both Camp Lejuene and Ft. Bragg, as Dr. Wintersteen presented the RRSR-PC training to their medical and behavioral health staff. These efforts were also highlighted at the 2014 American Psychological Association Convention in Washington, DC.

Near the end of Year 3, a number of schools became increasing interested in our efforts and how we might rollout a similar model in their settings. As demand increased, we presented training to school personnel in four large school districts across Pennsylvania. These initial trainings and discussions helped us develop the model for suicide prevention for schools that was most recently funded through the GLS Memorial Act in 2014.

Related to both or new interest in school-based suicide prevention, as well as our training initiatives, several project staff were involved in working with state legislators to pass a bill that now requires teacher training in suicide prevention and school readiness through the development and implementation of prevention and postvention policies and procedures. Student curriculum development and implementation is also recommended. It should be stated that any effort our project staff committed to these larger state efforts were provided outside the scope of their work on this federal grant.

While in many ways we exceeded our expectation for training, there is one project that we proposed to complete and were unable to finish. We had every intention of building a new, web-based archived training focused on suicide prevention for medical providers who work with LGBTQ youth. We had engaged the Mazzoni Center in Philadelphia in assisting us with the program planning and development. Unfortunately, there were unforeseen changes in their leadership and time allocation that impeded their ability to continue the partnership.

Finally, we have been working on an additional training series for primary care providers, but the end product is not expected to be completed until early 2015. The Behavioral Health in Pediatric and Adolescent Primary Care video series includes 14 30-minute training video for primary care providers who treat youth with a range of behavioral health concerns. The series contains 10 videos focused on common but challenging concerns, such as depression and substance abuse) and an additional four videos focused primarily on interventions, such as psychopharmacology and motivational interviewing, for a range of behavioral health concerns. Each video in the series begins with an introduction of the module by Dr. Wintersteen, the series host. Each module is then facilitated by an expert in the content area. The videos follow a television news magazine (e.g., Dateline) format with attractive editing in an engaging presentation. Each behavioral health condition modules includes brief epidemiology, diagnosis

and clinical presentation, differential diagnosis, assessment, intervention, and a case presentation. Each intervention module includes an introduction to the model, appropriate and inappropriate use of the model, and basic techniques. All modules include case presentations will include video vignette demonstrations.

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

As screening was a large part of our grant activities, we sought throughout the course of the grant to improve the BHS. We were able to make further modifications to the BHS in order to enhance ease of use and decrease time burdens on PCP staff. Many of these recent improvements made it easier for reporting of referrals and service utilization by the provider to the grant team. Embedded within the screening tool interface was the ability for the medical provider to select whether the patient was being referred to services, not being referred to services, or is already currently in services. In addition, interface allowed the medical providers to indicate the date of referral and whether the patient attended those services along with that date. This new feature along with the current procedure of having reports of identified suicidal adolescents being automatically sent to research staff and county coordinators dramatically improved the likelihood of reaching youth for follow-up of their behavioral health service utilization. We worked with the practices to ensure that this process was not only seamless but also conformed to all federal and local privacy regulations. Additional improvements made during the grant period included:

- We added a section on bullying to the screening tool and expanded our questions on access to firearms. These two domains have been well received by physicians and have led to increases in screening in many of our sites.

- An additional upgrade that was made was to translate the screening tool into Spanish and add it as an option on the BHS. This upgrade was made from a request from several practices that indicated that they had a large Spanish patient population and has been well received by the practices. One of our Philadelphia sites that came on to the project in Year 2 and serves a predominantly Spanish population has given positive feedback on having a comprehensive screening tool in Spanish readily available.

- Patient Trends – Sites can now view their patients' longitudinal data on – Suicide, Depression, Anxiety, Trauma, Eating Disorder, and Substance Abuse for the last 12 screens for a particular patient.

- Facility Screening Report – Sites can select a time period for (start and end date) to view a screening report for their site on the following categories – Suicide, Depression, Anxiety, Trauma, Eating Disorder, and Substance Abuse. The report displays the aggregate numbers or counts that met the criteria for the above-mentioned categories, for a selected time period.

- Export Screening Data – Sites can now select a time period for (start and end date) to download the raw data from the surveys completed by the patients in that facility.

- Training Center – Sites are able to view a video that will explain the screening tool and its various components. It will also explain the ways to implement the BHS in their clinic, ED, or school, and its benefits of implementing and administering it.

- As an additional option for our emergency department sites, a tailored version of our screening tool was created to enhance ease of use and decreased time and workflow burdens on ED staff. This has decreased the average screening time to 3-5 minutes.

Objective #4: Increase the integration of behavioral health services with medical services.

The County Task Forces continued throughout the grant 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 utilized by some of the practices and involved behavioral health facilities setting up a satellite structure within the medical office. This structure allowed a unified collaboration between the medical and behavioral health provider, reduced stigma by providing behavioral health services in a medical setting with which the patient is already familiar, and streamlined access to care by providing dedicated behavioral health services for these patients.

Triage Model #2: Intensify collaboration between the two systems. In many settings, co-location was not possible. One alternative was to strengthen the relationship between the medical and behavioral health facilities. This proved to be our most useful and widely welcomed service to the medical and behavioral health providers. The manner in which we executed this collaboration manifested in several different ways and varied from site to site. In one case, this involved setting up a behavioral health clinic one afternoon a week where a behavioral health worker can be on-site for assessment. This also included an agreement with the behavioral health agency to be available for consultation and triage when a suicidal youth is identified. As a result, the provider could call the agency, and the agency would provide an immediate response, whether it was assisting in decision making over the phone or sending someone for a face-to-face assessment. As previously stated, there was some variation of this model for many of the practices.

II. Results of Local Evaluation

Our local evaluation effort had two main parts: evaluating the feasibility of implementing new screening activities into PCP and other health settings and tracking identified suicidal youth to learn about service use.

We were able to implement our Behavioral Health Screening tool in over 40 primary care practices, emergency departments, and schools across a number of Pennsylvania counties over the course of the grant. Our evaluation included collecting information from the various sites about the number of adolescent patients that were screened. We also collected information from youth who completed the screening to help them understand the prevalence of certain behavioral health problems presenting in primary care and other health settings. Over 10,000 adolescents were screened during this cohort.

Youth who complete the screening tool and endorse suicidal ideation were invited to participate in the tracking study. The tracking study was designed to examine how many referred adolescents attend services. During the course of the grant, we were able to verify that 40% of the adolescents who were referred to further behavioral health services attended those services.

Based on our last data run, 3.6% of screened adolescents reported having current suicidal ideation. A larger group did not have current suicide ideation but had thought about suicide sometime in their life (12.2%).

Co-morbid Mental Health. In addition to identifying those who endorsed suicidal ideation and/or behaviors, the BHS detects patients with other psychosocial problems that place them at risk for suicide. Many of these were non-suicidal, but emotionally distressed youth that were referred to outpatient care as well. 24.8% of adolescents endorsed moderate to severe depression or anxiety (39.5%). Patient also reported above clinical levels for traumatic distress (23.5%) eating disorder (3.8%) and substance abuse (3.0%). Within the sample of adolescent reporting current suicidal thinking, they also reported moderate to severe depression (92.2%) or anxiety (95.6%) as well as clinical levels for traumatic distress (76.7%) eating disorder (16.7%) and substance abuse (11.1%). Analyses of the data suggested that patients endorsing lifetime suicidal thoughts were more at-risk for behavioral problems than patients reporting no prior thoughts of suicide, but less at-risk than patients with current suicidal ideation.

Access to a Gun. In addition to several other risk behavior assessed in the BHS, patients are asked if they have access to a gun. This affords the PCP to evaluated risk for self-harm or increased risk for harm to others. Of patients reporting current suicide ideation, 12.2% reported having access to a gun.

Patient Satisfaction. In addition to identifying those who endorsed suicidal ideation and/or behaviors, the BHS also surveyed patient satisfaction. Only 10% of adolescents reported feeling uncomfortable answering questions and 90% of adolescents felt that medical providers should be asking these questions.

III. Interface with Institutions of Higher Learning

Throughout this project we have worked with institutions of higher learning. Four key contributors to the project's success have been Drexel University, University of Pennsylvania School of Medicine (with The Children's Hospital of Philadelphia), Thomas Jefferson University, and the University of Pittsburgh Medical Center (with the STAR Center). In addition to project leaders at these institutions, our project has worked with The Commonwealth Medical College in Scranton to provide training to some of their medical students working in project practices.

IV. Collaboration with Other Federally-Supported Initiatives

The Principal Investigator of the GLS Grant was also the Principal Investigator for two other SAMHSA initiatives awarded to Pennsylvania: a System of Care Cooperative Agreement as well as a System of Care Expansion Planning Grant. Being in this position has made it possible to identify areas of collaboration between the various federal initiatives, especially

the Planning Grant which is focused on establishing ways for all counties in Pennsylvania to develop systems of care for youth with involvement, or at risk of involvement, in multiple child-serving systems.

V. Cultural Adaptations

The most significant cultural adaptation involved translating work initially developed with urban youth into working with youth from largely rural areas. The county coordinators played a significant role in helping with the rollout process and made the transition a success.

Another cultural adaptation developed for this project was the translation of the BHS into Spanish. This came about after several inquiries from providers in some of the northeastern communities serving Hispanic youth and families. For several years, we had the informational handout for parents translated into Spanish, but translating the entire screening tool into Spanish was a major accomplishment. All proper steps were taken to ensure the accurate translation. Additionally, we were able translate the BHS into Mandarin and Korean languages. Additional languages are being considered as we want to be able to disseminate the tool to a larger population.

VI. Locally Developed Approaches

The true uniqueness of our project was the ability of the project team to take an approach developed and piloted in one part of Pennsylvania and apply it in another part of Pennsylvania. Everything from the screening tool to the trainings for both PCPs and behavioral health providers were developed by researchers in the Commonwealth. This project provided us the necessary opportunity to bring several of these efforts together into a sustainable model. It was several years of piloting our work in primary care that we came to realize that our objectives could not be successful unless combined; thus, the approach to this project focused on this collaboration.

Budgetary and Personnel Adjustments

- None

Technical Assistance Feedback

- For SAMHSA identify:
    - The most helpful technical assistance provided for the project occurred during the grantee meeting, as well as conference calls with the GPO. The grantee meeting allowed us to see how other states were addressing similar issues that we were facing concerning consenting and follow-up of suicidal youth. This was particularly important as we made decisions about project changes and explored best approaches to addressing the specific needs of our project's target population (i.e., youth in primary care).

- For SPRC identify:
    - Two types of technical assistance provided by SPRC were most helpful. First, the grantee meeting provided an opportunity to work with other state evaluators on examining outcomes. Second, individual communication with the TAL gave us the opportunity to explore other efforts going on nationally and connect us to a few other grantees who were

exploring youth suicide prevention in primary care. This has been vital as we begin thinking about broader dissemination models and products that could be accessed by the entire Commonwealth as well as those serving youth outside of Pennsylvania. Lastly, SPRC has been a great partner in helping to collaborate with some of our grant activities. We partnered with SPRC to advertise the live webcast of the of our behavioral health integration conference that was hosted on Sept 12, 2013 at The Children's Hospital of Philadelphia, as well having SPRC host the archived sessions. This conference focused on behavioral health integration in primary care and included presentations on screening, assessment, and brief intervention in the primary care setting for youth who may be at risk for suicide, as well as afternoon sessions focused on several models for behavioral health integration including our state GLS project, an effort by investigators at the University of Pittsburgh Medical Center, and providers in Massachusetts who talked about psychiatric consultation available to primary care providers by phone. We appreciated all of the help SPRC provided in making the conference available to so many people across the world.

- For ICF identify:
    - Our relationship with ICF was extremely important in assisting us in providing SAMHSA with the necessary reporting information to assure that this project was compliant with the cross-site evaluation. This was the first grant completed by the Evaluation team that contained such an evaluation, and our ICF liaison was extraordinarily helpful in providing us with assistance. Also, the grantee meeting was a helpful venue for getting cross-site evaluation questions addressed. We are pleased to see that some of the cross-site evaluation data is now being shared with grantees at these meetings.

Collaborations

- The success of this project hinged on collaborations with a number of public and private partners.
- Medical and Nursing Associations:
    - PA Chapter of the American Academy of Pediatrics
    - PA Association of Family Physicians
    - PA Coalition of Nurse Practitioners
    - PA Community Health Centers
- Behavioral Health Providers:
    - PA Community Providers Association
- State Government:
    - Department of Public Welfare
    - Department of Health
    - Bureau of Drugs and Alcohol (Dept of Health)
- All of the primary care providers and their staff that we have come into contact with over the years that have provided ongoing training to our leadership team (albeit informal) on methods to make our efforts successful in their world.
- We now have 26 counties in PA with Suicide Prevention Task Forces working with youth at-risk

Products and Publications

- The following table is a list and description of any noteworthy curricula, presentations, products, or other materials developed through the project.

Adolescent Suicide Risk Assessment Training	This training is intended to provide youth suicide risk assessment training to nurse practitioners specifically and primary care providers more generally.
Attachment Based Family Therapy Training	This training will help mental health professionals develop a skill set in Attachment Based Family Therapy (ABFT). ABFT is the only manualized, empirically informed, family therapy model specifically designed to target family and individual processes associated with adolescent suicide and depression. This training was offered to mental health professionals in the three counties of this project. This is intended to increase the knowledge of mental health professionals
Awareness Bracelets	The county task force in Schuylkill county developed bracelets that have the crisis phone number on them. They use these as outreach and awareness within the county.
Behavioral Health Screening - Primary Care	The Behavioral Health Screen - Primary Care (BHS-PC) is a web-based self-report mental health screen that is designed specifically for adolescents and young adults. The BHS-PC has been moved a web-based platform to fit more easily into primary care office work flow patterns. This product is intended for use in primary care centers to screen youth on a variety of psychosocial and risk behavior scales. Youth will complete the BHS-PC prior to their appointment. When they complete the screen, a report will print for the provider to review before meeting with the youth. The BHS-PC is currently in use by 10 primary care sites in our region.
BHS-PC Training Video	In conjunction with our development of the new web-based platform for the Behavioral Health Screen - Primary Care (BHS-PC), we are currently developing a training video (dvd) that will coincide with the BHS-PC user's manual. Each primary care health center that we work with will receive both the video and the BHS-PC user's manuals for their staff. The video will detail the clinical and research applications of the tool and include step by step instructions for registration, administration, and printing of BHS reports. We also anticipate that the video will be made available online.
BHS-PC User's Manual	In conjunction with our development of the new web-based platform for the Behavioral Health Screen - Primary Care (BHS-PC), we have created a detailed user's manual. Each primary care health center that we work with will receive user's manuals for their staff. These manuals detail the clinical and research applications of the tool, and include step by step instructions for registration, administration, and printing. The manual also includes sample reports and information sheets for parents. The manual also includes newly developed pocket cards that detail procedures for the primary care site.
Brochure of Information for Interested Primary Care Practices	We developed a brochure to give interested primary care practices more information about the project and how they could become involved. This brochure includes information about the project design, the benefits to participation, and contact information for the local project coordinators.
Brochures for Parents and Adolescents	We have developed two different flyers with the same intent - to educate youth and parents about the importance of mental health. One flyer is designed for teens and explains therapy. The second flyer is designed for youth and parents and is about the importance of mental health and warning signs of depression. Both flyers seek to educate parents and youth about mental health and will be placed in primary care offices throughout our region.
CHOP Research Poster Day	Guy Diamond, the project director, and Shannon Chaplo, the project's research assistant presented an academic poster entitled "Pennsylvania Garrett Lee Smith Project: Youth Suicide Prevention in Primary Care" at the Children's Hospital of Philadelphia's (CHOP) annual Research Poster Day on February 23, 2011.
Cognitive Behavioral Therapy for Suicidal Adolescents Training	This training will help mental health professionals develop a therapeutic skill set in cognitive behavioral therapy (CBT), a treatment approach applicable to a variety of clinical problems.
Cognitive Behavioral Therapy for Suicidal Adolescents: Follow Up Training	This training is a follow up to the series held in 2009 and will help mental health professionals develop a therapeutic skill set in cognitive behavioral therapy (CBT), a treatment approach applicable to a variety of clinical problems. These problems might include depression, anxiety, attention deficit hyperactivity disorder and other emotional and behavioral disorders.

Community Suicide Prevention Program - Taking Steps Together	This took place in Lackawanna county. A local high school experienced the loss of three students by suicide in the fall of 2010. The GLS County Coordinator in Lackawanna coordinated and developed a two hour Community Program that was held at the high school in the evening. It was a 10 member panel of 2 psychiatrists, the school administrator, family survivors, GLS Primary Care site Physician, and an Addiction Counselor.
Do Something Cards	The Do Something cards were developed by the Schuylkill county suicide prevention task force. They detail the warning signs of suicide and the appropriate actions to take when someone is at risk.
Funeral Director Flyer	As a result of the grant, the Lackawanna County Suicide Prevention Task Force created a two-sided flyer to distribute to funeral directors throughout their county. The flyer entails a brief discussion of the important role that funeral directors play in supporting survivors of suicide a list of considerations for working with this population.
Greater Northeast PA Out of the Darkness Walk	Our event is a regional walk held in Wilkes-Barre PA. It raises awareness on suicide prevention, as well as supporting research and highlighting local efforts such as the Garrett Lee Smith Project in both Lackawanna and Luzerne Counties.
Information Sheet about Training and Screening	We created a two sided informational sheet about the trainings and screening provided as part of our project. In our efforts to recruit more primary care practices to participate, we needed more detailed information about screening and training to supplement the information in our project brochure. This will be used by the local coordinators when they approach new primary care practices about participation in our project.
Let's Talk: Suicidal Risk in Adolescents - Assessment and Treatment	This training was a teleconference titled "Let's Talk: Suicidal Risk in Adolescents - Assessment and Treatment" given by David Brent. M.D. The training was directed at primary care providers (PCPs), specifically pediatricians and family physicians. The goals were to educate PCPs about epidemiology and risk factors of adolescent suicide, effective assessment in primary care, and effective management of adolescents at risk for suicide in primary care.
Linking Together a Chain of Care Symposium	As a result of the grant, a one day symposium entitled "Linking Together a Chain of Care: The Pennsylvania Model for Suicide Prevention" took place on September 21, 2011. The purpose of the symposium is to bring together individual stakeholders who interact with youth and young adults and promote cross-collaboration of systems of care to prevent youth suicide, in keeping with the vision and mission of the grant. The target audience includes: Primary care and behavioral health providers, school nurses, Student Assistance Program mental health and drug and alcohol coordinators and liaisons, other school personnel, county suicide prevention task forces, representatives from the three GLS grant counties, crisis intervention workers, and concerned community members.
Local Suicide Prevention Task Forces	This project has supported the creation of suicide prevention community task forces in Lackawanna and Luzerne counties and is supporting the ongoing activities of the Schuylkill county task force. Each task force has its own statement of goals and objectives, but they all aim to have a wide range of stakeholders addressing issues related to suicide prevention in their communities.
Mental Health Resource Guides for Primary Care Providers	Each county involved in this project (Lackawanna, Luzerne, and Schuylkill) has developed a resource guide for primary care providers in their county. These guides are all short listings of mental health services available in their areas. The goal of these resource sheets is to ease the referral process by providing primary care practices with the contact information for mental health providers in their area.
MH/MR Directors Meeting 11.18.10	The project's principal investigator spoke at a meeting on November 18, 2010 with the commonwealth's county MH/MR directors. His presentation included information about Pennsylvania's current Garrett Lee Smith project, future directions for the project, and general information about suicide rates in Pennsylvania. The presentation was followed by a discussion on how a call to action is needed in the commonwealth and how and what MH/MR directors can do to address suicide including involvement with Pennsylvania's GLS project.
Outreach Talk at Pennsylvania Academy of Family Physicians Conference	We sent three people from our project to a conference organized by the Pennsylvania Academy of Family Physicians. The purpose of this outreach was to raise general awareness about suicide prevention in primary care and to recruit primary care practices to participate in our project.

PAAAP Pediatric Mental Health Webinar	As a result of the grant, the Pennsylvania chapter of the American Academy of Pediatrics (PAAAP) hosted a webinar on June 16, 2011 entitled "Pediatric Mental Health: Tools to Enhance Your Mental Health Practice." The webinar targeted primary care providers (pcp's) including physicians, physician assistants, nurse practitioners, nurses, office managers, and office staff. The webinar aimed to increase pcp's awareness of tools and resources to enhance their mental health practice as well as sample these tools and resources. 129 PCP's attended the webinar.
Parents are Partners: How to Help Parents to Help their Depressed and Suicidal Teens	This training was a teleconference on 9/21/10 titled "Parents are Partners: How to Help Parents to Help their Depressed and Suicidal Teens" given by David Brent. M.D. The training was directed at primary care providers (PCPs), specifically pediatricians and family physicians. The goals were to educate PCPs on how to assess important family characteristics that can promote or impede treatment, developmentally appropriate ways to balance a teen's need for confidentiality with a parent's need to know, and about interventions with families that can improve depressed and suicidal teens' outcomes.
PCPA Technology Conference Presentation	The project director, Guy Diamond, gave a conference presentation at the Pennsylvania Community Provider's Association Technology Conference on March 17, 2011. The presentation detailed the use of the behavioral health screening tool in Pennsylvania's GLS project and how the tool can be implemented into primary care for suicide prevention and other mental health problems.
Pharmacological Management Of Adolescent Depression In Primary Care Webinar	This webinar is supported by the Pennsylvania Department of Public Welfare and part of a statewide effort, in which the PAFP Foundation is a partner, aimed at preventing youth suicide. This event is an in-depth discussion about medication options in primary care and is a follow up to an earlier teleconference on assessment and treatment.
Provider Satisfaction Survey & Interview	A provider satisfaction survey and interview is being developed for the participating practices. The interview and survey will assess providers and primary care staff's overall satisfaction with the project as well as evaluate its key components: training, screening, and improving relationships with mental health providers.
Recognizing and Responding to Suicide Risk in Primary Care - Youth	This is a training designed to educate primary care staff about suicide risk in primary care.
Regional Kick-offs	This event was designed to raise community awareness about our suicide prevention project and to act as a catalyst to start up community-based prevention task forces in two of our counties. We held two separate events. We developed a power point presentation about suicide rates in these counties and how the grant is designed. Guy Diamond and Sherry Peters gave this presentation at each kick-off.
Regional Youth Suicide Prevention Workshops with County Task Forces/Community Members	Four regional youth suicide prevention workshops with county task forces/community members have been developed and supported by grant funding in order to assist in the grant's goal of creating a broad group of stakeholders. The four workshops took place on 10/25, 11/8, 11/11, and 11/29. The workshops were developed by the State Suicide Monitoring Committee. The committee wants to support the efforts of the local suicide task forces by creating more collaboration and communication between those involved with prevention efforts.
Schuylkill County QPR Trainings	QPR trainings given to various community groups (schools, churches, youth groups, primary care etc.) throughout Schuylkill County, one of the three target counties of PA's GLS youth suicide prevention project.
Scranton Temple Residency Program Health Fair	The Health Fair was located at the Scranton Temple Residency Program. We had tables with suicide prevention and postvention information. This included information from the PA Garrett Lee Smith Project, AFSP, and Lifeline resources.
Suicide Awareness Billboard	As a result of the grant, a suicide awareness message that included the phone number for the national suicide prevention hotline was printed on a billboard on a major highway going into Scranton, PA which is located in one of our targeted counties. The billboard company estimates that 35,000 cars pass this billboard each day. During this quarter it was up from April 2010 to October 2010.
Suicide Myths & Facts Video	Schuylkill County D&A Junior Council Members (High School Students) commissioned and created a suicide myths and facts video. The video will by the Speaker's Bureau for outreach talks to school groups.
Suicide Prevention	The Poster/Coaster Campaign was developed by the Schuylkill county suicide prevention task

Poster/Coaster Campaign	force. They detail the warning signs of suicide and the appropriate actions to take when someone is at risk as well as crisis hotline phone numbers.
Suicide Referral Resource Materials	The county task force in Luzerne county developed suicide prevention posters, suicide prevention and referral brochures, suicide referral forms, and easel boards that advocate use of the BHS-PC to be placed in patient waiting rooms.
Training about Co-Occurring Disorders	We collaborated with the State Department of Health to organize a training for mental health and drug & alcohol providers in our region about co-occurring substance abuse and mental health disorders.
Using Motivational Interviewing to Facilitate Adolescent Mental Health Related Behavior Change in the Primary Care Setting	This training was a webinar on 8/16/10 titled "Using Motivational Interviewing to Facilitate Adolescent Mental Health Related Behavior Change in the Primary Care Setting" given by Melanie Gold, D.O. The training was directed at primary care providers (PCPs), specifically pediatricians and family physicians. The goals were to educate PCPs on how to use motivational interviewing techniques with adolescents to promote mental health behavioral change, especially for depression and suicide.
Youth Suicide Prevention for Peers Gatekeeper Training	This was a gatekeeper training specifically developed for high school aged students. It was given to a group of 80 peer mentors at a high school in Lackawanna county in conjunction with a similar staff gatekeeper training. It provides basic information on suicide as well as how to respond to a peer that is at risk. It was developed using multiple resources:
Youth Suicide Prevention Gatekeeper Training for School Staff	This was a gatekeeper training specifically developed for school staff. It was information on suicides as well as to how to respond to a youth at risk. We gave out folders with suicide prevention brochures and resource information from AFSP, Lifeline, and SAMHSA, as well as the GLS Lackawanna Resource Sheets.

- Publications:

Wintersteen, M.B. & Diamond, G.S. (2013). Youth Suicide in Primary Care: A Model Program and Its Impact on Psychiatric Emergency Referrals. *Clinical Practice in Pediatric Psychology*, 1(3), 295–305.

Jenkins, A.L., Singer, J., Conner, B.T., Calhoun, S., & Diamond, G.S. (2014). Risk for Suicidal Ideation and Attempt among a Primary Care Sample of Adolescents Engaging in Non-Suicidal Self-Injury. *Suicide and Life-Threatening Behavior*, 1-13. http://dx.doi.org/10.1111/sltb.12094.

Sustainability

- We are putting many of our trainings onto our state website (www.payspi.org) in order to allow for broader access by individuals and organizations serving suicidal youth.

General Comments

- Were there any aspects of the project implemented that were not part of the original grant proposal? If so, provide a summary of these activities and outcomes. N/A
- Provide any other information or recommendations based on your suicide prevention and early intervention efforts that can inform SAMHSA's ongoing efforts to reduce youth suicide.
  As a result of our efforts, we are convinced that screening in primary care practices and linkage to behavioral health services is an essential component of a comprehensive suicide prevention plan.
- If possible, please provide an anecdote or story that illustrates the implementation and outcomes of one (or more) of your grant activities. N/A