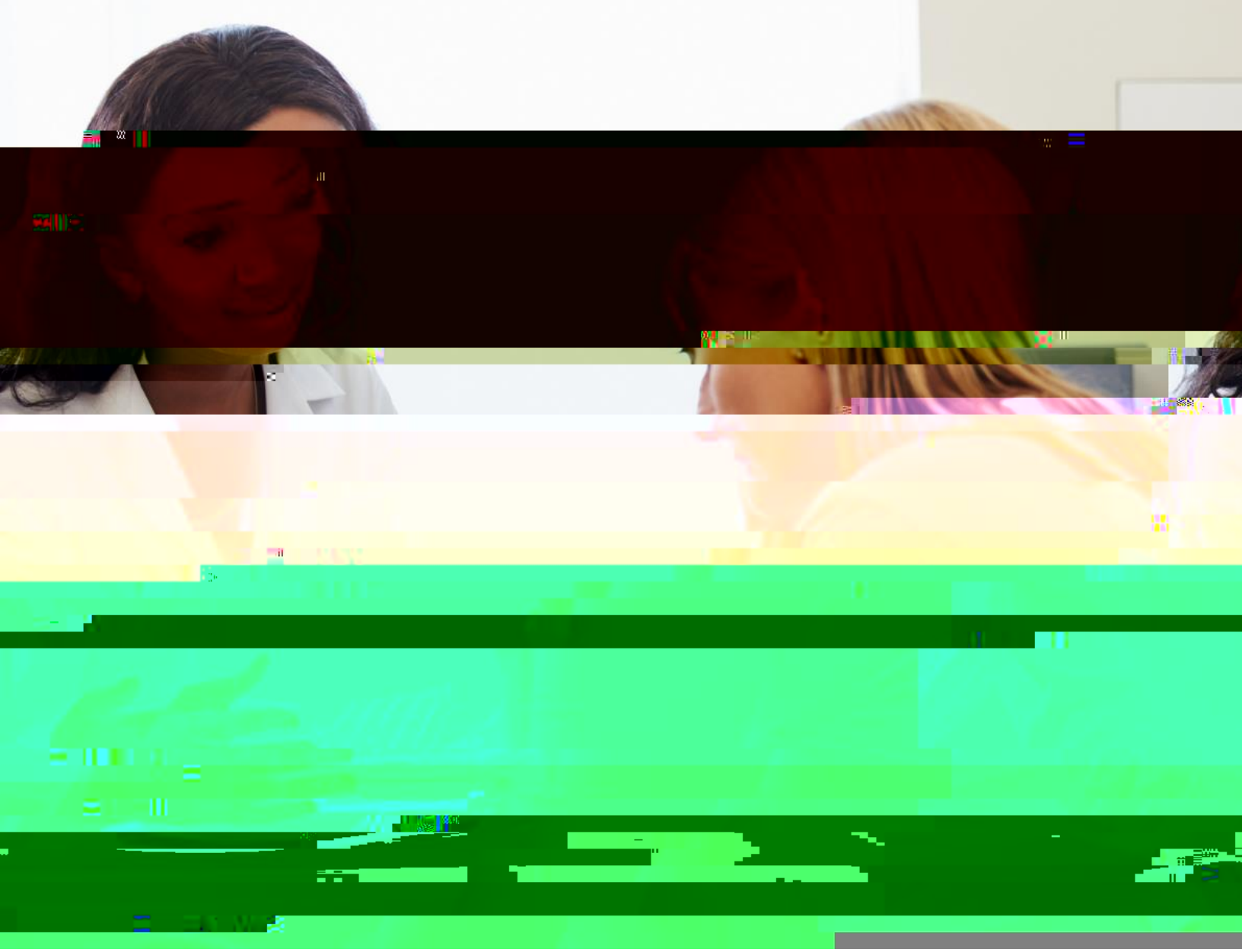

Suicide Prevention in Primary Care:
Trainings for Primary Care Clinicians and Their Teams: 2020-2021

January 2021
Evaluation Report

INTRODUCTION

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Impact

BACKGROUND

A Call to Action for Primary Care

Primary care clinicians are confronting increasing concerns for patients that may be at heightened risk for suicide. Suicide is a growing public health crisis: it is the tenth leading cause of death in the United States.[4] In 2018 alone, more than 48,000 individuals in the U.S. died by suicide—accounting for one death every 11 minutes.[5] Despite efforts to lower this suicide rate, it increased 35% from 1999-2018, becoming the second leading cause of death for individuals between the ages of 10-34.[6] Youth suicide is rising as well: between 2007-2009 and 2016-2018, suicide rates for adolescents and young adults (ages 10-24) increased in every U.S. state.[7]

[4] Centers for Disease Control & Prevention. 2020. "Preventing Suicide." Violence Prevention. Accessed December 22, 2020. https://www.cdc.gov/violenceprevention/pdf/Suicide-factsheet_508.pdf.

[5] CDC. 2020. "Web-Based Injury Statistics Query and Reporting System (WISQARS)." Atlanta, GA: National Center for Injury Prevention and Control. Accessed December 22, 2020. https://www.cdc.gov/injury/wisqars/index.html.

Curtin, SC. 2020. "State Suicide Rates Among Adolescents and Young Adults Aged 10-24: United States, 2000-2018." *National Vital Statistics Reports* 69(11): 1-9. Accessed December 22, 2020. https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr-69-11-508.pdf.

prevention at the individual, community, and societal levels.[13,14] And, given the magnitude and the variety of factors that contribute to suicide beyond mental health conditions, this effort cannot be perceived as the sole province of behavioral health organizations and providers. Clearly, the entire U.S. healthcare system must adopt evidence-based approaches to identify and care for those at risk of suicide.

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[13] "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention." 2012. Washington, D.C.: US Department of Health and Human Services. Accessed December 22, 2020. https://www.ncbi.nlm.nih.gov/books/NBK109917/.

Stone, D, Holland, K, et al. 2017. "Preventing Suicide: A Technical Package of Policy, Programs, and Practices." National Center for Injury Prevention and Control: Division of Violence Prevention. Accessed December 22, 2020. https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

Suicide Safer Care Training Overview

Training Development

This project's trainings derived primarily from our accompanying toolkit, *Suicide Prevention in Primary Care: A Toolkit for Primary Care Clinicians and Leaders*. This document emerged from the 2018-2019 pilot study, which drew upon both a literature review and the comprehensive Zero Suicide Toolkit and framework. Adapted specifically for primary care organizations, providers, and teams caring for underserved populations, trainings focused on three core components:

1.

Training Audience

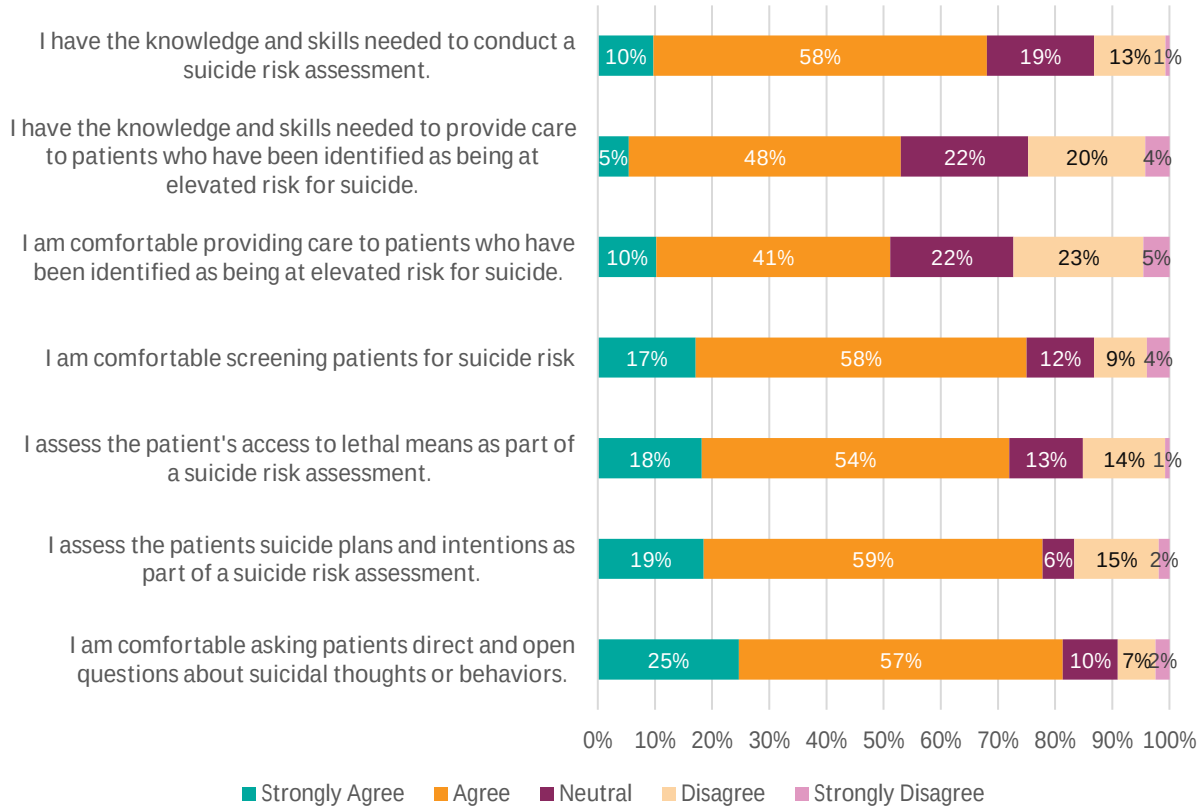
Trainings targeted a broad spectrum of primary care providers and their teams, and participants represented diverse roles within primary care settings. Table 2 includes a breakdown of training attendees by discipline.

Table 2: Training Participants by Discipline

Primary Care Providers	Primary Care Team Members	Behavioral Health Team Members	Others
Medical Doctor	Certified Medical Assistant	Counselor	Administrator
Nurse Midwife	Licensed Practical Nurse	Psychiatric Nurse	Case Manager
Nurse Practitioner	Registered Nurse	Psychologist	Dentist
Osteopathic Doctor	Medical Assistant	Practitioner	Others
Physician Assistant		Psychiatrist	EMR Educator
		Social Worker	Program Manager
		Substance Abuse Counselor	

EVALUATING THE IMPACT OF SUICIDE SAFER CARE TRAINING

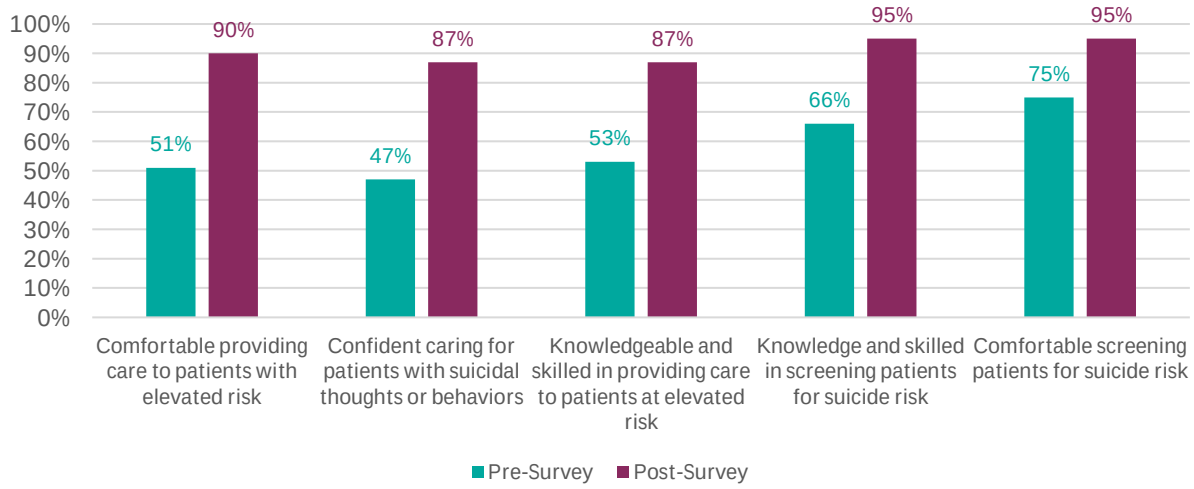
Figure 2: Pre-Training Assessment of Provider Ability and Confidence in Addressing and Treating Suicide Risk



Assessing Training Impact and Outcomes on Primary Care Providers

Providers' belief that they had the knowledge and skills necessary to provide care to patients identified as being at elevated risk of suicide, which rose 34% (from 53% pre-training to 87% post-training).
Providers' belief that they have the knowledge and skills needed to screen patients for suicide risk, which rose 29% (from 66% to 95% before and after trainings).

FIGURE 3: PRE/POST CHANGES IN PROVIDER SKILLS AND ABILITIES



Analysis of surveys by provider discipline shows an overall high level of confidence in knowledge and ability after trainings for nearly all providers. 100% agreed after trainings that using a standard approach to ensure screening, risk assessm (i)-3.99W*nq6w-37.00rosk (n)12.98 (6(i)-3.99Wfet5.996 (l)9

These significant increases were not limited to providers: survey analysis demonstrates improved knowledge, skills, and abilities in all participants, whether attendees were providers or healthcare team members. The greatest single improvement came in participants' belief that they have the knowledge and training needed to recognize when a patient may be at elevated risk for suicide, which rose 27% (from 64% pre-trainings to 91% post-trainings). Participants also reported an increase of 26% in their belief that they have the knowledge and skills to conduct a suicide risk assessment, their level of comfort in providing care to patients at elevated risk of suicide, and their confidence in their ability to provide treatment to patients with suicidal thoughts or behaviors.

Another important dimension to consider in Suicide Safer Care training outcomes was the program's ability to affect organizational attitudes and beliefs. ACU offered new trainings in 2020, including sessions specifically geared toward organizational leaders to help put in place strategies and tactics to support and reduce suicide risks in providers. Furthermore, each training attempted to take a holistic approach toward educating providers and healthcare team members in the importance of suicide prevention in primary care. Survey analysis revealed a variety of impacts in this realm in addition to core knowledge and skills.

Perhaps most importantly, the perception that suicide prevention is an important part of their role increased 14% across all SSC participants, with 95% of all attendees indicating this post-training. Healthcare team members, specifically, reported a strong increase of 19%—from 74% to 94% pre-and post-training, respectively. Furthermore, participants' perceptions of their organization's broader attitudes changed as well: providers' belief that that their practice's staff feel that suicide prevention is a critical part of their job increased from 58% to 89% in pre- and post-tests, respectively.

A Selection of Qualitative Feedback from Participants

Conclusion

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