Suicide Prevention Training in the Workplace

Interview with
Julie Scholz, Executive Director
Oregon Pediatric Society

Introduction

The Oregon Alliance to Prevent Suicide is part of a movement galvanized to help all young people embrace life. Our vision is to connect efforts across Oregon to:

- Promote a sense of **hope** and highlight resilience
- Make it safe to ask for **help** and to ensure that the right help is available at the right time
- Engage communities in the **healing** process after an attempt or suicide loss in order to prevent contagion

This paper, one in a series on suicide prevention training related to the workplace, is part of the ongoing work of the Alliance Workforce Development Committee. The Alliance wishes to express its appreciation to Julie for sharing her experiences and lessons learned about implementing suicide prevention training within the Oregon Pediatric Society.

Julie Scholz, Executive Director
Oregon Pediatric Society

The Oregon Pediatric Society (OPS) is a non-profit membership organization that provides education and training, advocacy, and networking for the pediatric health care field in Oregon. Its mission is to promote the optimal health and development of infants, children, adolescents, and young adults in partnership with their families and communities, and to support its members who care for them. OPS is the state chapter of the American Academy of Pediatrics (AAP), a professional association of 68,000 members that sets standards for pediatricians and pediatric patient visits. For more information, see: https://oregonpediatricsociety.org

Julie is the executive director of OPS. Her professional work experience includes nonprofit management; health research and promotion; marketing and public affairs; international video production; and children, youth and adult experiential learning, mentoring, and psycho-social training. She has been a member of the Oregon Alliance for Suicide Prevention since 2016. Julie's commitment to suicide prevention is evidenced by the success of OPS's expanded focus on suicide prevention training across Oregon, promotion of the chapter's work with the AAP, and organizational support of the 2019 Senate Bill 48 (Adi's Act) and other behavioral health legislation and policies.

Thanks, Julie, for talking with us about the Oregon Pediatric Society's suicide prevention training program. Before we talk about the training, tell us a bit about the organization and how it supports the important work of the pediatric health field in Oregon

The OPS has only four staff yet has a statewide reach, and we're active at the national level through the American Academy of Pediatrics. We work closely with many partners across Oregon. In addition to advocacy and networking for our members, OPS offers continuing medical education, quality improvement projects, and training statewide. Because we're talking about training today, I'd like to focus on that aspect of the organization. Our trainings are designed for the pediatric workforce – primary care teams which include medical providers/clinicians, nurses, medical assistants, mental health providers, front desk and administrative staff. OPS trainings are provided in a variety of ways – lectures, group discussions, webinars and online videos, all to improve adolescent and child health care in Oregon.

Our partnership with the Oregon Health Authority funds part of our training program.

Give us a brief background on the suicide prevention training effort - what was the impetus behind launching the training program?

Starting in 2013, OPS began an adolescent behavioral health initiative to help providers identify and address pediatric patient depression, unhealthy alcohol and drug use, and suicide risk by using standardized screening and assessment tools designed for patients ages 10-24 years old. This training was funded through the Oregon Health Authority's (OHA) former Addictions and Mental Health division and the OHA Public Health division. For OPS, receiving OHA funding enabled us to build our capacity to develop curriculum and train the pediatric community across the state. The training module focused on how to use validated tools to identify signs of depression and substance abuse, and help practitioners with medication management, therapy options and referrals to community resources.

Clinics and clinicians were trained on how to use the screening tool called the PHQ-9 (Patient Health Questionnaire) modified for adolescents (PHQ-A)--with the ninth question screening for suicide ideation—during an office visit. The tool is primarily oriented toward depression and we know depression isn't always related to suicide. That means a depression assessment may miss important signs about the potential for suicide. OPS continued focusing on training the pediatric workforce on the PHQ-A and SBIRT (Screening, Brief Intervention, and Referral to Treatment) for substance abuse until Ann Kirkwood, OHA Youth Suicide Prevention Coordinator and our OHA Health Systems Division contract administrator, began working with OPS in 2016 and asked that OPS do more around suicide prevention. Our 2017 contract renewal reflected this in its deliverables.

For workforce acceptance, there is a need for specific training and evidence-based tools designed for the pediatric medical providers and patient visit that probably differ from other community suicide prevention

interventions such as ASIST and CALM. Doctors need to use validated tools and are under time constraints with how much time they can spend in patient visits; they are wary of anything that takes too much time or throws off their packed patient schedules. For buy in, we have to be sensitive to their time constraints, while also enforcing that suicide prevention can literally be a life or death matter. As one physician said, "It's not one more thing on the plate; it is the plate." For example, if a patient presented signs of meningitis, every effort would be made by the entire clinic and time would be adjusted to immediately take care of that person.

In 2017, OPS pulled together an expert panel of 25 – including primary care clinicians (pediatricians, family practice, pediatric nurse practitioners), school-based health center (SBHC), child psychologists and psychiatrists, Zero Suicide proponents and tribes among others were represented. The panel helped us

figure out what to train pediatricians on when it comes to suicide screening. A panel member brought forward information on a new validated tool from the National Institute of Mental Health which was very helpful. This tool is called the asQ. It stands for "ask suicide-screening questions". After reviewing the documentation, research data and discussing its merits (along with anticipated resistance from stakeholders), the asQ was adopted.

It is likely OPS's separate two-hour suicide prevention training wouldn't have happened if OHA hadn't ask us to focus more on suicide prevention, financially supported that work, and our advisors discovered exciting new pediatric tools. Because hundreds of Oregon pediatric medical staff had been trained and supported by OPS in depression screening, and the standardized tool PHQ-A was actively used by practitioners, it gave us opportunities to build on our past relationships, reputation, and trust in OPS's work in advocating for change, but it also created some barriers for implementation. We were asking busy clinicians to accept yet one more tool for patient visits.

Describe a bit about the training –what's covered during training, who provides the training and who participates, etc.

When we provide clinical trainings, we include all staff in the pediatric clinic, hospital department, or school-based health center setting. That means pediatricians, family practice physicians, physician assistance, nurse practitioners and nurses, medical assistants, front desk, and administration are all part of the process. We believe it is important all staff are trained because at any step along the way to seeing a patient, a warning sign for suicide might be picked up and can be acted upon.

The OPS Suicide Prevention training is led by pediatrician and child psychiatrist trainers. Physicians often listen to other physicians, and the trainers can speak about how these tools work in their practices. OPS began offering trainings in clinics in 2008. People know about OPS across the state and we have good relationships in the communities we serve. These past relationships help us recruit people to attend the in-person trainings. We also recruit attendees and trainers from our OPS membership, and sometimes get connected to physicians through their Coordinated Care Organization.

In the training, we provide information on the warning signs for suicide, suicide risk screening and assessment, managing risk (including lethal means counseling), safety planning and referrals to behavioral health or hospitalization. All clinic staff attend and as mentioned earlier this is to be sure that warning signs aren't overlooked at any point of contact within the clinic. For the doctors, there is a focus on using the asQ tool and follow-up. The asQ (ask suicide-screening questions) tool consists of four or five yes and no questions. This is a very short, less than one-minute process. If the patient answers yes to one or more of

the questions, it indicates a further mental health and suicide safety assessment is required. According to the National Institute of Mental Health, a yes response to any of the four questions identified 97% of youth aged 10-21 at risk of suicide. The second level of assessment is a follow-up to the asQ. It is called a brief suicide safety assessment (BSSA) and guides what happens next in terms of safety and support. Support can be professional help and/or referral to community resources.

We also support the Columbia-Suicide Severity Rating Scale (C-SSRS) because this has been used in the field for a long time and many primary care providers are more comfortable with it. The C-SSRS is a simple series of questions to assess risk for suicide.

How was the idea of suicide prevention training received by pediatricians and others who would be participating?

In the medical field there is always the concern about having enough time. Most if not all doctors are so pushed for time and adding one more thing to an office visit is challenging. Our recommendation that screening be universal for all adolescent patients at all regular patient visits was met with some resistance. What helped create acceptance was sharing data and offering a validated tool to use. In our training curriculum, we share that 23% of people younger than 35 were seen by their primary care provider (PCP) within 30 days prior to dying by suicide; 62% were seen in the past year. Patients who died by suicide visit their PCPs more than two times as often as mental health practitioners.

The PHQ-9 works well for screening for depression, yet can miss those at risk of suicide – up to 28% -- especially because suicidal thoughts aren't always obvious unless the direct questions are asked. Emphasizing this data is part of what helped with provider buy in.

By sharing data, acknowledging time constraints, training to use a tool that been validated, securing physicians and child psychiatrist for trainers, and having the conversation about how it could be a life or death situation moved the training forward. We've gotten positive feedback about clinical changes since implementation of the asQ in Oregon

Has implementing suicide prevention training changed practices within the pediatric community? What key changes have you seen or would like to see?

The obvious change in clinical practice is the implementation of regular and consistent suicide prevention screening and assessment tools as well as follow-up actions. There have also been changes in how medical practitioners approach the conversation about suicide –having the words and feeling more confident in talking about it with families is enormously important.

One area where we would like to see policy change is at the Coordinated Care Organization (CCO) level. In 2012, the state of Oregon transformed its Medicaid program by establishing 16 "coordinated care organizations," or CCOs, to provide comprehensive care for its Medicaid population. The CCOs are working at a local level to transform the health care delivery system to bring better health, better care and lower costs to Oregonians. One of the ways they are doing that is through a set of defined measurements to track progress on reaching identified benchmarks and provide financial incentives. This is what propelled acceptance of OPS's depression and SBIRT trainings – both reflected CCO metrics for pediatric medical providers. OPS would like to see the CCO metric committee work towards establishing measurements related to suicide prevention screening as well.

In terms of lessons learned – what would you like to share with other professional groups considering suicide prevention training?

I would like to share a few lessons learned and while there are some that are very specific to the pediatric medical field, I'd like to highlight a few that I believe are transferable to agencies and non-profit organizations that may or may not be part of the pediatric area.

First, funding. In the non-profit sector funding is about having the time to develop training and resources for expenses related to delivery of training. Funding provides the staff and organizational capacity to

dedicate time to do the job well. It is also helpful to have funders, like OHA, who become part of the partnership.

Next is having supportive experts who are available to contribute ideas, research materials and resources, and share their experiences. In our instance, they were a tremendous help with change management. Change is challenging under the best of circumstances and having trusted experts engaged in the process is beneficial.

Buy-in. Not everyone will embrace something new particularly when it challenges their beliefs or is perceived as a threat to how they do their job. It is critical that leadership understand this and hear the concerns of those who resist or oppose the idea of suicide prevention training. Engage with both supporters and those less than enthusiastic early in the process. We found our expert panel to be so helpful on this front. Their areas of expertise were invaluable in answering questions, dispelling myths and addressing worries.

Lastly, training is not enough. We found you have to have a follow-up process in place – things like coaching, technical assistance, or simply checking-in. What really made a difference for OPS and the practitioners was having learning cohorts or learning communities. Collaborative learning is so powerful in terms of problem solving and sharing what works (or doesn't) and best practices.

Anything you would like to add, Julie?

The effort to put together a suicide prevention training is so worth it. We've seen positive changes across our state and I know there are more to come. It is interesting how Oregon is considered one of the smaller states population-wise, yet we're influencing the conversation about suicide prevention training for the pediatric field nationally. I've shared our training and outreach model and our training curriculum with the American Academy of Pediatrics and they are looking at how to share it with the AAP's 68,000 members nationally. Small state, big impact!