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The Development of a Brief Suicide Screening and Risk Assessment Training Webinar for Rural Primary Care Practices

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Abstract

Although primary care practices have the potential to be crucial intervention points for suicide prevention in rural areas of the United States, primary care staff are often underequipped to deal with suicide and have limited access to high-quality training opportunities on this topic. This manuscript reports on posttest data collected from a sample of primary care staff ($N = 16$) regarding the acceptability of a brief, online interactive training webinar designed for primary care practices in rural West Virginia. The majority of participants reported the webinar was relevant to their practices (73.3%) and that they would recommend it to a fellow professional (75.0%). Higher proportions of participants reported confidence (75.0%) and comfort (68.8%) asking patients about suicide than they did regarding their ability to complete a risk assessment (50.1%) and a safety plan (56.3%) with a suicidal individual. Only half (56.3%) thought it was important to screen all primary care patients for suicide. Future research should use tracked pre- and posttest data to evaluate the effectiveness of trainings that include a focus on risk assessment and safety planning, education about the potential benefits of universal suicide risk screening, and that can be delivered through asynchronous methods.

Keywords

suicide prevention; rural mental health; primary care services

Suicide is a significant global public health problem. Recent estimates indicate that over 800,000 individuals die by suicide globally each year (World Health Organization [WHO], 2015), and, in the United States, over 44,000 people died as a result of suicide in 2015 alone (Centers for Disease Control and Prevention [CDC], 2015). Suicide rates have been significantly higher in rural than in urban areas (Gamm, Stone, & Pittman, 2003; Hirsch & Cukrowicz, 2014), and recent data from the CDC (2017) regarding urban/rural suicide rates from the years 2009–2015 indicate that this disparity is increasing. According to the CDC (2017), in 2015, the suicide rate in rural areas was roughly 22 per 100,000, which was 83% higher than the suicide rates in urban areas of the United States (approximately 12 per 100,000).

Primary care practices have the potential to be crucial intervention points for suicide prevention in rural communities. One study found that 83% of a sample of individuals who died from suicide had visited a primary care provider (PCP) within the year prior to their death and 50% visited a PCP in the month prior to their death (Ahmedani et al., 2014). In contrast, only 29% of individuals who died from suicide reported an outpatient mental health visit within the year prior to their death (Ahmedani et al., 2014).

For individuals living in rural communities, the proportion of suicidal individuals who seek out support from a primary care practice may be even higher, as it has been found in rural settings that individuals with poorer mental health had 25% more chronic primary care visits than those without mental health issues (Arcury, Preisser, Gesler, & Powers, 2005). Additionally, because of the shortage of mental health professionals in rural areas (Gamm et al., 2003; Hendryx, 2008) and the disproportionately high levels of social stigma around seeking help for mental health in these communities (Gamm et al., 2003; Hoyt, Conger, Valde, & Weihs, 1997; Rost, Smith, & Taylor, 1993), suicidal individuals are more likely to turn to primary care practices for help with mental health issues than to counseling agencies (Hirsch, 2006).

Primary care practices rely on the expertise and cooperation of multiple types of professionals, including medical and behavioral health providers, nursing and medical staff, administrative support staff, directors, and administrators. For the purposes of this study, the term *primary care staff* refers to the collection of individuals who are required for a primary care practice to function successfully, including providers, medical and support staff, and administrators. Unfortunately, significant deficiencies in both suicide-related knowledge and training have been noted for all these groups, including medical residency training programs (Sudak et al., 2007), nursing education programs (Kotowski & Royce, 2017; Puntill et al., 2013), doctoral psychology programs (Bongar & Harmatz, 1989; Dexter-Mazza & Freeman, 2003), and master's level social work programs (Feldman & Freedenthal, 2006; Ruth, Gianino, Muroff, McLaughlin, & Feldman, 2012). In addition, one study that surveyed a large sample of community health workers found that, compared to physicians and behavioral health clinicians, administrators and support staff were found to have the lowest levels of suicide-related skills and knowledge (Smith, Silva, Covington, & Joiner, 2014).

These deficiencies in training also appear to have a significant impact upon the quality of care provided in primary care practices for suicidal individuals. One study in the U.K. found that 40% of patients who died by suicide had no mental health diagnosis during their primary care visit, and in 50% of cases no risk assessment occurred (Milton, Ferguson, & Mills, 1999). In the study by Ahmedani and colleagues (2014), nearly half of those individuals who died by suicide who received any type of medical care in the month prior to their death did not receive any type of mental health diagnosis during their visits. Saini and colleagues (2014) found that 45% of a sample of patients who died from suicide were rated by primary care and mental health professionals as low risk.

Providing trainings on suicide risk assessment for primary care staff is one way to improve the quality of care provided to patients who present with suicidal thoughts and behaviors. Suicide-related trainings designed for nurse care managers and primary care providers have

been found to increase suicide detection among primary care patients (Nutting et al., 2005; Pfaff, Acres, & McKelvey, 2001) and have been found to help decrease the number of false negatives identified by providers along with a minimum of false positives (Pfaff et al., 2001). Primary care physicians who have received training in suicide also have reported increased confidence in assessing suicidality (Kaplan, Adamek, & Martin, 2001), improved self-perceived competency in dealing with suicidal patients, and increased willingness to treat suicidality among their patients (Graham, Rudd, & Bryan, 2011).

Suicide-related training often is not a focus for primary care practices, however. Saini and colleagues (2014) found that only a third of a sample of practices in the United Kingdom had suicide-related trainings in place, and these were typically only available to the general practitioners, not nursing and other allied health professionals (Saini et al., 2014). Rural primary care practices are at a disadvantage because they often do not have the same geographic access to high-quality continuing education trainings that their urban counterparts do (Weingardt, 2004); suicide in rural areas also is impacted by geographic, environmental, and cultural factors (Hirsch et al., 2014), indicating that trainings for primary care staff need to be specialized and include rural-specific content.

One potential way to address the geographic, environmental, and cultural barriers that face rural primary care practices is by providing rural-focused suicide-related trainings online. Previous studies of online suicide risk assessment and gatekeeper trainings in public health settings and schools have found that the majority of participants are generally receptive of this method of training (Gryglewicz, Chen, Romero, Karver, & Witmeier, 2016; Lamis, Underwood, & D'Amore, 2017; Stone, Barber, & Potter, 2005) and that participants reported significant increases in suicide-related knowledge (Lamis et al., 2017; Stone et al., 2005) as well as improvement in suicide-related attitudes and self-efficacy (Lamis et al., 2017).

Evidence-based interventions for suicide need to be developed to address the specific needs of rural communities (Zaheer et al., 2012). However, previous studies have not examined online models of suicide-related trainings designed for rural communities in Appalachia, such as West Virginia, where suicide rates are disproportionately high (American Foundation for Suicide Prevention, 2015). In order to provide preliminary evidence for the acceptability of online, suicide-specific training, this article describes the design and implementation of a brief, interactive online webinar on suicide screening and assessment designed specifically for primary care staff in rural West Virginia. Survey data is reported regarding the webinar's acceptability and corresponding recommendations for future implementation efforts are discussed.

Method

Webinar Design and Implementation

The training webinar was titled "Suicide Screening and Assessment in Primary Care" and was partially modeled after a companion training developed for the Suicide Prevention Toolkit for Rural Primary Care (DeHay, Ross, & McFaul, 2015), but it was tailored specifically to West Virginia providers and to fit within a 1-hr format. The webinar reviewed

suicide statistics in the state of West Virginia, the extent to which primary care practices have contact with suicidal individuals, guidelines for how and when to screen for suicide risk, risk factors and warning signs for suicide, how to complete a risk assessment with a patient who screens positive, and how to complete an individualized safety plan for a suicidal patient. The webinar included didactic material and two interactive case vignette exercises. In the first exercise, case examples were reviewed and participants were asked to discuss whether they would screen for suicide risk for each patient. In the second exercise, participants were asked to review a case involving a suicidal patient, and rate the individual's level of risk (low, moderate, or severe). The webinar was delivered using the Zoom platform during a lunch hour and lasted for approximately 50 min; participants were free to participate in any or all of the session. In addition, a digital recording was made of the webinar and those participants who requested could have the digital copy and the PowerPoint slides emailed to them after the training. All webinar materials (slides, vignettes) are available from the author on request.

The webinar was advertised through the West Virginia Practice-Based Research Network and the West Virginia Clinical and Translational Science Institute. Participants were asked to email the trainer to register prior to the training. They were then sent a web link through which they could access the training on the specified date and time.

Participants

Because the webinar was offered using the Zoom platform, participants were able to log on individually or in groups. Although it was impossible to track the exact number of participants, there were 22 connected devices. The final sample included 16 individual participants who completed demographic and follow-up surveys.

Measures

All participants who attended the webinar were invited to participate in a survey and were either sent a link to a follow-up survey or given a paper-and-pencil version on site. In order to measure the acceptability of the webinar, participants were asked to rate their agreement with the following statements on a scale of 1 to 5 (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*): (a) "this webinar was relevant to my practice," (b) "the format in which the material was delivered was easy to follow," and (c) "I would recommend this webinar to a fellow professional." In order to gain preliminary data regarding the appropriateness of the content, participants also were asked follow-up questions about the knowledge domains covered in the training. Using the same rating scale described in the preceding text, participants were asked to rate their agreement with the following statements: (a) "I feel it is important to screen every primary care patient for suicidality," (b) "I feel confident in my ability to ask patients questions about suicide," (c) "I feel comfortable asking patients about suicide," (d) "I have adequate knowledge regarding the warning signs for suicide," (e) "I have adequate knowledge about what groups are most at highest risk for suicide," (f) "I feel confident in my ability to put together a safety plan with a suicidal individual who is not being hospitalized," and, (g) "I feel confident that I can make an accurate risk assessment of a suicidal individual without the input of a mental health professional." All participants completing the follow-up surveys gave informed

consent and human subjects review board approval was obtained from West Virginia University's Office of Research Integrity and Compliance prior to any of the research activities associated with the webinar.

Results

The majority of the participants who completed follow-up surveys were White (93.8%), female (68.8%), and reported that they treated both pediatric and adult patients in their practices (85.7%). Ages ranged from 21 to 68, and the mean age was 36.69 ($SD = 12.64$). Participants who completed the surveys were diverse in terms of occupation. Three participants reported they were nurses (LPNs or RNs), 2 were doctors of medicine (MDs), one was a behavioral health provider (psychologist), and 9 (56.3%) described their occupation as "other." The "other" category included five allied health professionals (medical assistants, care coordinators, and other medical technicians), two compliance and research professionals, one billing professional, and one chief financial officer.

In terms of the acceptability of the webinar, the majority of respondents agreed or strongly agreed that it was relevant to their practice (73.3%), that it was easy to follow (81.3%), and that they would recommend it to a fellow professional (75.0%). In regard to the knowledge domains targeted in the webinar, the proportion of agreement was highest for the questions that asked participants about their knowledge of risk factors for suicide (81.3%), confidence asking patients about suicide (75.0%), comfort asking patients about suicide (68.8%), and knowledge about the warning signs for suicide (68.8%). In contrast, ratings of agreement were lower for the items regarding the importance of screening all patients for suicide (56.3%), completing a risk assessment with a suicidal individual (50.1%), and completing a safety plan for a suicidal patient (56.3%).

Discussion

This study provides some preliminary evidence for the acceptability of a brief, interactive online training on suicide screening, risk assessment, and safety planning for professionals in primary care practices in rural West Virginia. The majority of participants reported that the webinar was easy to follow and that they would recommend it to a fellow professional. The majority also agreed that the webinar was relevant to their day-to-day practices, which indicates that targeting medical and behavioral health providers as well as health-related and administrative staff in primary care practices with suicide-related training may be beneficial. This supports other findings that online suicide-related trainings are acceptable to community service providers (Gryglewicz et al., 2016; Lamis et al., 2017; Stone et al., 2005) and expands these findings to all staff and to the rural primary care setting.

In the follow-up survey, the majority of participants reported they felt knowledgeable regarding the risk factors and warning signs for suicide and that they felt comfortable and confident in their ability to ask patients about suicide. Although these data do not give evidence of the webinar's effectiveness (as there is no matched pretest data), they do give some information about what areas may need more emphasis in future training efforts designed for primary care staff.

In regard to the question regarding universal suicide risk screening, only 56% of participants thought this was a warranted practice. Although the most recent U.S. Preventative Services Task Force statement maintains that there is not enough evidence to support the use of universal suicide risk screening for adults in primary care (LeFevre & the U.S. Preventative Services Task Force, 2014), the Joint Commission (2016) recently released a sentinel event alert recommending that all health care settings routinely screen for suicide risk. In addition, research on universal suicide risk screening in other medical settings has found that this practice increases suicide detection rates (Betz et al., 2015; Wintersteen, 2010) and increases the number of behavioral health referrals made for patients (Wintersteen, 2010). As more evidence is collected regarding the utility of universal suicide risk screening in primary care, future trainings may want to educate primary care staff on the potential benefits of universal suicide risk screening in their practices.

Almost half of participants reported being “neutral” or disagreeing with the statement that they felt comfortable completing a risk assessment or a safety plan with a suicidal individual, indicating that this might be an additional area that needs more attention in future trainings. Covering content related to discomfort with the topic of suicide may be beneficial as well, as many primary care providers have reported discomfort to be a main barrier to suicide risk screening and assessment in primary care (LeCloux, Aguinaldo, Lanzillo, & Horowitz, 2017).

This study did have some limitations. Only a proportion of total participants completed the demographic and posttest surveys, and because of the online delivery method it was impossible to track how many additional individuals participated but did not fill out surveys. Thus, data regarding the acceptability of the webinar was not available from all participants. Second, it also was not possible to track which participants attended for part or all of the webinar, which may have impacted which portions of the training material to which they were exposed. The sample size was small, indicating that replication of these data with larger samples is warranted. Finally, the sample was recruited from individuals who had already registered for the webinar, which might indicate a more favorable bias toward technology-based trainings.

Despite the limitations, the fact that this brief, online training was found to be acceptable for primary care staff in rural West Virginia is encouraging, especially given the high workloads and time limits in primary care practices (Michail et al., 2016) and the cultural stigma attached to suicide in rural communities (Hirsch et al., 2014). Other research has found that online modes of delivering evidence-based interventions can be just as effective as in-person modes (Dimeff et al., 2009), and future research should measure the effectiveness of suicide-specific webinars for rural primary care such as this one. Studies also should examine the effectiveness of asynchronous online trainings, as this might be the most effective way of disseminating knowledge to primary care staff in rural communities that is both necessary and welcomed.

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