SAFETY-A Phase II (Expansion) Updates

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Phase I (Pilot): Outcomes

- 68 primary care providers (PCPs) trained
- **Feasibility and Acceptability of Training:**
  - PCPs very satisfied with the training
  - Attended an average of 3.4 out of 5 training sessions (only 29% attended all 5)
- **Feasibility and Acceptability of Intervention:**
  - 79% of respondents (*n*=42) used SAFETY-A at least once in 6 months
  - Used an average of 7 times per PCP (range: 1 – 26)
  - **288 total uses** of SAFETY-A over 6 months
  - Insufficient time most common barrier for not using all SAFETY-A methods

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Feasibility and Acceptability of a Brief Intervention for Youth Suicidal Thoughts and Behaviors Among Pediatric Primary Care Providers

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ABSTRACT

Background: Suicide is a leading cause of death among youth, and rates continue to increase across the United States. Pediatric primary care providers (PCPs) are uniquely positioned to identify acute periods of increased suicidal ideation and provide timely intervention.

Objective: The present study assessed the feasibility and acceptability of training and implementation of a primary care-adapted version of Safe Alternatives for Teens and Youth-Acute (SAFETY-A), a brief, strengths-based, cognitive-behaviorally oriented, family intervention for suicidal thoughts and behaviors in youth, among pediatric PCPs.

Method: This multisite pilot study involved collaboration between eight Texas-based academic institutions who assisted with the recruitment and training of 68 PCPs. PCPs attended five SAFETY-A training sessions and completed self-report surveys for 6 months post-training.

Results: Prior to SAFETY-A training, PCPs indicated a significant training gap, with 83% indicating that they had not received sufficient prior training in suicide risk assessment and risk reduction/intervention. PCPs found SAFETY-A training acceptable, reporting significant improvements in knowledge, skills, and confidence. PCPs also found SAFETY-A implementation feasible, using the intervention a total of 288 times over the course of 6 months (*M* uses per PCP = 6.9). However, PCPs found the SAFETY-A training schedule less feasible, with many PCPs unable to attend all five training sessions.

Conclusions: Findings suggest that a tiered training structure allowing for more flexibility in training commitment might be more feasible for busy PCPs seeking training in SAFETY-A. Ongoing efforts to feasibly scale-up SAFETY-A training efforts across Texas incorporate these findings with the goal of making SAFETY-A training available to all PCPs across the state.

Changes Made in Phase II (Expansion)

- **Training schedule not feasible for most PCPs:**
  - Offer tiered training options
    - Level 1: 1-hr presentation (recorded)
    - Level 2: 3-hr master training
    - Level 3: 7.5-hr full competency training with consultation calls
    - Suicide Risk Assessment Training: 1-hr live training, to-be-recorded soon
- **Not feasible to use all components of SAFETY-A intervention:**
  - Continue to emphasize necessary adaptations for primary care setting
  - No one-size-fits-all!
- **Need to scale up:**
  - Develop our own trainers so not relying on ASAP Center
  - Enlist CPAN in train-the-trainer
  - Develop recurring schedule of trainings
  - Involvement from all HRIs

Phase II (Expansion): By the Numbers

- **Level 1**
  - 82 PCPs registered, 5 completed
- **Level 2**
  - Begins this Friday 8/1
- **Level 3**
  - 42 PCPs attended Master Training, 3 completed full training
- **Train-the-Trainer**
  - 9 trainers completed, 8 retained
  - Recurring schedule of monthly trainings through August 2027* (subject to change)
- **Suicide Risk Assessment Training**
  - 167 PCPs attended over 11 trainings

Goals for Phase III (Dissemination)

1. **Disseminate recurring training opportunities to PCPs across Texas**
   - Primary care clinics + residency programs
   - Analyze attendance patterns and make adjustments as needed
   - Can offer individualized training dates
   - All hands on deck for recruitment!
2. **Maintain pool of SAFETY-A trainers in good standing**
   - Offer additional train-the-trainer cohorts as needed
3. **Train CPAN staff in SAFETY-A to support PCPs**
4. **Create and disseminate “Best Practices” guidelines for PCPs not yet trained in SAFETY-A**

Key Discussion Points

- Effective, continuous dissemination across the state
- Involvement of residency programs