VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Assessing and Managing Suicide Risk in Primary Care

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Presentation Overview

- Challenges of Assessing Suicide in Primary Care
- Advantages and Disadvantages of Using Standardized Suicide Risk Measures
- Options in Primary Care for Management of Patients Resistant to Mental Health Referrals

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Scope of the Problem

- Approximately 35,000 people die by suicide each year in the U.S.
- Estimated 45% of those dying by suicide saw their primary care physician within one month of death (McDowell, Lineberry, & Bostwick, 2011)
- One VA study found 63% suicide decedents had **at least one** primary care visit in year prior to death (Denneson et al., 2010)

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Why Don’t Primary Care Providers Ask About Suicide?

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Too Many Barriers

- Time
- Expertise
- Fear
- Overwhelmed
- Not a big problem

- Other reasons?

Screening vs. Assessment

What's the Goal?

Screening

- Snapshot
- Quick
- Focused
- Next steps

Assessment

- Comprehensive
- Specialty care
- Case conceptualization
- Treatment planning

Cost/Benefit of Screening

Who Should be Screened?

- At a minimum, anyone being seen for depression or with a history of depression
- Those with alcohol abuse problems
- Receiving catastrophic medical news
- Exhibiting significant changes in mood

McDowell et al., 2011

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Other Conditions to Monitor

- Comorbid anxiety or agitation
  - Particularly PTSD, panic disorder, social anxiety disorder, and generalized anxiety disorder
- Significant sleep problems (Ribeiro et al., in press)

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Mention of Suicide/Desire for Death

Doesn’t always mean there is a crisis

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Know the Warning Signs

- Significant anxiety
- Psychomotor agitation (e.g., “feeling like want to crawl out of my skin”)
- Poor sleep
- Concentration problems
- Hopelessness
- Social isolation
- Significant increase in substance use

McDowell et al., 2011

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What Information do You Need?

- Step-wise approach
  - Move from general to specific
- Feeling hopeless or thinking about death?
- Specific thoughts about suicide?
- Family history and own history of self-directed violence

McDowell et al., 2011

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What Tools Should I Use?

- No standardized measure can predict who will/won't engage in self-directed violence
- Identification of similarity between an individual patient and known groups
- Single item indicators **very limited utility**
- Valid and reliable, in particular with good criterion validity

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Potential Measures

- Heisel and colleagues (2010) reported 15-item Geriatric Depression Scale cut-off of 5 for men and 3 for women accurately identifying ideation
  - Designed for primary care patients 65 and older
- Patient Health Questionnaire-9 78.9% agreement with SCID-I
  - 10.2% false positives, 10.8% false negatives (Uebalacker et al., 2011)

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Suicidal Behaviors Questionnaire-Revised

- Cut-off score of 8 discriminates between adult psychiatric inpatients with/without history of suicide attempt/serious consideration
- 7 cut-off for non-clinical
- Valid, reliable, easy to administer and score
- Self-report can be completed prior to appointment
- Specifically designed as a suicide screening tool

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How Accurate is the SBQ-R?

- Adult psychiatric inpatients 95% of those with a history of serious ideation/attempts (positive predictive value)
- 87% of those without a history of suicidality (negative predictive value).
- 5% false positives
- 13% false negatives
- Non-clinical undergrads PPV & NPV = 1.00

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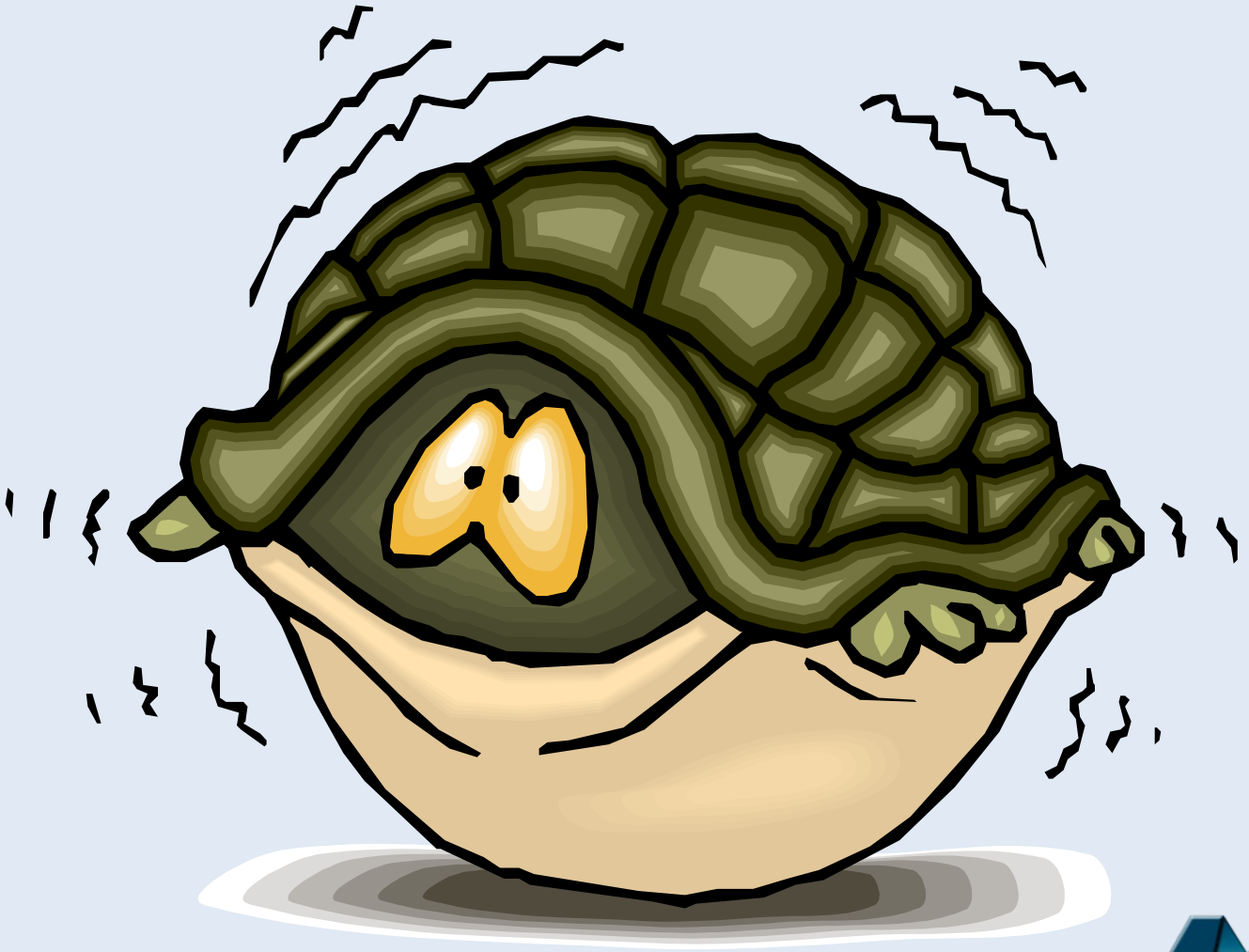
My Patient is High Risk
Now What do I do?



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Managing At-risk Patients

- Don't try to convince your patient that "life isn't that bad"
- Chatting about psychosocial issues isn't enough
- Need a plan ahead of time so know what to do with screening data
- Longitudinal monitoring, structured follow-up, appropriate referral to mental health

Vannoy et al., 2011

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Safety Planning

- Fairly quick and easy to complete in CPRS
- Print, discuss, and send home with patient
- Consider involving significant others
- Keeping safe until can be seen by mental health
- Hospitalization does not have to be first option

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Treatment of Likely Drivers of Suicide

- Collaborative care models may be particularly effective for treating depression (McDowell et al., 2011)
  - Education and support for physicians
  - Depression care managers
  - Monitoring patient outcomes and adherence
  - Facilitating communication between patients, primary care, and mental health providers
- Treatment of substance use disorders
- Consider antidepressants

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To Refer or Not to Refer

- Do they have a plan?
- Have they taken steps to prepare/practice?
- Access to lethal means?
- Intent to die?

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Disposition

- Tied to imminence of risk
- More frequent primary care contact
- Case management
- Outpatient mental health
- Intensive outpatient treatment
- Inpatient hospitalization

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But I Don’t Want to Talk to Mental Health

- May not be necessary
- Empathy and concern enough?
- Other supports?

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When Can I Stop Worrying?

- Once identified as elevated risk need to keep monitoring
- Successful treatment of contributing factors
- Periodic assessment for increased problems
- Watchful waiting stance

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Thank You for Your Attention

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