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
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)
Why Don’t Primary Care Providers Ask About Suicide?
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
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)
Mention of Suicide/Desire for Death

Doesn’t always mean there is a crisis
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
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
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
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)
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
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
My Patient is High Risk
Now What do I do?
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
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
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
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?
Disposition

• Tied to imminence of risk
• More frequent primary care contact
• Case management
• Outpatient mental health
• Intensive outpatient treatment
• Inpatient hospitalization
But I Don’t Want to Talk to Mental Health

• May not be necessary
• Empathy and concern enough?
• Other supports?
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
Thank You for Your Attention

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