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Ed Boudreaux, PhD, Behavioral Health Consultant

Hello, this is Ed Boudreaux. I'm a Clinical Psychologist and a Behavioral Health Consultant and today we're going to talk about Positive Suicide Screens in primary care. And we're going to talk a little bit about screening and responding to a positive screen.

We're going to answer four primary questions today. What are some challenges associated with screening for suicide risk in primary care? How is suicide risk usually identified? What are some practical recommendations for managing positive suicide screens in primary care? And, finally, what are some high-yield resources for more information on this topic?

Following this presentation, our expectation is that you will be better prepared to understand how to respond to a positive suicide risk screening in primary care settings.

Let's talk a little bit about clinicians in primary care and their screening for suicide risk. First, most clinicians are a little reluctant to screen for suicide risk because of four primary barriers. First, many clinicians are just uncertain as to what to do. They're uncertain as to how to screen for suicide risk and they're uncertain as to what to do if the person screens positive. So that uncertainty tends to reduce the probability that the question even gets asked. But they're also concerned about the time and the delay that screening for suicide risk and having to handle a positive might cause. Those delays might cause backups in their patient lists, so they're reluctant to ask the question because of a fear that it might cause delays and backup in their schedules.

Many clinicians also fear liability. They're afraid that if they ask the question and they find out that the patient has some suicide risk that if they discharge the patient or the patient goes home and hurts themselves, that they're going to be held liable for that patient's morbidity or mortality. So, that fear of liability makes them not want to even ask the question because they feel like if they don't ask and they don't know, then they're not liable. But when they do ask, there's also such a strong liability fear that clinicians tend to err on the side of a very conservative approach and want to send those patients to the emergency department, which may or may not be appropriate but certainly is going to lead to time constraints and delays and further backup in the person's clinical schedule. So, this fear of liability is associated with sending the patient to the emergency department from the primary care clinics and that just exacerbates this problem of the time delays. And all of these barriers are really influenced by some deeper barriers like a lack of training and suicide risk assessment, overbooked schedules, poor understanding of the legal expectations in these situations. And the fact that many clinics don't even have a primary care provider on site.

So how is suicide risk usually identified then? Because clinicians are reluctant to screen widely for suicide risk, it's usually indicated, identified when the patient is being treated for depression. So if the patient is being treated by the primary care provider for depression and self-discloses that they are suicidal or actually demonstrates some suicidal behavior or a family member or a

caregiver expresses some concern that the person might be thinking about hurting or killing themselves. This is the most common way that suicide risk is identified in primary care settings. But it can be detected through routine screening. This is becoming more and more popular and more and more common. There are many screeners out there for depression and suicide. They have different strengths and weaknesses, but probably the one that's most commonly used currently in practice is the PHQ-9. And Item 9 on that, on the PHQ-9 is the suicide risk screening item. We'll talk a little bit more in depth about that item.

So Item 9 is worded this way: Over the past two weeks, have you had thoughts that you would be better off dead or of hurting yourself in some way? And you can see the response options here: not at all, several days, more than half the days, and nearly every day. A positive on this item is defined by any value that is greater than or equal to one, so in other words, any value that's other than "not at all". You'll notice that this item has two components. It has a passive ideation item, a component, the "better off dead" and an active ideation component, the "hurting yourself in some way". Many clinicians feel like this leads to a high false positive rate. In other words, it might identify many patients who are not seriously suicidal. But regardless of the clinicians' perceptions of this item, if a person is positive, the general recommendation is that they require some kind of further assessment by the clinician. It's for this reason that most experts recommend that the clinic have written protocols in place that define what additional actions are taken if the patient screens positive on Item 9, or for that matter, if they screen positive for any suicide risk screening. Who takes the actions and when are the actions taken? So these protocols should define each of these components. Once the protocols are clearly written and established for the clinic, personnel should be trained on the protocols and they should be readily available for any clinic personnel who wants to review them. And, optimally, the adherence to the protocol should be measured and monitored, reinforced and key behaviors should be incentivized using a continuous quality improvement protocol. So in other words, it's not sufficient to just establish the protocols, it's important to have all personnel trained and for performance to be monitored on a regular basis under ideal circumstances.

I've provided an example of a really well thought-out protocol that is actually used in primary care by the Institute for Family Health. I recognize that the quality of the image here isn't such that you can read everything on the screen, so if you're interested in finding this document, you can Google: Institute for Family Health clinical pathways for managing suicide. But I'm also going to go into a little bit more depth in the following slides to describe the protocol.

The important thing to recognize is that the Institute for Family Health protocol starts with the PHQ-9. So, the PHQ-9 is used as a routine screening instrument for depression in these clinics. And if the person is positive on the Item 9, the suicide question, then this automatically triggers the clinician to also administer the Columbia Suicide Severity Rating Scale screening version.

So the CSSRS screen. This screening has three to six items that further assesses the patient's suicidal thoughts and suicidal behavior. And if the person is positive on the CSSRS screen, then the clinician adds a suicide-related entry to the problem list for that patient to document that the person has suicide risk. And that they complete a safety plan with the patient. They also

complete the CSSRS lifetime and recent assessment and do a full risk assessment. And, finally if they continue to monitor the patient longitudinally, using the CSSRS. It's important to note that if when the full version of the CSSRS, what's called the lifetime and recent version, is administered and the clinician establishes that the person is at some risk for suicide but is not at the highest risk group, so they're not imminent, then most of the time, it's important to get a mental health clinician involved in that patient's case. And if there's no mental health clinician on site, then the clinician should arrange for a referral to a mental health provider in the community. If the CSSRS and the risk assessment shows that the patient is at really high risk, so they're at imminent risk and that the clinician is really concerned about the patient being safe, then they should consider arranging for safe transportation to the emergency department.

In this slide, I've provided a little more detail on that CSSRS screening version. You can see where it's located here at this URL if you want to look at the actual scale itself and I've provided an image of the scale. As you can see, there are six items. The starred items are the required items that assess for passive suicidal ideation, active suicidal ideation, and suicidal and preparatory behaviors at the end. The items three through five are only assessed if the person has active suicidal ideation or, in other words, answers positive to the second item. I've also provided the location for the full version of the CSSRS and the image to the right just shows the front page of that assessment. It's more extensive and takes a little bit of time to get trained on how to use it properly and during the assessment, it takes a little bit longer to really establish the full recent and lifetime severity of the person's suicide risk, but it's particularly important to really characterize where the patient's suicide risk falls.

So let's talk a little bit about liability. If suicide risk is identified, no matter how it's identified, whether it's during clinical, in clinically-indicated assessment or through screening, the clinician is responsible for completing a risk assessment, determining the level of care needed, so can the person still be managed in outpatient or do they need to go to the emergency department. They need to be kept safe while the person is in the treatment setting and during transfer if the person is going to go to another care setting like the emergency department. The clinician needs to provide suicide prevention resources to the patient, like the LifeLine number. And the clinician is responsible for treating the patient using best practice standards including a regular monitoring and re-assessment of a patient's suicide risk, as we described earlier in the written protocol. The clinician must document suicide risk assessment and actions taken, along with any medical decision-making to help explain the decisions that the clinician has made. A few miscellaneous tips, if treating a patient for depression, the primary care clinician must assess suicidal ideations and behavior. This is an expectation by the joint commission and other bodies that if the patient is being treated for depression, the suicide risk is being addressed.

Anxiety, impulsivity, and alcohol use are important risk factors to assess, especially in depressed patients, because they further increase the patient's risk for suicide. Any patient at moderate or higher risk on the full version of the CSSRS likely needs a mental health clinician involved in care. Many primary care clinicians are comfortable treating patients for depression, but when they get to the moderate or higher risk for suicide, then really mental health clinicians should probably be involved in the care of that patient. The clinician would want to develop mental health resource

lists ahead of time so they're not spending time searching for mental health resources while the patient is there. And if the patient is at high risk and need to go to the emergency department, it's important to arrange for an ambulance even if the family member offers, to avoid problems with a medical decision that the patient needs emergency care that contradicts what the family believes and then the family members take the patient home and the clinician is left in a tough spot with a decision to send the patient to the ED but the patient never gets there.

Alright, we're going to close with a review of some high-yield information, in case you're interested in finding out more. This is the Institute for Family Health Clinical Pathway for Suicide Prevention that I mentioned earlier. It's located here at this link. But also, I wanted to mention that if the health system is using the Epic electronic health record and you search for preventing suicides in primary care settings under their clinical programs, you can find even more extensive discussion of this clinical pathway. Here are two other resources. There's an article that has been published in the Mayo Clinic Proceedings. It is right on target. It's titled "Practical Suicide Risk Management for the Busy Primary Care Physician." It takes probably about fifteen minutes to read this article. And SAMHSA publishes the Suicide Assessment Five-Step Evaluation and Triage Guide, the SAFE-T, which is a really simple suicide risk assessment guide that can help the primary care clinician to ensure that they're covering all of the important steps that are involved in a suicide risk assessment. There's some handy brochures and pocket cards that can be used by the clinicians at this website. So it comes as kind of a package and I found it to be really useful in primary care as it's very focused.

So in summary, once suicide risk is identified, primary care clinicians are responsible for responding to it. We would prefer to have written protocols that are in place that would enable the right thing to be done. The right thing to be the easy thing. And it needs to include a risk assessment, appropriate levels of care, intervention, and documentation. So the pathway or the protocol should ensure that these, all of these things are clearly spelled out. The common example of a protocol is to use the PHQ-9, Item 9 as a screener, to further follow up a positive screen with the CSSRS screener, and if the person's positive on that, on the CSSRS screener, then the full CSSRS is administered. It's a very structured approach to screening and assessment. And, finally a mental health clinician is strongly advised to be involved if the patient is of moderate or higher risk on the CSSRS.

Thank you for your time. My information is on the slide and I'm happy to respond to any questions.