Assessment and Management of Suicidal Patients in Integrated Primary Care

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Canadian Collaborative
Mental Health Care Conference

Faculty/Presenter Disclosure

- **Faculty:** Kent A. Corso

- **Relationships with commercial interests:**
  - **Grants/Research Support:** None
  - **Speakers Bureau/Honoraria:** None
  - **Consulting Fees:** None
  - **Other:** None

Canadian Collaborative Mental Health Care Conference

Disclosure of Commercial Support

- **This program has not received financial support from** any organization.
- **This program has not received in-kind support from** any organization.

- **<u>Potential for conflict(s) of interest</u>:**
  - I declare no conflicts of interest.

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Mitigating Potential Bias

- N/A

Learning Objectives

1. Describe how to efficiently and accurately screen for and assess suicide risk, and determine an appropriate disposition within a brief 20 minute primary care appointment.
2. Practice creating crisis response plans suitable for the primary care behavioral health model.
3. Identify brief evidence-based interventions for managing suicidal patients in integrated primary care settings.
4. Describe the roles of all primary care team members who can collaborate to address suicide in primary care.

Poll #1

What is the total hours of formal suicide training you have had in your lifetime?

A.60-90 minutes

B.2 hours

C.4 hours

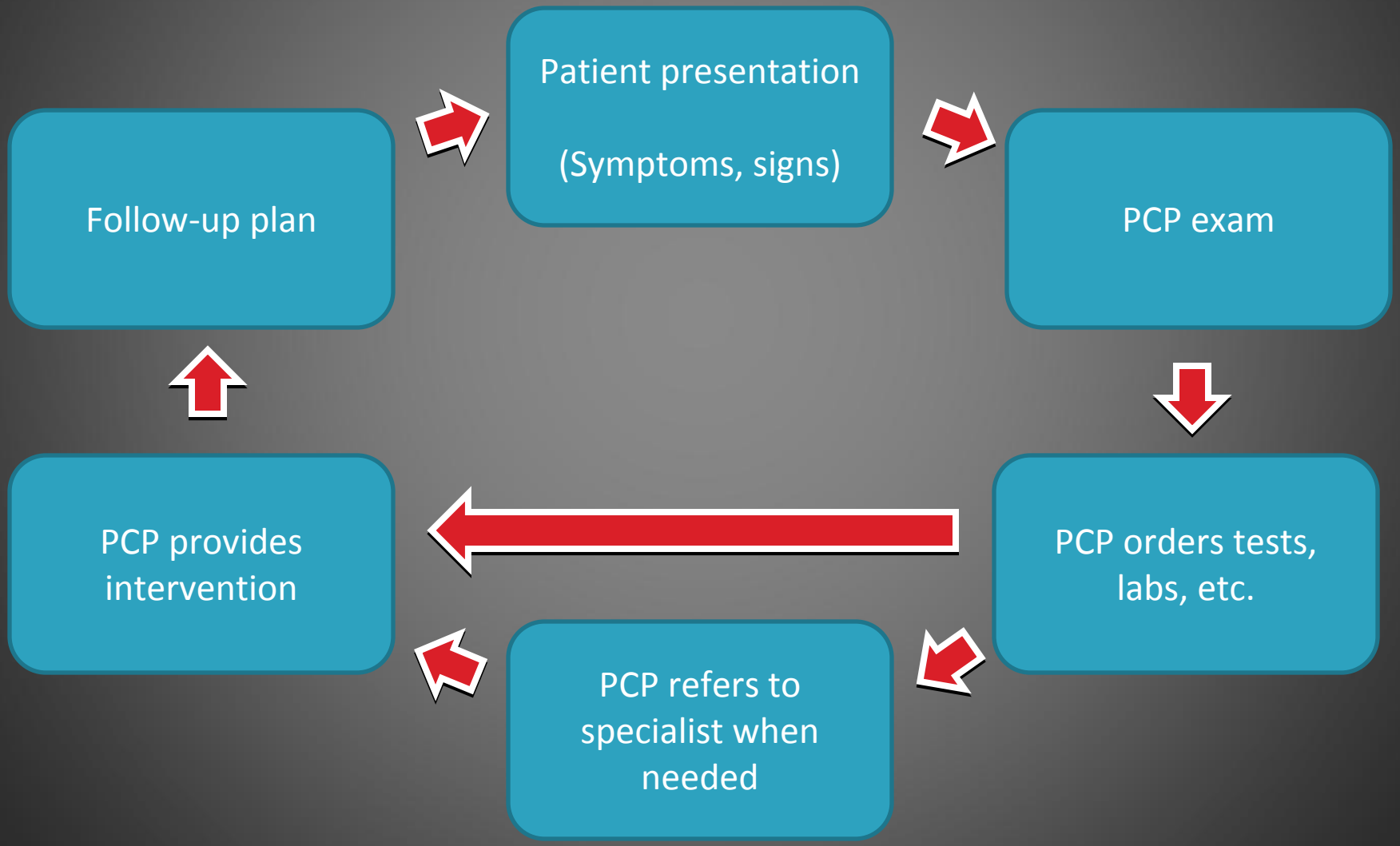
D.8 hours

E.More than 8 hours

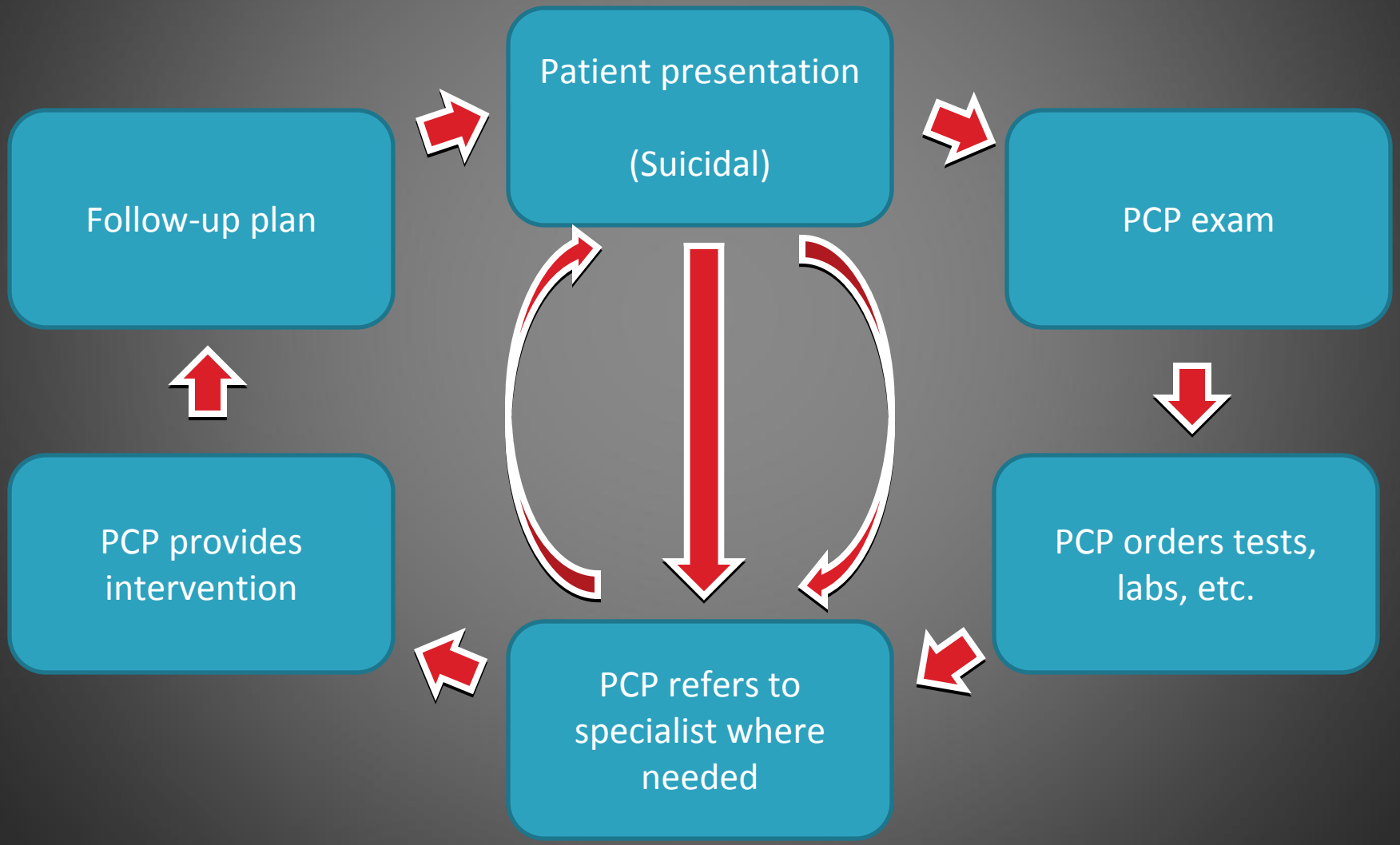
Thank you for caring about this issue!

Suicide training for MH providers tends to be weak...

Typical Primary Care Appointment



Typical PC Appt for Suicide Risk



Primary care and general medical settings have been identified as a key setting for addressing suicide, especially for older, depressed adults

(US Public Health Service, 1999)

(Unutzer et al., 2002)

The De Facto MH System

- 70% of PC appointments are for issues associated w/ psychosocial factors (Gatchel & Oordt, 2003)
- Of the 10 most common complaints in PC, 85% do not have an identifiable organic etiology up to several years later (Kroenke & Mangelsdorf, 1989)
- Proportion of medically unexplained symptoms ranges from 20-74% (Kroenke, 2006)

The De Facto MH System

- 80% of U.S. population visit PC at least 1x per year (Narrow, Regier, Rae, Manderscheid, & Locke, 1993)

- PC patients represent the full spectrum of mental health conditions (Olfson et al, 2000)

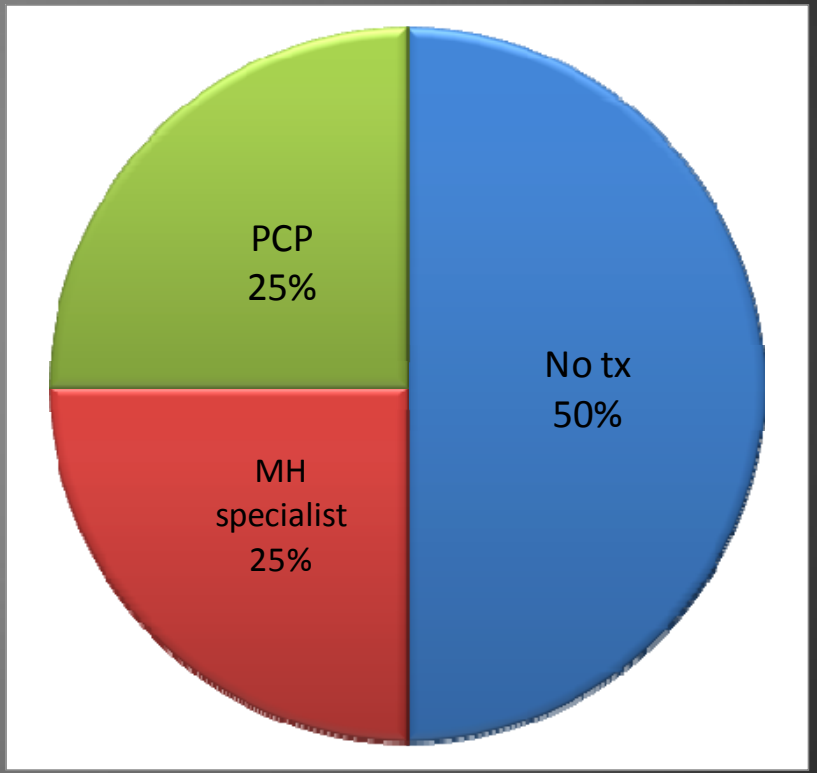
19% Major Depressive Disorder
15% Generalized Anxiety Disorder
8% Panic Disorder
8% Substance Abuse

36% to 77% meet criteria for > 1 DSM disorder

The De Facto MH System

- 18% annual incidence rate of MH dx (Narrows et al, 1993; Reiger et al, 1993)
  - 50% do not seek MH tx
  - Of 50% seeking MH tx, half visit PCP only
- PCPs prescribe:
  - 70% of all psychotropic meds
  - 80% of antidepressants

Stats do not include patients with "subsyndromal" issues



Possible Reasons

- Assignment of PCPs as “gatekeepers”
- Improved identification/detection of MH conditions
- Decreased use of psychotherapy
  - Psychotropic meds with low side effect profiles
  - PCP dissatisfaction with specialty MH care
  - Cost of specialty MH care

Suicide in Primary Care

- Estimated 1-10% of PC patients experience suicidal symptoms at any given time
- Of individuals who die by suicide:
  - 45% visit PCP within one month (Luoma, Martin, & Pearson, 2002)
  - 20% visit PCP within 24 hrs (Pirkis & Burgess, 1998)
  - 73% of the elderly visit w/in 1 month (Juurlink et al., 2004)

Suicide in Primary Care

- Suicidal patients report poorer health and visit medical providers more often (Goldney et al, 2001)
  - Greater levels of bodily pain
  - Lower energy
  - More physical limitations
- Medical visits increase in frequency in weeks preceding death by suicide (Juurlink et al, 2004)
  - Up to 3 visits per month for suicidal patients

Suicide in Primary Care

Top 5 chief complaints by patients during the visits immediately preceding their suicides:

Anxiety

Unspecified gastrointestinal symptoms

Unexplained cardiac symptoms

Depression

Hypertension

Only 19.6% of PC patients receive “minimally adequate” mental health treatment from general medical settings alone

(Wang et al., 2002)

Prevalence Rates

Prevalence rate for suicidal ideation and suicidal behaviors in general medical settings = 2 to 5%

(Cooper-Patrick, Crum, & Ford, 1994; Olfson et al, 1996; Pfaff & Almeida, 2005; Zimmerman, et al., 1995)

For PC patients prescribed psychotropic medication, prevalence = 22%

(Verger et al., 2007)

For PC patients referred to integrated MH provider, prevalence = 12.4%

(Bryan et al, 2008)

Barriers to Accessing MH Care

#1 reported reason patients do not access specialty MH treatment:

"I don't need it"

Of those patients who do believe they need treatment, 72.1% would prefer to do it on their own

(Keesler et al., 2001)

Barriers to Accessing MH Care

Additional barriers to accessing specialty MH treatment:

Uncertainty about how to access services

Time constraints

Inability to afford services

Not enough MH providers

Economic limitations

(transportation, unemployment, housing instability, etc)

Challenges in Managing Suicide

- PCP seeks to turn over complete responsibility for managing high-risk patients to BH provider
  - In some cases, this could violate practice standards
- Over-responding to suicidal patients
  - Mistaken assumption that hospitalization is “gold standard” treatment for suicide risk

Other Problems

- GPs noted suicide risk in only 3% of patients who died by suicide (Appleby et al, 1996)
- Nonpsychiatric providers less likely to ask about suicide, and pts are less likely to endorse SI (Coombs et al, 1992)
- Suicidal pts much less likely to communicate suicide risk to nonpsychiatric providers than MH providers (Isometsa et al, 1994)

Why Do We Choose to Address Suicide in Primary Care?

1.

Suicidal patients simply “go to the doctor” when they’re not feeling well

2.

The first stop is almost always primary care

3.

Suicidal patients continue to access PC services for health-related problems

Poll Question #2

How many minutes do you typically take to perform a thorough suicide risk assessment?

A. 5

B. 10

C. 20

D. 30

E. >30

Myth:

Suicide assessment must be a lengthy and time-consuming process

Reality:

Suicide assessment and management can be adapted to the context

Role of Nurses and Medical Assistants

- Screening for suicidal symptoms
- Care coordination upon disposition

(Bryan & Corso, 2014)

Role of PCP

- Follow-up assessment and risk determination
- Warm hand-off
- Medication management

(Bryan & Corso, 2014)

Role of BHC

- Integration of MH into primary care is practical and effective approach
- Risk assessment primarily
- Additional management interventions if needed
- Transition/bridge to specialty MH services

(Bryan & Corso, 2014)

Fluid Vulnerability Theory

Suicide risk is actually comprised of two dimensions:

1. Baseline: Individual's "set point" for suicide risk, comprised of static risk factors and predispositions

2. Acute: Individual's short-term or current risk, based on presence of aggravating variables and protective factors

Everyone's Shared Role

Understanding suicide risk from a chronic disease management model

- Suicide risk can be chronic, with periods of acute worsening/exacerbation
- Suicide risk tends to be progressive over time
- Role of primary care is to maintain improvement between acute episodes and prevent relapse

“Rules of Thumb”

- Eliminate psychobabble and complex theories, both for patients and for PCPs
- 5-10 minute rule: if it can’t be explained and taught in 5-10 minutes, then it’s too complex
- Strategies must be evidenced-based

Everyone's Role in Managing Suicide Risk

- Patient-level (direct) impact on suicide risk
  - Direct patient care with patients, especially those at elevated risk for suicide
- Population-level (indirect) impact on suicide risk
  - Reducing risk factors and enhancing protective factors through high volume, low intensity strategies
  - Regular consultation and feedback to PCPs that alters their practice patterns in desired ways

Implications for Care

- Suicide risk fluctuates over time from moment to moment, & can re-emerge after resolution
- In PC, there is no such thing as a “closed case”
- Multiple attempters especially will require ongoing monitoring, preventive interventions

Why is Suicide Screening So Important in Primary Care?

- Only 17% of pts endorsing SI on paper-and-pencil screeners disclosed SI to PCPs during medical appt (Bryan et al, 2008)

- 6.6% of depressed pts endorsed SI/DI on PHQ-9 (Corson et al., 2004)
  - 35% of positive screens had SI
  - 20% of positive screens had plan

"…approximately one-third of the patients who endorsed the PHQ-9 death or suicide item in our study had active suicidal ideation and received urgent clinical attention, which would not have occurred had they not been administered the item addressing thoughts of death or self-harm."

(Corson et al., 2004)

A Collaborative Approach

Critical communications:

- Reinforce help-seeking behaviors
- Ending patient's distress is most important goal
- Protecting safety is essential
- Help is available, and it works

Don’t try to talk the patient out of killing themselves

A Collaborative Approach

Respect the patient's autonomy and ability to kill themselves

Don't moralize

Avoid power struggles about options that limit the patient's autonomy

Common Reactions to Suicidal Patients

Over-react
and perhaps impose unnecessary external controls or reactions

Under-react
and perhaps deny the need for protective measures

Ignore
or abandon the patient

Suicide-Related Terms

Suicide attempt

Intentional, self-enacted, potentially injurious behavior with any (nonzero) amount of intent to die, with or without injury

Nonsuicidal self-injury

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

Suicidal ideation

Thoughts of ending one's life or enacting one's death

Nonsuicidal morbid ideation

Thoughts about one's death without suicidal or self-enacted injurious content

Standardizing Suicide Language

Consider eliminating the following terms:

Suicide gesture

Parasuicide

Suicide threat

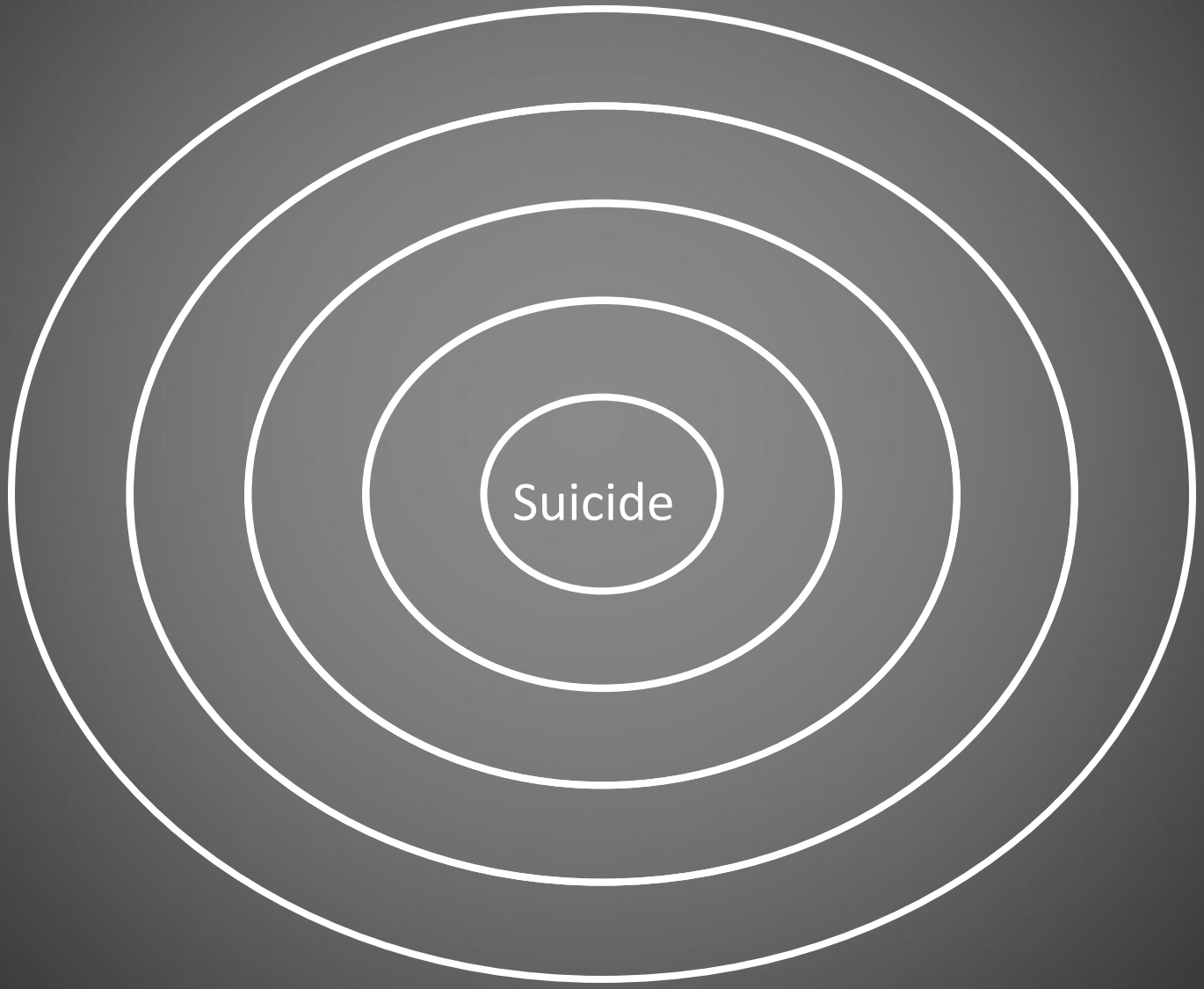
Self-mutilation

Accurate & Brief Risk Assessment

Table 4. Factors Associated With an Increased Risk for Suicide

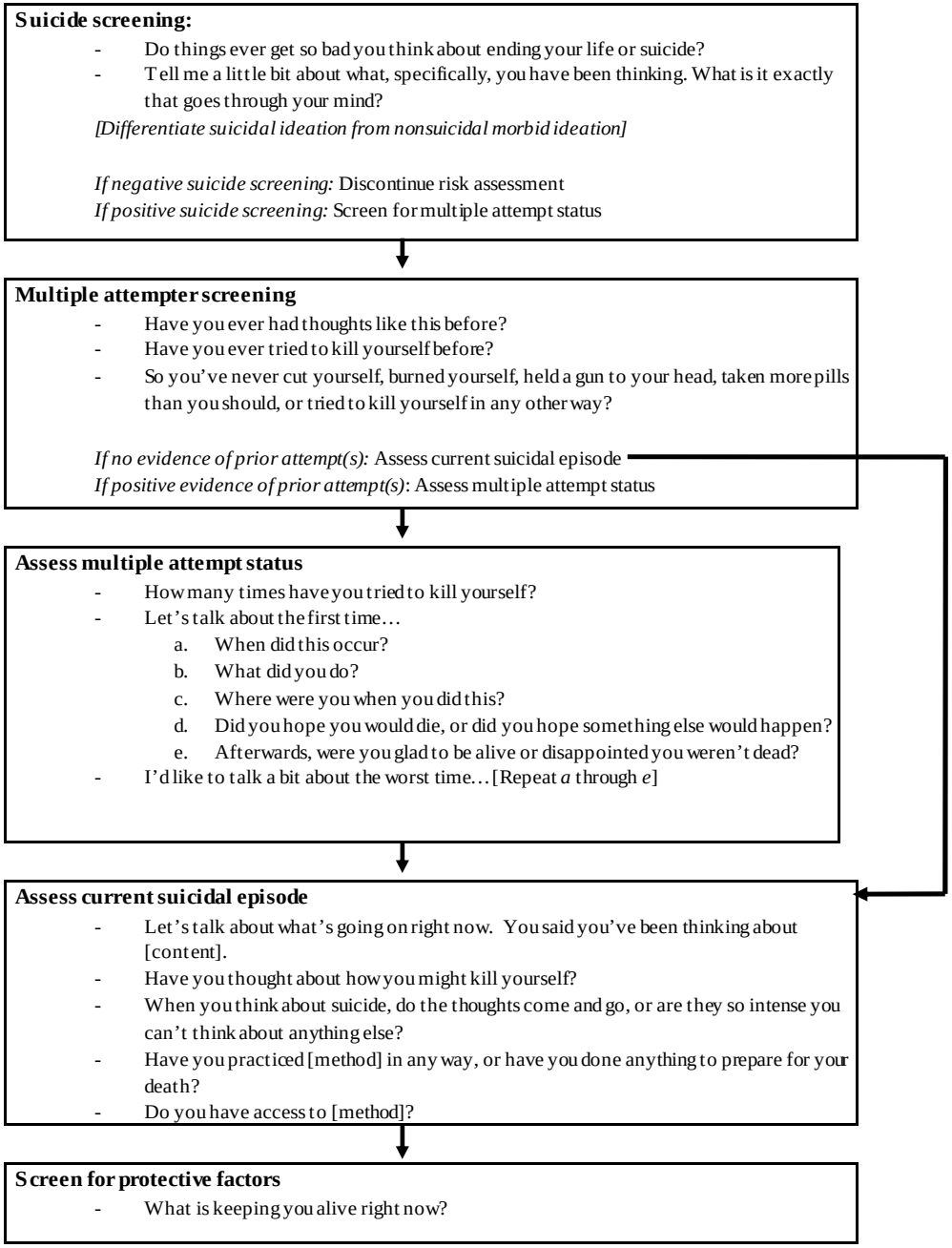
Suicidal thoughts/behaviors
Suicidal ideas (current or previous)
Suicidal plans (current or previous)
Suicide attempts (including aborted or interrupted attempts)
Lethality of suicidal plans or attempts
Suicidal intent
Psychiatric diagnoses
Major depressive disorder
Bipolar disorder (primarily in depressive or mixed episodes)
Schizophrenia
Anorexia nervosa
Alcohol use disorder
Other substance use disorders
Cluster B personality disorders (particularly borderline personality disorder)
Comorbidity of axis I and/or axis II disorders
Physical illnesses
Diseases of the nervous system
Multiple sclerosis
Huntington's disease
Brain and spinal cord injury
Seizure disorders
Malignant neoplasms
HIV/AIDS
Peptic ulcer disease
Chronic obstructive pulmonary disease, especially in men
Chronic hemodialysis-treated renal failure
Systemic lupus erythematosus
Pain syndromes
Functional impairment
Psychosocial features
Recent lack of social support (including living alone)
Unemployment
Drop in socioeconomic status
Poor relationship with family[a]
Domestic partner violence[b]
Recent stressful life event
Childhood traumas
Sexual abuse
Physical abuse
Genetic and familial effects
Family history of suicide (particularly in first-degree relatives)
Family history of mental illness, including substance use disorders
Psychological features
Hopelessness
Psychic pain[a]
Severe or unremitting anxiety
Panic attacks
Shame or humiliation[a]
Psychological turmoil[a]
Decreased self-esteem[a]
Extreme narcissistic vulnerability[a]
Behavioral features
Impulsiveness
Aggression, including violence against others
Agitation
Cognitive features
Loss of executive function[a]
Thought constriction (tunnel vision)
Polarized thinking
Closed-mindedness
Demographic features
Male gender[c]
Widowed, divorced, or single marital status, particularly for men
Elderly age group (age group with greatest proportionate risk for suicide)
Adolescent and young adult age groups (age groups with highest numbers of suicides)
White race
Gay, lesbian, or bisexual orientation[b]
Additional features
Access to firearms
Substance intoxication (in the absence of a formal substance use disorder diagnosis)
Unstable or poor therapeutic relationship[a]

Proximal vs. Distal Risk Factors



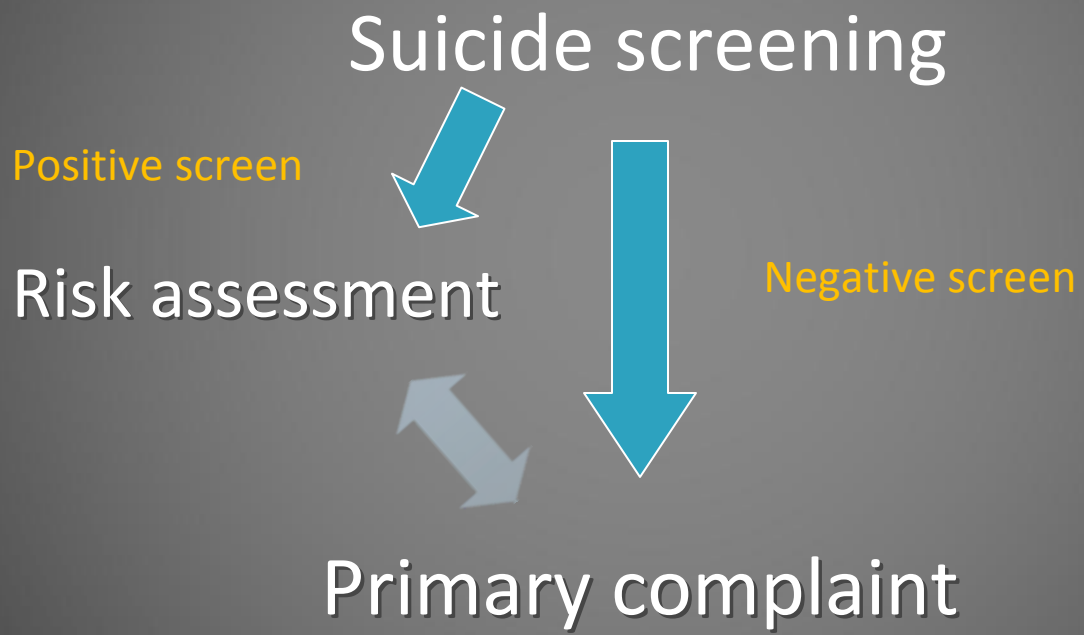
Suggested Assessment Approach

1. Suicide screening
2. Differentiate suicidal from nonsuicidal morbid ideation
3. Assess for past suicidal behaviors
   - If positive history, assess multiple attempt status
4. Assess current suicidal episode
5. Screen for protective factors



(Bryan, Corso, Neal-Walden, & Rudd, 2009)

Two-Stage Approach



Potential survey screening methods for PC

Patient Health Questionnaire-9 (PHQ-9)

Behavioral Health Measure-20 (BHM-20)

Outcomes Questionnaire-30 (OQ-30)

Beck Depression Inventory-Primary Care (BDI-PC)

Columbia Suicide Severity Rating Scale

No matter which approach is adopted, suicide screening should become a routine part of all patient evaluations, regardless of diagnosis or presenting complaint

Clinical questioning approach

"Many times when people feel [describe symptoms or complaints] they also think about death or have thoughts about suicide. Do you ever wish you were dead or think about killing yourself?"

"Do things ever get so bad you think about ending your life?"

"Have you recently had thoughts about suicide?"

Sequencing

Presenting problem / current ideation

Past suicidal episodes

(Start with first and move forward in time)

Current suicidal episode

(Shea, 2002)

"I got very angry when they kept asking me if I would do it again. They were not interested in my feelings. Life is not such a matter-of-fact thing and, if I was honest, I could not say if I would do it again or not. What was clear to me was that I could not trust any of these doctors enough to really talk openly about myself."

Survey vs. Interview Methods

Patients tend to report suicide risk with greater frequency on surveys as compared to face-to-face interviews

(Bryan et al., 2009; Corson et al., 2004)

Surveys can result in high false positives that must be clarified via interview

Differentiate suicidal from nonsuicidal ideation

- Suicidal ideation has stronger relationship with suicidal behaviors than nonsuicidal morbid ideation (Joiner, Rudd, & Rajab, 1997)

Suicidal ideation associated with significantly higher levels of psychological distress than nonsuicidal morbid ideation

(Edwards et al., 2006; Fountaoulakis et al., 2004; Liu et al., 2006; Scocco & DeLeo, 2002)

Assess for past suicidal behaviors

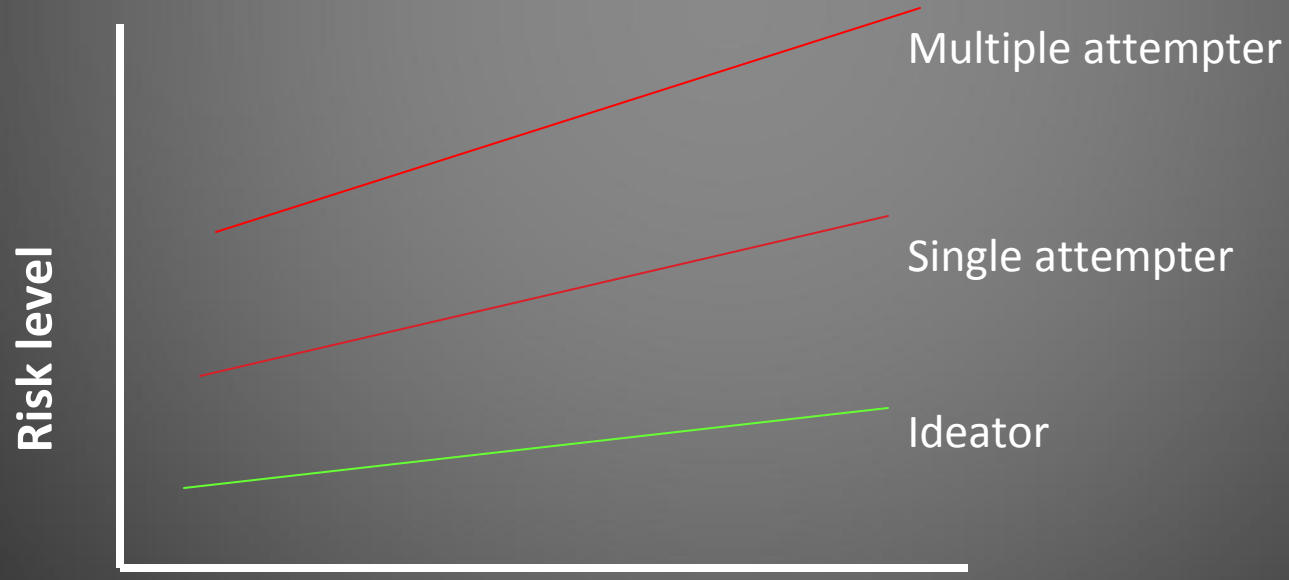
Past suicide attempts are the most robust predictor of future suicidal behaviors, even in the presence of other risk factors

(Clark et al., 1989; Forman et al., 2004; Joiner et al., 2005; Ostamo & Lonnqvist, 2001)

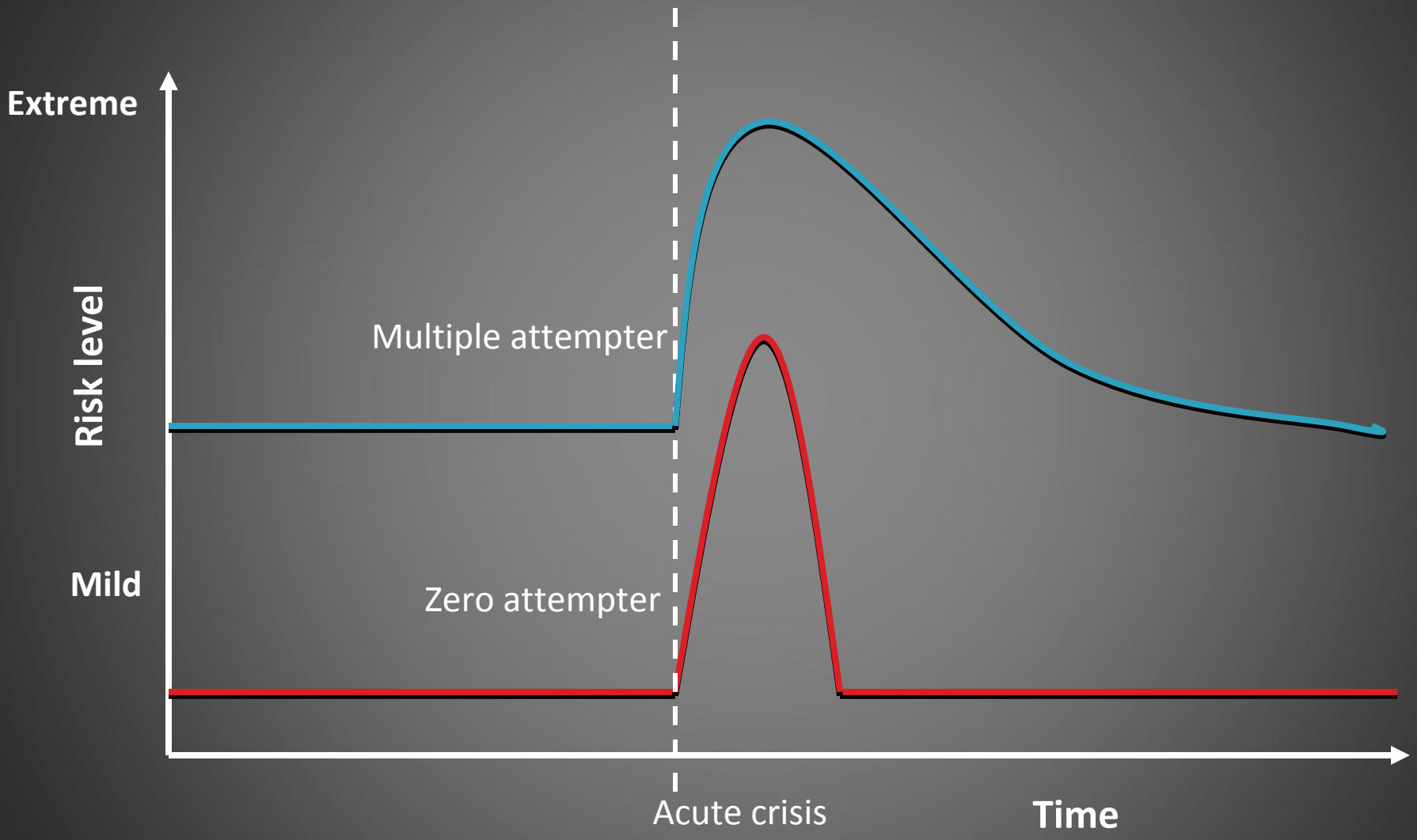
Assess for multiple attempt history

Why Bother?

- Three distinct groups:
  - Suicide ideator: Zero previous attempts
  - Single attempter: One previous attempt
  - Multiple attempter: 2 or more previous attempts



(Rosenberg et al, 2005; Rudd, Joiner, & Rajab, 1996; Wingate et al, 2004)


Extreme
Risk level
Mild
Multiple attempter
Zero attempter
Acute crisis
Time

Multiple Attempters

- Objective indicators are better predictors than subjective indicators (Beck et al., 1974; Beck & Steer, 1989; Harriss et al., 2005; Hawton & Harriss, 2006)
- Survival reaction can serve as indirect indicator of intent (Henriques et al., 2005)
- “Worst point” suicidal episode better predictor than other episodes (Joiner et al., 2003)

Assess the current suicidal episode

Current Suicidal Episode

Two factors of suicidal ideation

Resolved Plans & Preparation

- Sense of courage
- Availability of means
- Opportunity
- Specificity of plan
- Duration of suicidal ideation
- Intensity of suicidal ideation

Suicidal Desire & Ideation

- Reasons for living
- Wish for death
- Frequency of ideation
- Desire and expectancy
- Lack of deterrents
- Suicidal communication

Current Suicidal Episode

Intent

Objective

- Isolation
- Likelihood of intervention
- Preparation for attempt
- Planning
- Writing a suicide note

Subjective

- Self-report of desired outcome
- Expectation of outcome
- Wish for death
- Low desire for life

Ideation

Resolved Plans & Preparation

- Sense of courage
- Availability of means
- Opportunity
- Specificity of plan
- Duration of suicidal ideation
- Intensity of suicidal ideation

Suicidal Desire & Ideation

- Reasons for living
- Wish for death
- Frequency of ideation
- Desire and expectancy
- Lack of deterrents
- Suicidal communication

Access to Lethal Means

Suicidal intent has weak relationship with lethality of suicide attempt

(Brown et al., 2004; Plutchik et al., 1988; Swahn & Potter, 2001)

Patients tend to have inaccurate expectations about lethality of methods

(Beck, Beck, & Kovacs, 1975; Brown, Henriques, Sosdjan, & Beck, 2004)

Availability of means demonstrates strong association with lethality

(Eddleston et al, 2006; Peterson et al, 1985)

Assess protective factors

Protective Factors

Less empirical support than risk factors

Buffer against suicide risk, but do not necessarily reduce or remove risk

Provide clues for intervention

Often prime positive emotional states

Protective Factors

- Intact reality testing
- Children in home
- Spiritual beliefs / practices
- Moral beliefs
- Social stigma
- Future-oriented thought
- Presence of positive social relationships
- Fear of death / suicide
- Problem-solving skills
- Goals / aspirations

Strategies for Managing Suicide Risk

Crisis Response Plan
versus
Safety Contract

Crisis Response Plan

- Decision-making aid
- Specific instructions to follow during crisis
- Developed collaboratively
- Purposes:
  1. Facilitate honest communication
  2. Establish collaborative relationship
  3. Facilitate active involvement of patient
  4. Enhance patient's commitment to treatment

(Rudd, Mandrusiak, & Joiner, 2006)

Crisis Response Plan

- Written on 3x5 card or behavioral rx pad
- Four primary components / sections:
  1. Personal warning signs of emotional crises
  2. Self-management strategies
  3. Social support
  4. Professional support & crisis management

SAMPLE

- Go for a 10-15 min walk
- Practice breathing exercise
- Call family member to talk: xxx-xxxx
- Repeat above
- Contact Dr. Me at xxx-xxxx & leave message
- Call hotline: 1-800-273-TALK
- Go to ED or call 911

Crisis Response Plan

Practice

Brief Interventions

What Works

Adaptation of empirically-supported, effective strategies for risk assessment and management from specialty MH care and applying it to the PC context

Brief Interventions

Interventions must target suicide risk by "deactivating" one or more components of the suicidal mode

During acute crises, interventions should emphasize emotion regulation and crisis management skills

Brief Interventions

- 53 psychosocial clinical trials targeting suicidality (Bryan & Rudd, 2010)
  - "Clinical trial" = study including both treatment and control (or comparison) condition
  - Randomization not required
  - 28 (53%) were cognitive-behavioral
  - Only one RCT has utilized military personnel

Brief Interventions

- Reasons for living list
- Survival kit (“Hope Box”)
- Behavioral activation
- Relaxation skills training
- Mindfulness skills training
- Cognitive restructuring
  - ABC worksheets
  - Coping cards
  - Challenging beliefs worksheets

Antidepressant and the Role of BH Providers

- Patients initiated on antidepressants can be followed by BH providers for PCPs
  - Meets FDA recommendations and intent of warning label
  - Enables psychoeducation focused on medication adherence
  - Combines medication therapy with behavioral therapy, which is more effective than either alone

Recommending Hospitalization

- Providers tend to respond to suicide risk with “alarmist” or “better safe than sorry” attitude
- Inpatient hospitalization often mistakenly assumed to be “gold standard” for suicide risk
- Educate PCPs about judicious and appropriate use of hospitalization
- PCPs should make ultimate decision about referring patient for inpatient evaluation in collaboration with BH provider

Post-Discharge Follow-Up

The week immediately following discharge from inpatient hospitalization is highest risk period for suicidal patients (Qin & Nordentoft, 2005)

Same-day / next-day walk-in appointments can be useful for risk management

Transitions to Specialty MH

The “black hole of MH”:

Consult reports back from specialty MH are exceedingly rare, even when PCP made referral

- Develop system to document transfer of care to specialty MH tx
  - Confirm MH appt during f/u appt or phone call
  - Document “proof of attendance”

Transitions to Specialty MH

Don’t assume patients can easily access MH care (or even know how to)

Teach patients how to find a MH provider:

- Searching for possible providers
- Rehearsing / practicing what to say on the phone
- Educating patients about the first appt
- Educating patients about the importance of therapeutic relationship

Transitions to Specialty MH

- Follow-up with patients in-person or over the phone
- Document “proof of attendance”
  - Provider name
  - Business card
  - Release of medical information

Remember there are no “closed cases” in primary care

Poll Question #3

Did you learn something new today?

A. Yes

B. No

Poll Question #4

On a scale of 1-10, 10 being the most likely and 1 being minimally likely, how likely are you to incorporate the information from today's webinar into your practice as an IBHC?

A.1

B.2

C.3

D.4

E.5

F.6

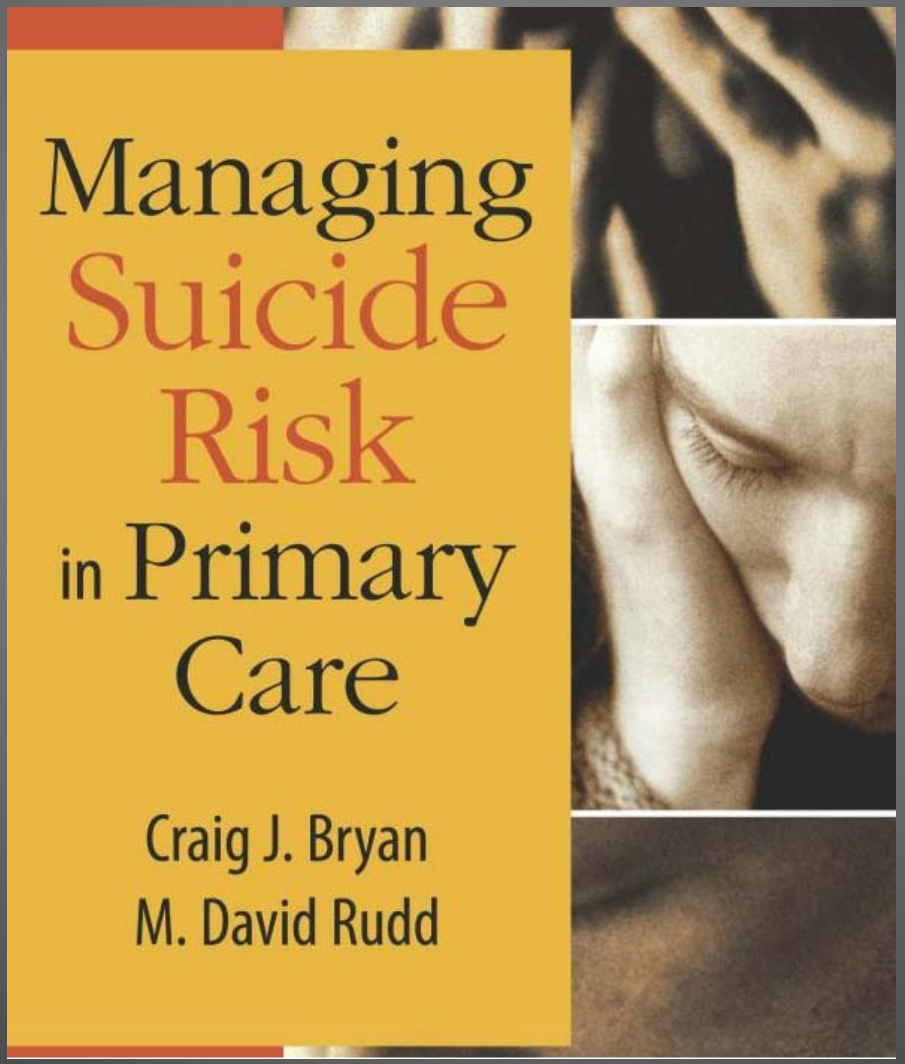
G.7

H.8

I.9

J.10

Book Recommendation



QUESTIONS

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