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Program Evaluation and Research Unit

Considerations of universal suicide risk screening in primary care settings

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Discussion Objectives

- **Increase subject matter knowledge and expertise** on universal suicide risk screening, including use in primary care settings
- **Identify best practices** from the literature
- **Determine implications** for **implementation** of the NW PA program based on the literature
- **Propose solutions** based on anticipated barriers to implementation

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Universal Suicide Risk Screening

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What is universal suicide risk screening?

- **The Joint Commission[1]**
  - 2007: National Patient Safety Goal requiring all behavioral health patients who present at psychiatric and general hospitals be screened for suicide risk.
  - 2016: All patients presenting to medical settings be screened for suicide risk.
- **Zero Suicide Model[2]**
  - All patients are screened for suicide risk at first contact and at all subsequent contacts.
  - All staff members use the same tool and procedures to ensure clients at risk for suicide are identified.

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Why screen for suicide risk?

- Suicide is a global public health crisis – 10th leading cause of death in the U.S. [3]
- Suicide risk is higher among people with comorbid medical illnesses (e.g., cancer, diabetes, and even asthma). [4]
- Majority of people who died by suicide visited a healthcare provider in the months before their death. [5]
- Many patients do not disclose suicidal thoughts unless asked directly, and most medical settings do not screen for suicide risk. [6]

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Poll Question

Does your organization use a standardized screening measure for suicide risk?

Type in the chat box:

What screening tool(s) does your organization use, and how were they chosen?

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What tools are used to screen for suicide risk?

Several tools are commonly used with varying levels of evidence to support their use with patients: [7]

- **Suicide risk screening tools**:
  - Ask-Suicide Screening Questions (ASQ)
  - Patient Safety Screener (PSS-3)
  - Columbia-Suicide Severity Rating Scale (C-SSRS)*
- **Depression screening tool (proxy)**:
  - Patient Health Questionnaire (PHQ-9) (specifically question 9)

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* Used as a part of the NWPAVSPP

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Where does suicide risk screening take place?

Standardized screening tool	Locations where commonly used
ASQ	EDs, inpatient units, outpatient units, primary care
PSS-3	Acute care settings (EDs, inpatient)
C-SSRS	Medical, inpatient, outpatient
PHQ-9	Primary care

(Zero Suicide Toolkit, 2021)

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What are some challenges in implementation?

- Difficulty selecting an evidence-based tool across the lifespan and across different healthcare settings.
- Difficulty in routinized use by providers and provider attitudes and beliefs about suicide.
- Systems have developed “untenable rules” due to guidance on interpreting positive screens (e.g., “strict safety precautions”).
- Impact of COVID-19 may require revision of models for screening, brief intervention, and referral to treatment.

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(Pao, Mournet, and Horowitz, 2020)

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Poll Question

What are some additional challenges your organization has faced in implementing universal suicide risk screening?

Type in the chat box:

How has your organization addressed these challenges to implementation?

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Universal Suicide Risk Screening and Primary Care Settings

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Why primary care?

- Many patients see primary care providers (PCPs) instead of mental health professionals because of stigma, confidentiality concerns, and mental health provider shortages.
- High percentage of patients who completed suicide or attempted suicide but did not die visited a healthcare provider in the year prior to their death/attempt.
- More than half of patients who have died by or attempted suicide visited a healthcare provider within a month of their death/attempt.

LeCloux, Aguinaldo, and Lanzillo et al., 2021

Is there evidence to support universal suicide risk screening in primary care?

- Studies of universal suicide risk screening programs in EDs and primary care settings have found that such programs can:
  - Increase – suicide risk screening and detection rates;
  - Decrease – acute care utilization, and;
  - Increase – behavioral health linkage rates.
- Growing evidence to suggest screening program efficacy, particularly when paired with brief intervention and referral to treatment.

LeCloux, Aguinaldo, and Lanzillo et al., 2021

What about considerations for rural areas?

- Suicide rates **disproportionately higher** in rural settings.
- Stigma related to mental illness, confidentiality concerns, and mental health provider shortages are **intensified** in rural settings.
- Rural settings more often have a lack of qualified medical and behavioral health providers, greater transportation issues, more social isolation, and unique environmental and cultural factors.
  - Conceptualizations of masculinity
  - Greater access to lethal means

LeCloux, Aguinaldo, and Lanzillo et al., 2021

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What are barriers to implementation in primary care settings?

- Concerns about effect of asking about suicide
- Low levels of confidence in managing mental health concerns
- Limited formal training on screening and assessment
- Lack of time/heavy caseloads
- Difficulty integrating into existing workflows
- Inadequate personnel to administer screening
- Insurance reimbursement

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LeCloux, Aguinaldo, and Lanzillo et al., 2021

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Case Study: Rural PCPs

Study objectives

PCPs interviewed about:

- Opinions about universal suicide risk screening in rural primary care settings
- Barriers to suicide risk screening specific to their practices
- Interventions that would make universal suicide risk screening more feasible

Participant sample

15 total PCPs:

- 100% White
- Slightly more than 50% male
- Mean age 44.8 years
- Majority were MDs
- Ten practiced in metropolitan area, 5 in designated rural county

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LeCloux, Aguinaldo, and Lanzillo et al., 2021

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Findings – opinions about feasibility and utility

Four major themes:

1. Importance of screening for suicide risk
2. Opinions about feasibility of universal suicide risk screening in primary care
3. Desire for more knowledge regarding efficacy of universal screening
4. Concerns about cost-benefit ratio of universal screening

LeCloux, Aguinaldo, and Lanzillo et al., 2021

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Findings – barriers to implementation

- Lack of access to mental health/crisis resources
- Disruption in clinic workflow
- Inadequate ability to follow-up with patients who screened positive for suicide risk
- Cultural beliefs including fear of losing access to firearms
- General burdensomeness of screening in primary care
- Concerns about patient follow-up
- PCP discomfort with topic and lack of training in screening

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LeCloux, Aguinaldo, and Lanzillo et al., 2021

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Findings – strategies to increase feasibility of screening

Five themes:

1. Use of technology and/or electronic medical records for screening
2. Using a multidisciplinary team approach to screening
3. Having standardized protocols for screening and assessment
4. Having access to co-located behavioral health
5. Additional training on the topic of suicide and suicide risk assessment

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LeCloux, Aguinaldo, and Lanzillo et al., 2021

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Discussion – opinions about feasibility and utility

- More access to evidence regarding efficacy of screening programs – evaluate “cost benefit” ratio prior to implementation
- Dissemination of results regarding efficacy and impact of universal screening critical to implementation of screening programs
- Educating PCPs about evidence for screening patients in primary care critical to implementation

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Discussion – barriers to implementation

- Adequate support services and/or innovative solutions (e.g., telehealth) needed to support suicide risk screening programs in primary care settings
- Screening programs in primary care settings – brief, efficient, and minimize burden on PCPs as much as possible
- Integrating training on topics of suicide screening, risk assessment, and treatment critical when considering implementation of universal suicide risk screening programs in primary care settings

LeCloux, Aguinaldo, and Lanzillo et al., 2021

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Discussion – strategies for successful implementation

- Integrating computerized/electronic screening along with multidisciplinary team approach – added benefit of increasing efficiency and decreasing burden to PCP
- Importance of standardized and streamlined programs for screening, risk assessment, and follow-up with patients identified as at-risk
- Training on topic of suicide, suicide risk screening, and suicide risk assessment useful intervention
- Implementation of co-located behavioral health to address lack of access

LeCloux, Aguinaldo, and Lanzillo et al., 2021

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Implications for Intervention

Evidence of efficacy →

Training →

Workflows →

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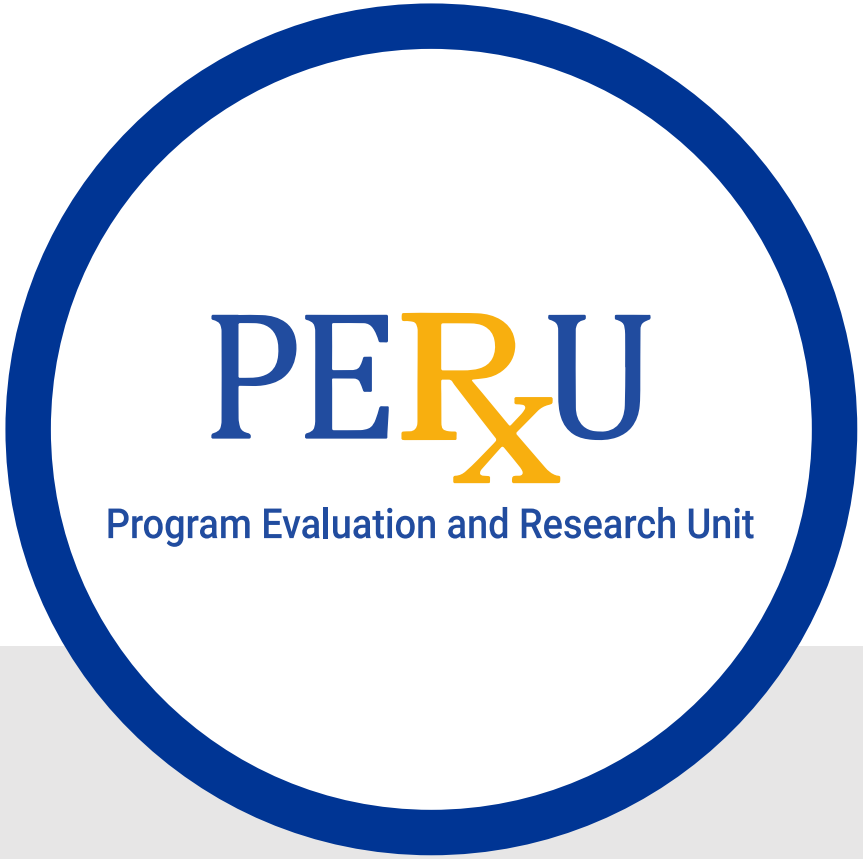

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