Other studies (not of Veterans)

- Christensen-LeCloux et al (Gen Hosp Psych 2021)
  - 196 patients surveyed in rural clinic in West Virginia
  - 96% believed PCPs should screen for suicidal thoughts
  - Most had positive or neutral experience
  - Preferred talking with provider (not pen and paper)
- Richards et al (JGIM 2019)
  - Qualitative interviews of 37 Kaiser Permanente patients
  - Being asked about suicide felt appropriate and valuable
  - Mismatch between lived experience and PHQ-9 9th item
  - Disclosure involved weighing hope against fears of consequences
  - Provider relationship and listening facilitated discussions

Risks of poor screening experiences

- Non-disclosure or partial disclosure
- Less engagement in appropriate care following screening/assessment
- Distrust of providers and the system if Veterans feel they are not being “heard”

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HSR&D funded project: Understanding Impact of VHA's Suicidal Ideation Screening Initiative: Veteran Perspective

- Co-Investigators:
  - Lauren Denneson PhD
  - Nasi Bahraini PhD
  - Edd Post MD, PhD
  - Kathleen Carlson PhD
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- Other Team members
  - Victoria Elliott MScPH
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Main Aims

1. In national samples of Veterans screened in *primary care*, *specialty mental health*, and *emergency department* settings, using quantitative surveys, characterize Veteran experiences with the VA Risk-ID screening and clinical evaluation process.

2. Conduct semi-structured qualitative interviews with Veterans and staff who participate in VA Risk-ID screening.

3. Among Veterans screened in primary care and emergency departments, examine the extent to which screening process and survey variables are associated with mental health treatment utilization variables over 6 and 12 months.

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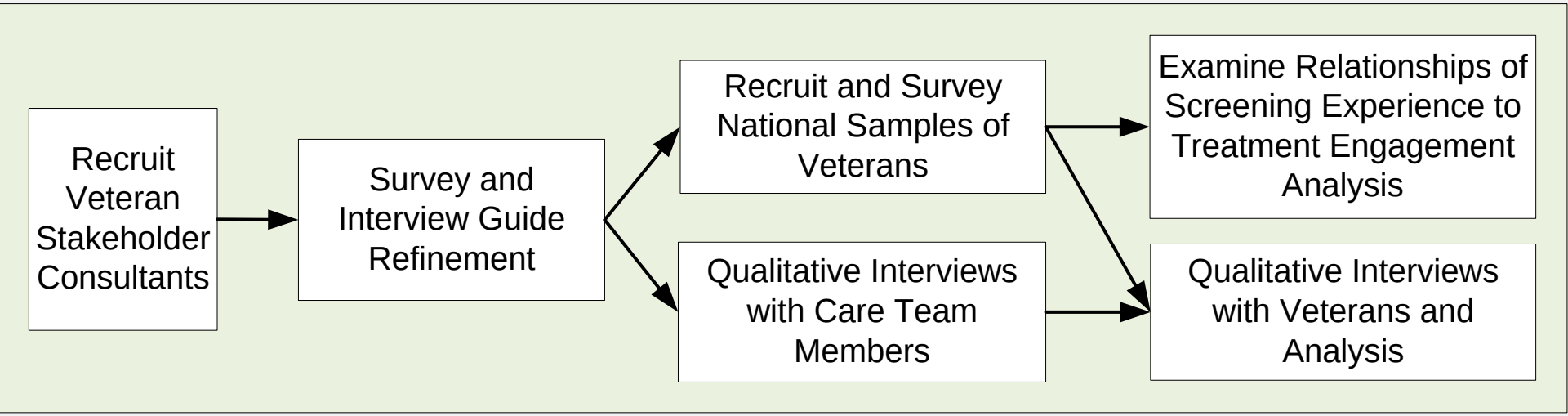
Main study components



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Recruitment

- Used CDW to identify individuals screened in prior week
- Excluded those with institutional living; dxd cognitive disorders, recent screen
- Stratified by sex (CDW) and C-SSRS result
- Randomly selected potential participants from these groups
- Mailed to 2,001 Veterans screened in primary care
- Sent up to two follow up mailings
- $35 compensation for survey completion
- Asked if interested in follow up phone interview

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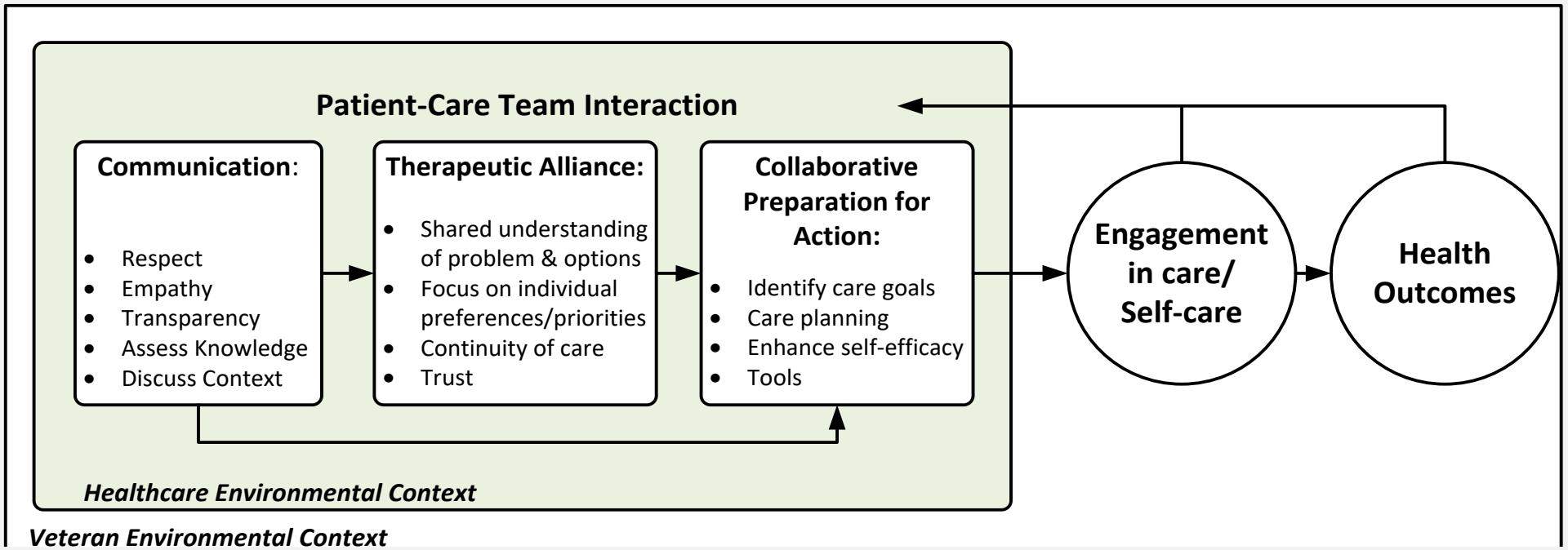
Framework and measures



Main Measures:

- Demographics and clinical characteristics
- Communication (*CAHPS*); Alliance (*STAR-P*); Collaboration (*CollaboRATE*)
- Experiences and satisfaction with screening
- Personal and institutional barriers to help-seeking and disclosure

Analysis

- Quantitative
- Comparisons: t-tests; chi-square; Fisher's exact test
- Stratify by C-SSRS positive vs negative
- We plan to weight analyses for non-response
- Additional analyses planned to examine predictors of satisfaction and potentially other attitudes

- Qualitative
- Interviews recorded and transcribed
- Thematic analysis
- 2 primary and 2 secondary coders in total

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Survey response (overall response rate 43.4%)

Measure	Survey not returned No, N = 1,133 (57%)	Survey returned Yes, N = 868 (43%)	p-value
C-SSRS			<0.001
Negative	54%	62%	
Positive	46%	38%	
Age Mean (SD)	54 (17)	61 (16)	<0.001
Sex			0.82
Female	43%	42%	
Race (N=1,869; categories not shown)			0.87
Ethnicity (N=1,917)			<0.001
Hispanic or Latino	11%	5.4%	
Not Hispanic or Latino	89%	95%	
Marital status (N=1,987)			0.23
Living with partner	48%	51%	
Rural/Urban (N=1,833)			0.72
Rural	35%	36%	
Service connected			<0.001
>=50%	44%	52%	
Any mental health condition diagnosed past year			0.025
Yes	44%	39%	

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>=50%	44%	52%	
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Yes	44%	39%	

Demographics of respondents (N=868)

Measure	Overall N = 868	C-SSRS (-) N = 541	C-SSRS (+) N = 327	p-value[1]
Age, Mean (SD)	61 (16)	63 (15)	57 (16)	<0.001
Gender				<0.001
Female	41%	47%	32%	
Male	58%	52%	67%	
Non-binary/Decline to answer	1.0%	1.1%	0.9%	
Ethnicity* (N=866)				0.14
Hispanic	8.7%	7.5%	11%	
Non-Hispanic	91%	92%	89%	
Race* (N=862)				0.42
American Indian or Alaska Native	1.3%	0.9%	1.9%	
Asian	1.2%	1.1%	1.2%	
Black/African-American	22%	21.7%	21%	
Multi-racial	7.5%	6.5%	9.3%	
Native Hawaiian or Pacific Islander	0.5%	0.2%	0.9%	
White	68%	70%	65%	
Religious/spiritual belief “strong” (N=794)	71%	76%	63%	<0.001

Demographics of respondents (N=868)

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White	68%	70%	65%	
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Demographics of respondents continued (N=868)

Measure	Overall N = 868	C-SSRS (-) N = 541	C-SSRS (+) N = 327	p-value[1]
Married/Living together (N=797)	52%	52%	52%	0.98
Some college or greater (N=820	76%	77%	73%	0.21
Employed (part/full-time) (N=796)	32%	32%	32%	>.99
Rural residence (N=811)	36%	37%	35%	0.74

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Clinical characteristics

Measure	C-SSRS Screen Result			
	Overall N = 868	Negative N = 541	Positive N = 327	p-value[1]
Service-connected disability				0.004
Above 50%	48%	44%	54%	
Below 50%	52%	56%	46%	
Past year diagnosed mental health conditions (any)				<0.001
No	60%	72%	42%	
Yes	40%	28%	58%	
Overall health functioning (Well Being Inventory) (N=813)				<0.001
Mean	3.3	3.8	2.6	
Psychological distress (Kessler-6, reverse scored) (N=811)				<0.001
Mean	2.5	1.9	3.4	

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Attitudes toward screening (unweighted)

Measure	Overall, N = 868	Negative N = 541	Positive, N = 327	p-value
Appropriate for Primary care nurses or medical assistants to ask Veterans about thoughts related to suicide (N=804)				0.48
No	9.3%	8.7%	10%	
Yes	91%	91%	90%	
Appropriate for Primary Care provider to ask Veterans about thoughts related to suicide (N=806)				0.43
No	6.1%	5.5%	7.1%	
Yes	94%	95%	93%	

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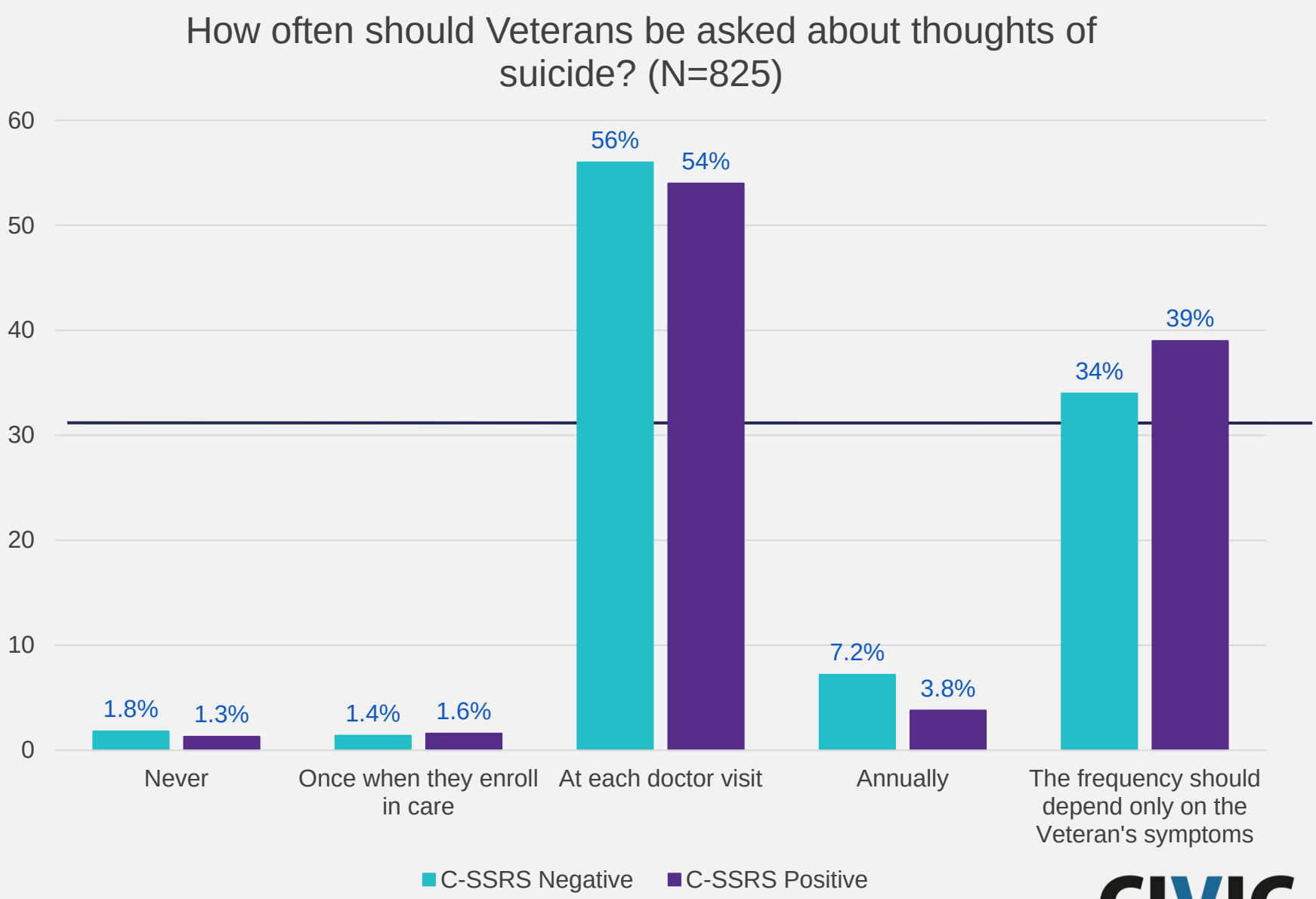

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Attitudes toward *suicide* (see Cwik et al ,Compr Psychiatry 2017)

Measure	Overall, N = 868	Negative N = 541	Positive, N = 327	P-value
Suicidal thoughts – no matter how sad, isolated or lonely people are, they should not consider suicide as a way out (N=800)				<0.001
No	32%	15%	58%	
Yes	68%	85%	42%	
Suicidal thoughts – everyone has a right to commit suicide (N=793)				<0.001
No	77%	86%	62%	
Yes	23%	14%	38%	

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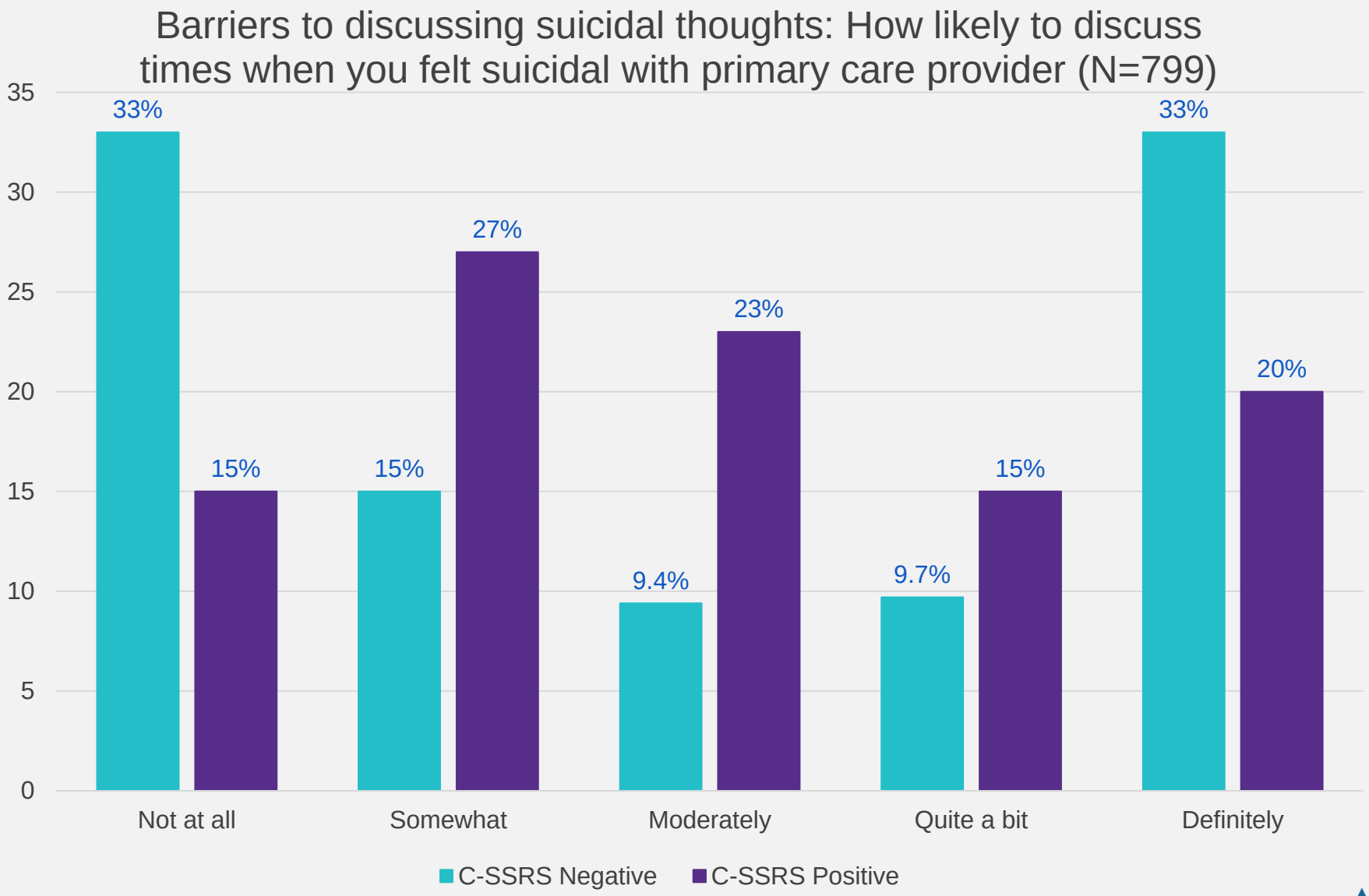
Barriers to seeking health care (Ouimette et al Psychol Serv 2011)

Subscale	Overall N = 868	Negative N = 541	Positive N = 327	p-value
Barriers to care – Staff skills and sensitivity (N=811)				<0.001
Mean (SD)	1.91 (0.96)	1.78 (0.95)	2.12 (0.92)	
Barriers to care – Logistic barriers (N=817)				<0.001
Mean (SD)	1.52 (0.55)	1.46 (0.53)	1.63 (0.56)	
Barriers to care – Not fitting in (N=817)				0.002
Mean (SD)	1.26 (0.50)	1.21 (0.46)	1.33 (0.55)	
Barriers to care – Discomfort with help seeking (N=799)				<0.001
Mean (SD)	2.03 (0.75)	1.84 (0.73)	2.33 (0.68)	
Barriers to care – Concerns about social consequences (N=769)				<0.001
Mean (SD)	1.98 (0.83)	1.70 (0.70)	2.43 (0.83)	



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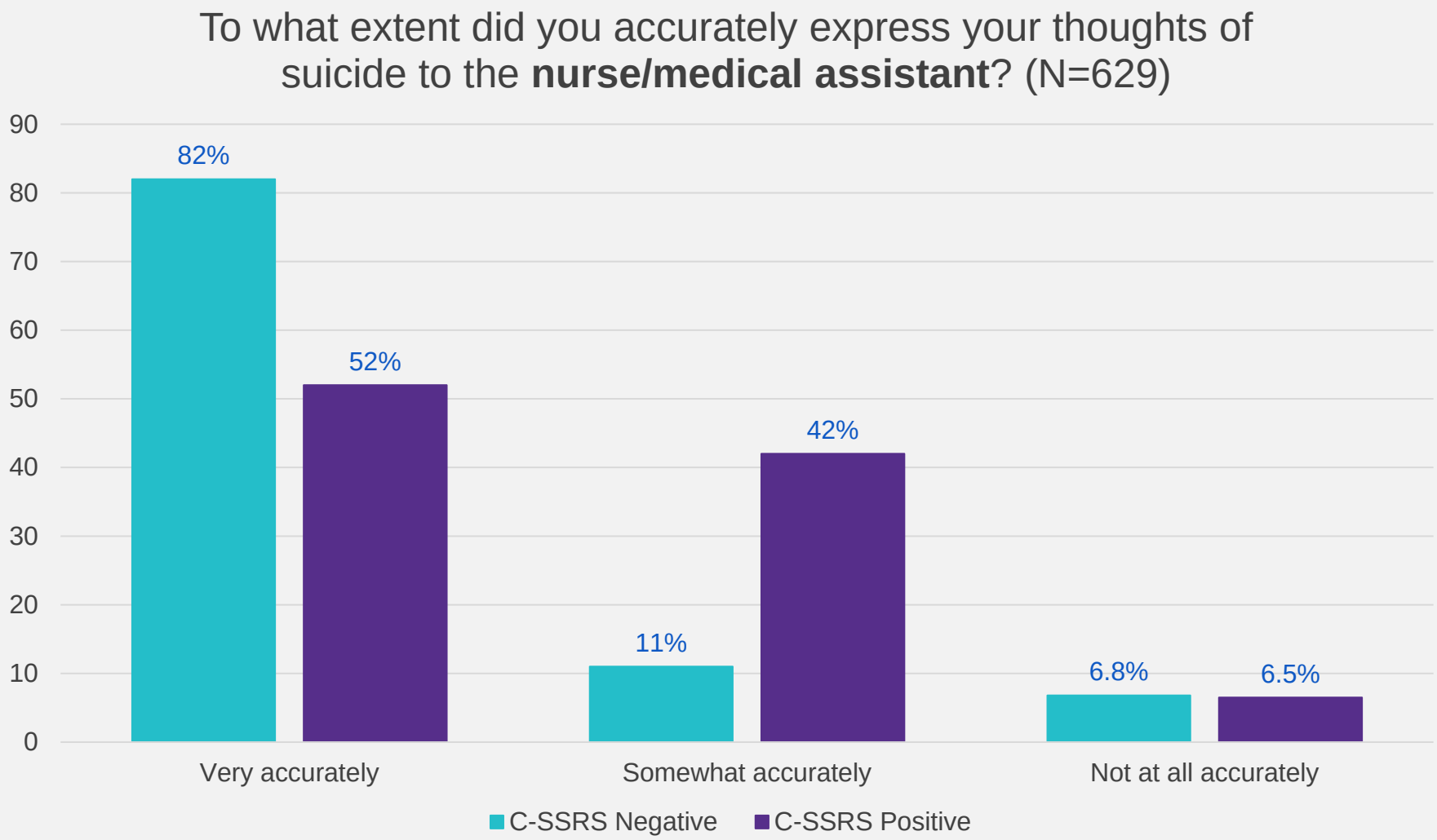
Disclosure of suicidal thoughts



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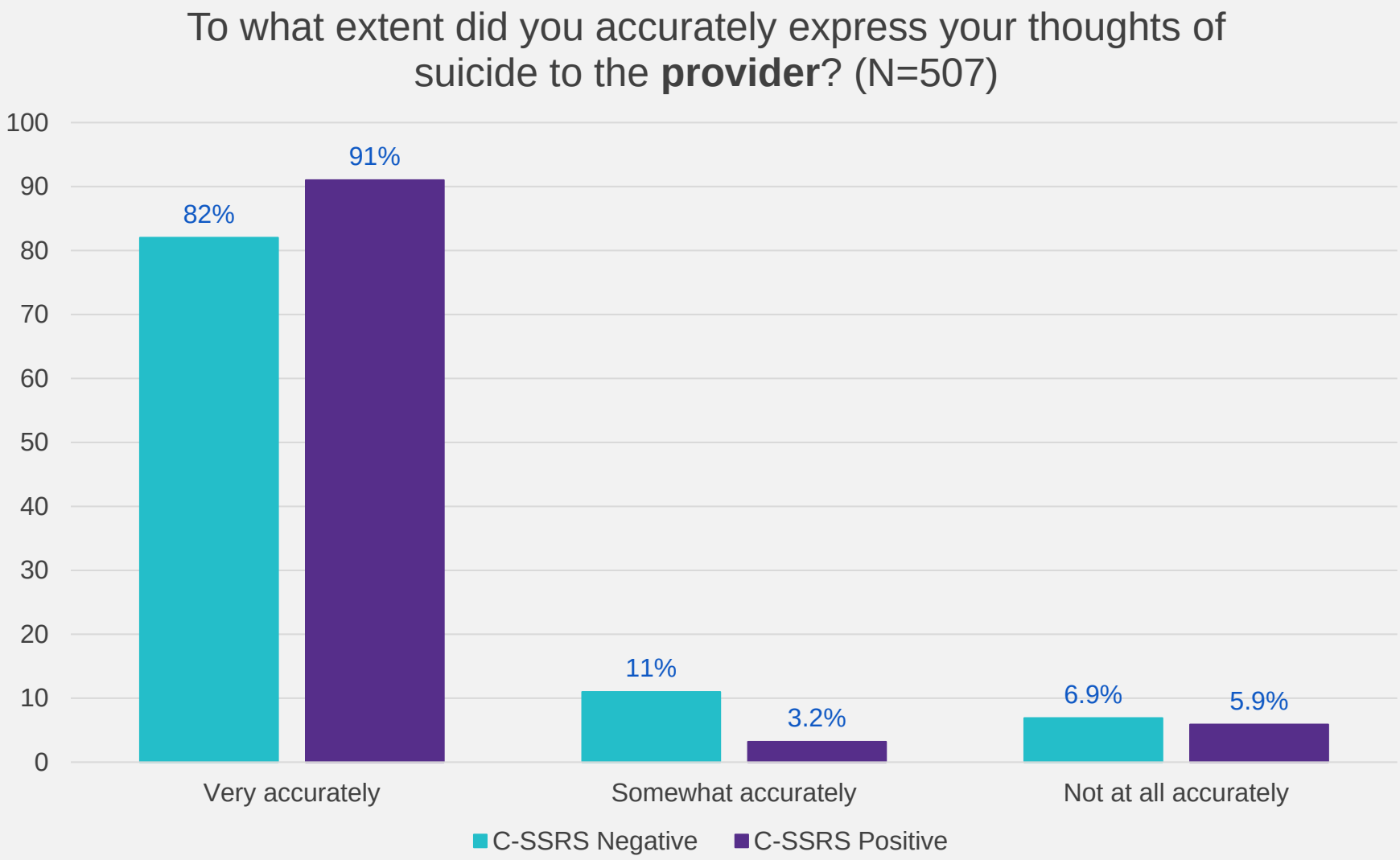

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Summary of responses: To what extent did you accurately express your thoughts of suicide to…

	C-SSRS negative	C-SSRS positive
"Very accurate" response to nurses/medical assistant	82%	52%
"Very accurate" response to primary care provider	75%	70%

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Disclosure takeaways

- Overall, 30% of those screened reported not being completely accurate in expressing their thoughts
- 5%-7% overall reported being not at all accurate in expressing their thoughts
- Veterans with positive C-SSRS screens were less likely to accurately express their suicidal thoughts than Veterans who screened negative
- People who screen positive reported more barriers including barriers to care, attitudes toward suicide (*how many people who screened negative did not overcome those barriers?*)
- Veterans with positive screens were more likely to accurately express suicidal thoughts to providers than nurses/medical assistants
- Up to 1/5 of individuals who had negative C-SSRS screens did not express their thoughts about suicide very accurately

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Qualitative Findings

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Veterans are “used to” screening questions and generally don’t mind being screened for suicidal ideation in primary care.

Asking directly is appreciated, but not if it is impersonal.

- *“It’s fine the way they ask me. You know I’d rather be, somebody be direct to me instead of like sugarcoat it or whatever.”* (1 30)
- *“She turned around and she looked at me and she asked me if I was having some mental health issues maybe with suicide and I said yes. But that told me that there was definitely a line of communication right there.”* (1057)
- *“I’m just thinking that it’s a cookie cutter approach, the best I can tell as far as the question itself and also how it’s asked. I mean if you ask an Iraq, Afghan Veteran who’s lost a friend or two to suicide, I guess you might think you want to not be insensitive by making it sound like it’s a canned, scripted question.”* (1486)

It's good to ask because people are reluctant or ashamed to bring it up

- *…I mean I know from personal experience when you feel that way you can't really talk to your spouse about it. You don't really talk to your friends about it. You kinda push it down inside and just keep it to yourself. So, on one hand it's good because maybe they feel like well in this environment I can speak freely, and I can get the help I need. (1203)*

- *It's not something I should be ashamed of. You know suicidal thoughts I guess happen probably a lot more than people realize. And I'm an open book. I don't have problems talking about what's going on*. (1055)

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Veterans fear consequences of disclosing suicidal thoughts

- *"…I felt like they was sending out a team for me. I was like oh gosh let me, let me get out of here before someone comes and forces me to go…I'm like oh my God just leave me alone, just leave me alone. Let me, let me go deal with it however I deal with it and So, whenever they ask after that I was like nope." (1429)*

- *Well, I can tell you that my biggest fear was that I was, they were gonna lock me up in the rubber room at the big hospital. And because that happened to a friend of mine who is no longer with us anymore…but they locked her up in a room upstairs on the fifth floor, took her clothes, took her phone, took her jewelry, took everything, everything and locked her up. I don't know for how long."(1057)*

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Repeated screening can be annoying and take time away from care, but many think good to do anyway

- *"It's getting like, it's just getting frustrating because it's likely they ask you the same questions. Like they're reading, they're reading the question the way it is and they're like, you know the answer already. Like it just feels like you're wasting everyone's time maybe? Yes, it's wasting time."* (1519)
- *"I just think that you shouldn't be asking that every time. I just think that you might feel that you're not addressing what you're really coming to the office for, that you're more concentrating on ..."* (1764)
- *"So, on one hand it's good because maybe they feel like well in this environment I can speak freely, and I can get the help I need. On the other hand, if people are hearing this all the time maybe it becomes static…But I mean I can see value, I can see value in asking. For sure."* (1203)

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Trust and rapport make a difference

- *"…because I just know like, at least I believe that they truly care about me. So, yeah, I liked it. ..Because they'll remember the conversation I had, they'll remember things I said to them when I do show up there. So, I kinda go like, oh, they, I feel like they invested in knowing me as a person*. (2553)
- *Yeah, so if it was* [last doctor] *and her nurse I probably would've just lied and said no I'm fine…That's not someone you actually wanna be honest with, someone that you don't trust, or feel are incompetent. Yeah trust, I just could not feel comfortable with either one of them.* (1055)
- *It's one of the main reasons why when I do go in, they don't get an honest response. Or they don't get anything from me because I feel that you're not for me, you're not trying to help me, you don't wanna help me, and why even go through it, go through the motions it seems. So, I can come in feeling suicidal and I leave out feeling suicidal then."* (1429)

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How quantitative and qualitative findings line up/add up

- Population-based screening in primary care is generally accepted by Veterans
- Disagreement as to desired frequency, as repeated screening can be seen as unnecessary, annoying or interfering with other appointment goals.
- There are important intrapersonal and interpersonal barriers to disclosing suicidal thoughts:
  - Intrapersonal: Feelings of shame; discomfort with help-seeking; fears of consequences
  - Interpersonal: Trust, “cookie-cutter” questioning
- Non-disclosure or partial disclosure is common

Some study limitations

- We have not yet weighted for non-response/stratification
- Some people may not have felt comfortable answering some questions truthfully—e.g., people may *under-report* that they did not respond truthfully to screening questions during appointments
- Survey was limited in how many items we could include
- In qualitative analyses, we worked with a small group—results are meant to help inform survey results and to generate hypotheses rather than to generate firm conclusions.

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Next steps include

- Characterize individuals who have lower levels of satisfaction or higher levels of discomfort with screening
- Examine predictors of disclosure
- Examine relationships between response to screening and subsequent utilization of services
- Examine screening efforts in mental health and emergency department settings

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We need to not be overly reliant on screening

- One-third to over one-half of Veterans who are asked about suicide during their last visits prior to suicide, deny suicidal thoughts (Denneson et al Psych Svcs 2010; Denneson et al Suicide and Life-Threatening Behavior 2016 , Smith et al J Clin Psychiatry 2013)
  - Reason: Suicidal thoughts are often transient and/or
  - Reason: Veterans may be reluctant to disclose
- In one study of over 500,000 individuals screened with the PHQ-9 9th item, over one-third who died within 30 days of screening had screened negative (Simon et al J Clin Psychiatry 2016)
- Staff concerns related to Risk ID include:
  - How to assess individuals with chronic suicidal ideation or individuals who are already known to be at risk.
  - Templated screening/assessment taking time away from other important clinical activities (Dobscha et al, under review)

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2019 VA/DoD Clinical Practice Guideline

- "We recommend an assessment of risk factors as part of a comprehensive evaluation of suicide risk, including but not limited to: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, and agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms."
  - Strength of Evidence: "Strong for"

Clinical strategies for screening

Domain	Approach
Alliance	• Screening should ideally be done by person on the team who knows patient best • Screening should be personalized
Communication	• Language should be straight forward, direct and understandable. • Maintain eye contact and do not make computer entries during the screening • Screening should be as conversational as possible. • Be aware of the potential for patients' perceived shame and avoidance around suicidal thoughts and fears of consequences of disclosure
Collaboration	• Describe purpose of screening, treatment options and type of treatment to expect in mental health.

Supplemental Slides

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C-SSRS-Screener used in VA as of 5/2022

Provide the responses to the following questions for the time period designated	Past month	
Ask Questions 1 and 2	**YES**	**NO**
1) Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?		
2) Over the past month, have you had any actual thoughts of killing yourself?		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 7.		
3) Over the past month, have you been thinking about how you might do this?		
4) Over the past month, have you had these thoughts and had some intention of acting on them?		
5) Over the past month, have you started to work out or worked out the details of how to kill yourself?		
6) If yes, at any time in the past month did you intend to carry out this plan?		
7) In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life (for example, collected pills, obtained a gun, gave away valuables, went to the roof but didn't jump)?	**Lifetime**	
8) If YES, ask: Was this within the past 3 months?	**Past 3 Months**	

ACUTE Therapeutic Risk Management – *Risk Stratification Table*

ROCKY MOUNTAIN MIRECC

HIGH ACUTE RISK

Essential Features

- **Suicidal ideation with intent to die by suicide**
- **Inability to maintain safety independent external support/help**

Common Warning Signs

- A plan for suicide
- Recent attempt and/or ongoing preparatory behaviors
- Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse)
- Exacerbation of personality disorder (e.g., increased borderline symptomatology)

Common Risk Factors

- Access to means
- Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)

Action

Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.

These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g. keep away from sharps, cords/tubing, toxic substances).

During hospitalization co-occurring psychiatric symptoms should also be addressed.

INTERMEDIATE ACUTE RISK

Essential Features

- **Suicidal ideation to die by suicide**
- **Ability to maintain safety, independent of external support/help**

These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.

Action

Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis).

Outpatient management of suicidal thoughts and/or behaviors should be intensive and include:

- frequent contact,
- regular re-assessment of risk, and
- a well-articulated safety plan

Mental health treatment should also address co-occurring psychiatric symptoms.

LOW ACUTE RISK

Essential Features

- **No current suicidal intent AND**
- **No specific and current suicidal plan AND**
- **No preparatory behaviors AND**
- **Collective high confidence** (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety

Individuals may have suicidal ideation, but it will be **with little or no intent or specific current plan**. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.

Action

Can be managed in primary care.

Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.

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