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ScienceDirect

Comprehensive Psychiatry 60 (2015) 149–155

COMPREHENSIVE PSYCHIATRY

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Prevalence of suicidal ideation and other suicide warning signs in veterans attending an urgent care psychiatric clinic

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Abstract

Background: Suicide prevention in the clinical setting is focused on evaluating risk in the coming hours to days, yet little is known about which factors increase acute risk.
Purpose: To determine the prevalence of factors that may serve as warnings of heightened acute risk.
Methods: Veterans attending an urgent care psychiatric clinic (n = 473) completed a survey on suicidal ideation and other acute risk warning signs.
Results: More than half the sample (52%) reported suicidal ideation during the prior week. Of these, more than one-third (37%) had active ideation which included participants with a current suicide plan (27%) and those who had made preparations to carry out their plan (12%). Other warning signs were also highly prevalent, with the most common being: sleep disturbances (89%), intense anxiety (76%), intense agitation (75%), hopelessness (70%), and desperation (70%). Almost all participants (97%) endorsed at least one warning sign. Participants with depressive syndrome and/or who screened positive for post-traumatic stress disorder endorsed the largest number of warning signs. Those with both depressive syndrome and post-traumatic stress disorder were more likely to endorse intense affective states than those with either disorder alone. All p-values for group comparisons are <.008.
Conclusion: Our major findings are the strikingly high prevalence of past suicidal ideation, suicide attempts, current suicidal ideation and intense affective states in veterans attending an urgent care psychiatric clinic; and the strong associations between co-occurring post-traumatic stress disorder and depressive syndrome with intense affective states.

Abbreviations: SI, suicidal ideation; SA, suicide attempt; SWS, suicide warning signs; AAS, Association of Suicidology; VA PEC, Veterans Administration psychiatric emergency clinic; DepS, current depressive syndrome; PHQ-9, Patient Health Questionnaire depression scale; AUDIT-C, Alcohol Use Disorders Identification Test; PC-PTSD, Primary Care Post Traumatic Stress Disorder scale.

Financial support was provided by the Majda Foundation.

Disclaimers: None.

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http://dx.doi.org/10.1016/j.comppsych.2014.09.010
0010-440X/

1. Introduction

Suicide is a major public health problem. More than 39,000 Americans die each year from suicide making it the 10th leading cause of death in the United States [1]. Recent reports of increasing suicide rates among the armed forces and military veterans [2] have led to renewed calls for more effective prevention [3]. Prevention in the mental health clinical setting is focused on assessing and formulating risk, and triaging patients accordingly to appropriate and effective care. Long--term risk factors which increase risk over many years are well known and include the presence of a psychiatric illness and/or substance use disorder, and a history of a suicide attempt (SA). However, less is known about the emotions, feelings, and behaviors that increase risk over the coming hours to days, acute risk; the time frame most relevant to clinicians.

A set of suicide warning signs (SWS) that address acute risk was proposed by an American Association of Suicidology (AAS) expert panel in 2006. They recognized that for clinicians who must make decisions about the safety of their patients in the coming hours to days, research based SWS would be of greater value than long-term risk factors [4]. They suggested that although there is some overlap, SWS differ from long-term risk factors in a number of clinically important ways. Among these differences is the potential to immediately reduce risk by modifying acute risk factors such as anxiety and insomnia [5].

There is little research to guide the selection of specific SWS because few studies focus on acute risk. Thus Rudd and colleagues chose "variables with the most promise [for eventual scientific verification] and immediate impact on clinical practice" [4,6]. In addition, even fewer studies have assessed the specificity of acute risk factors to individuals at risk of a suicide attempt or death by suicide by also evaluating SWS in individuals without suicidal thoughts or behaviors (attempts) (for example [7]).

The AAS expert panel's proposed list of SWS [4] can be seen as comprising three broad categories: 1) suicidal ideation (SI) including passive ideation (the wish to be dead), active ideation (thoughts of killing them self), making a suicide plan, and preparing a specific suicide plan such as purchasing a gun; 2) indirect behaviors including acting recklessly or engaging in risky activities; withdrawing from family, friends, and society; the inability to sleep or sleeping excessively; and increased drug or alcohol use and 3) intense affective states (intense feelings or emotions) including anxiety, agitation, anger/rage, feeling trapped, hopelessness, and dramatic changes in mood. For the present study we added the affective states of desperation, abandonment, self hatred, and feeling out of control [7]. As the first step toward the goal of identifying SWS, we examined the prevalence of proposed SWS in a sample of individuals with a range of past and current states of suicidal thoughts and behaviors. We chose a Veterans Administration psychiatric emergency clinic (VA PEC) for our study setting because VA PEC visitors represent a heterogeneous population that includes veterans at high risk of SI and SA such as recent returnees from Iraq and Afghanistan [8], and veterans with acute and chronic psychiatric or substance use disorders [9]. We used a self-administered survey to determine the prevalence of SI as well as other SWS in veterans attending the PEC. We also explored whether sociodemographic and clinical characteristics, such as a current depressive syndrome (DepS) and a positive screening for post-traumatic stress disorder (PTSD), might be associated with SWS.

2. Methods

2.1. Setting

The San Diego VA PEC is part of the San Diego VA medical center and is staffed by a second year psychiatric resident and an attending psychiatrist.

2.2. Sample

Participants were veterans who checked into the PEC between January and May of 2010. The PEC is located in the same building as the hospital and clinics and provides walk in access to psychiatric services during weekdays from 8 am to 4 pm. When veterans are contacted after a referral to mental health services they are told that the PEC is available should they need help before their initial appointment. Once established with mental health services they are provided with resources for care if their provider is not available and the PEC is included in these resources. Veterans brought in by police or paramedics are seen in the emergency department (ED). Veterans reporting to the ED were not included in this study. Exclusion criteria were a medical record flag for history of violent behavior; acute intoxication requiring transfer to the emergency department for medical clearance; a diagnosis of dementia; acute psychosis or confusion; visible intense agitation or anger requiring immediate intervention by the clinical staff; and impaired decision-making capacity. Out of 911 total visits to the PEC during the five month study period, 757 (83%) were unique visits. Of these, 38 veterans could not be accessed by the researcher and 107 met the exclusion criteria, leaving 612 veterans who met study criteria. Of these 612 veterans, 106 (17%) refused to participate and 24 had unusable surveys. In addition, 9 had missing data for SI and thus could not be categorized leaving a final sample size of 473. Compared to all veterans seen in the PEC in June of 2010, study participants were modestly younger (46.6 vs. 49.3 years of age, $p = .016$), but did not differ by gender or service war era.

2.3. Protocol

The study was approved by the University of California, San Diego institutional review board (IRB) and the San Diego VA research committee. Participants were informed during the consent process that although the survey was confidential, endorsement of any current SI or SA on the survey or verbally would be reported to the clinical staff.