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Primary care clinician responses to positive suicidal ideation risk assessments in veterans of Iraq and Afghanistan

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ABSTRACT

Objective: To examine primary care clinician actions following positive suicide risk assessments administered to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans.
Methods: We identified OEF/OIF veterans with positive templated suicide risk assessments administered in primary care settings of three Veterans Affairs (VA) Medical Centers. National VA datasets and manual record review were used to identify and code clinician discussions and actions following positive assessments. Bivariate analyses were used to examine relationships between patient characteristics and discussions of firearms access and alcohol/drug use.
Results: Primary care clinicians documented awareness of suicide risk assessment results for 157 of 199 (79%) patients with positive assessments. Most patients were assessed for mental health conditions and referred for mental health follow-up. Clinicians documented discussions about firearms access for only 15% of patients. Among patients whose clinicians assessed for substance abuse, 34% received recommendations to reduce alcohol or drug use. Depression diagnoses and suicidal ideation/behavior severity were significantly associated with firearms access discussions, while patient sex, military service branch, and substance abuse diagnoses were significantly associated with recommendations to reduce substance use.
Conclusion: Greater efforts are needed to understand barriers to clinicians' assessing, documenting and counseling once suicidal ideation is detected, and to develop training programs and systems changes to address these barriers.

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1. Introduction

Veterans utilizing Veterans Health Administration (VHA) services die by suicide at a higher rate than the general population [1], and while specific rates of suicide among veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) are unknown, OEF/OIF veterans have high rates of previously documented risk factors for suicide including depression, substance use disorder (SUD), posttraumatic stress disorder (PTSD), chronic pain and traumatic brain injury [2–8]. Furthermore, the rate of suicide among active duty OEF/OIF soldiers has increased in recent years, a trend which could follow this group into postdeployment [9].

The Department of Veterans Affairs (VA) has implemented a multimodal strategy to improve detection and response to suicide risk [10]. As one part of this strategy, the VA designated assessment for possible suicidal ideation (SI) among veterans at higher risk for suicide as a national performance goal. Specifically, since 2007, brief templated, structured suicide risk assessment tools are administered across the VA as part of routine care following positive depression and PTSD screens. These tools, typically consisting of less than five items, are designed to be used in conjunction with clinical judgment to assess suicide risk. Depression and PTSD screening, and the use of templated suicide risk assessments to assess for SI, frequently occur in primary care settings [11].

Prior research indicates that up to half of individuals have contact with primary care clinicians in the month prior to suicide, while a smaller proportion has contact with mental health care clinicians during that month [12,13]. As such, primary care clinicians may play a critical role in addressing suicide risk of veterans by detecting and treating important mental and general medical conditions, and being prepared to identify and intervene when veterans are at high risk. However, despite these high contact rates, there are substantial gaps in our knowledge of how primary care clinicians address suicide risk.

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A recent study by Smith et al. [14] showed that a minority (34%) of VA patients with a history of depression had a mental health diagnosis coded during final nonmental health visits within 30 days prior to suicide, and only 41% were receiving recommended dosages of antidepressants. Vannoy et al. [15,16] found that while primary care clinicians may use language and communication approaches that support patient disclosures of SI, primary care clinicians are frequently challenged to go beyond assessment to develop well-defined and structured treatment plans when they encounter SI. Aside from this small group of studies, little is known about the specific actions primary care clinicians take when they encounter SI in their patients.

Two risk factors of particular importance for clinicians to address with veterans who disclose SI are firearms access and alcohol and drug use. Nearly three quarters of veteran suicides in Oregon between 2000 and 2005 were firearms deaths [13]. Other studies suggest that veterans are significantly more likely to use firearms as a means for suicide than nonveterans [17]. National survey data have shown that individuals with an SUD have a sixfold greater likelihood of a lifetime suicide attempt than those without SUDs [18]. Among veteran suicide decedents in Oregon who received care in the VA healthcare system during the year prior to death, 20% were given an SUD diagnosis during that year, the second most common mental health disorder diagnosed after mood disorders [13,19]. In addition, it is well-documented that intoxication frequently precedes suicide attempts and death by suicide [20,21], especially among those who die by gunshot wound [21].

The main objective of the current study was to describe primary care clinician discussions and clinical actions following depression screening and positive suicide risk assessments (indicating SI) administered to OEF/OIF veterans. A secondary objective was to identify correlates of documented clinician–patient discussions and actions related to two key suicide risk factors: discussions of firearms access and counseling to reduce alcohol or drug use.

2. Methods

This study was approved by the institutional review boards of the participating medical centers. Methods for the overall research project have been described in prior publications [11,22].

2.1. Settings

This study was conducted at three VA Medical Centers (VAMCs) located in the northwest, southwest and northeast regions of the United States. Each VAMC is closely affiliated with a local university, has active research and teaching activities and has both metropolitan and rural-based primary care clinics. Each utilizes VA's computerized patient record system (CPRS), an integrated electronic medical record that contains progress notes, pharmacy and laboratory data.

Brief screens for a variety of conditions and disorders including depression are administered routinely in the VA, facilitated by a reminder system embedded within CPRS. Specific screen items and scoring algorithms often vary by VA site. For veterans not currently receiving depression care, the VA requires annual depression screening using the 2-item or 9-item Patient Health Questionnaire (PHQ-2 or PHQ-9—the first two items of the PHQ-9 are the PHQ-2) [23]. A positive depression screen triggers a reminder to clinicians to conduct a suicide risk assessment. A suicide risk assessment tool based on questions from the National Clinical Reminder (NCR) Suicide Assessment Questions [24] was disseminated in late 2007; this five-item tool includes questions about hopelessness, thoughts of taking one's life and prior suicide attempts [24]. Individual VA facilities could choose to use this tool, the PHQ-9 (which includes the ninth item, "Over the past 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"), or develop their own assessment tool. The NCR tool and PHQ-9 were used as the suicide risk assessment tools most of the time (98%) at the three sites during the study period (Table 1) [11].

2.2. Subjects

We first identified veterans of OEF/OIF who had a recorded contact at one of the three VAMCs between April 1, 2008 and September 30, 2009. OEF/OIF status was determined using the national OEF/OIF Roster [11]. OEF/OIF Roster data were then matched to data from the VA Decision Support System (DSS), a national database containing demographic, clinical, utilization and cost information [25]. To be included in the current study, a veteran had to (a) have a positive depression screen conducted in a primary care setting at one of the three VAMCs; (b) a suicide risk assessment conducted using the NCR Suicide Assessment tool or the PHQ-9th item, conducted within a month of the positive depression screen; and (c) a positive suicide risk assessment result (Fig. 1).

2.3. Measures

2.3.1. Independent variables

Most demographic information, including race/ethnicity data, was extracted from DSS. The OEF/OIF Roster contained education, military

Table 1
Most commonly used templated suicide risk assessment tools

Construct	Measure	Response options	Positive result
Depression	PHQ-2		
	Over the past 2 weeks, how often have you been bothered by: 1. Little interest or pleasure doing things? 2. Feeling down, depressed or hopeless?	0 = Not at all 1 = Several days 2 = >Half the days 3 = Nearly every day	Sum ≥ 3
Suicidal Ideation	PHQ-9, 9th item		
	Over the past 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?	0 = Not at all 1 = Several days 2 = >Half the days 3 = Nearly every day	Score ≥ 1
	VA NCR Pocket Card Risk Assessment 1. Feeling hopeless about the present/future? 2. Thoughts of taking your life? 3. When did you have these thoughts? 4. Do you have a plan to take your life? 5. Have you ever had a suicide attempt?	Yes/No	Item 2 = yes