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Richards, JE., Hohl, SD., Whiteside, U., Ludman, EJ., et al., (2019) If you listen, I will talk: The experience of being asked about suicidality during routine primary care, *Journal of General Internal Medicine*, 34(10), 2075-2082. DOI: 10.1007/s11606-019-05136-x

Author's declarative title:

Primary care suicide screening: the importance of comprehensive clinical assessment.

Implications for practice and research

- Suicide screening in primary care is acceptable to people when they feel cared for, the assessor has time to listen and they are informed about what will happen.
- Suicide screening should not be limited to the use of measurement tools, more accurate assessment is achieved using a comprehensive clinical assessment.

Context

Suicide is preventable yet worldwide approximately 800,000 people die by suicide every year. Suicide prevention is a global public health priority[1] and primary care providers are important gatekeepers in identifying people experiencing suicidal thoughts. Factors influencing the accuracy of suicide assessment include stigma preventing disclosure and fear of consequences of disclosure. Suicidal thoughts are rarely constant, varying in their presence and severity, and may therefore not be present at the time of an assessment. Suicidal thoughts are deeply personal requiring an assessor who is skilled in establishing a rapport and active listening. Suicide assessment tools have low predictive accuracy[2] making it crucial that they are not used as the sole assessment approach.

Methods

The study by Richards and colleagues[3] focused on exploring the experience of people screened for depression and suicidal thoughts in a primary care setting. Participants were purposively selected from an electronic medical database in one state in the USA. Participants were eligible to take part in the study if they were over 18 and had completed the ninth question specifically focused on "*Thoughts that you would be better off dead or of hurting yourself in some way*" from PHQ9; a validated primary care depression screening tool. Data were collected via semi-structured telephone interviews and analysed using a deductive framework identified in literature and inductive coding generated directly from the interview data using content analysis to produce themes.

Findings

Thirty-seven people were interviewed; 68% were female and 76% were white. 24% of participants reported no suicidal thoughts in PHQ9 and of those who completed a detailed suicide risk assessment tool, 21% (n=3) scored the highest risk. Four themes were identified; 1) Participants believed being asked about suicidality was contextually appropriate and valuable, 2) some participants described a mismatch between their lived experience and the PHQ9, ninth question, 3) suicidality disclosures involved weighing hope for help against fears of negative consequences and 4) provider relationships and acts of listening and caring facilitated discussions about suicidality.

Commentary

Primary care settings need to accurately screen patients that require more detailed suicide risk assessment. Richards and colleagues[2] described screening results from incrementally applied health screening tools to identify suicidal thoughts. A limitation of this approach is the low predictive value of rating scales in suicide risk[3]. Current recommended practice in the UK[2], in line with the WHO[1] suicide prevention strategy, recommend comprehensive clinical risk assessment to identify modifiable suicide risk factors. Modifiable factors include, for example, substance use, coping strategies and psychological wellbeing.

Identification of these factors can only be achieved through a clinical assessment that prioritises listening to the patient's description of their needs and distress and is not over-reliant on the use of assessment tools. Richards and colleagues[2] identified that patients felt the screening questions in PHQ9 did not relate well to their experiences, particularly the nature of their distress. A clinical assessment may also facilitate spending time listening to the person helping them feel cared for and able to disclose deeply personal thoughts related to suicide[3]. Training is required to ensure that primary care providers have the requisite skills and knowledge to assess suicide, make a formulation of need and refer for appropriate intervention[1].

The stigma associated with suicide is recognised as an important factor preventing early identification of those in need of interventions[1,3]. The WHO[1] suicide prevention strategy acknowledges the need for interventions at societal level including public education and information to reduce stigma and fear and facilitate timely access to help. Richards and colleagues[3] described the need for patients to have more information about what would happen to them should they disclose suicidal thoughts. There may however be a need to provide information about mental health more generally in a primary care setting not limited to times when the person is already distressed.

References

1. World Health Organization (2014) Preventing suicide: a global imperative, World Health Organization, Geneva.
2. Large, M.M., Ryan, C.J., Carer, G., Kapur, N., (2017) Can we usefully stratify patients according to suicide risk? *BMJ*, 359, doi:10.1136/bmj.j4627
3. Richards, JE., Hohl, SD., Whiteside, U., Ludman, EJ., et al., (2019) If you listen, I will talk: The experience of being asked about suicidality during routine primary care, *Journal of General Internal Medicine*, 34(10), 2075-2082. DOI: 10.1007/s11606-019-05136-x

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Competing interests: no competing interests to declare.