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Implementing Routine Suicide Risk Screening for Psychiatric Outpatients With Serious Mental Disorders: I. Qualitative Results

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Abstract

The objective of this study was to acquire process information, clinician and client feedback during implementation of a routine suicide risk screening program for outpatients with serious mental disorders. We studied implementation of a suicide-screening tool in a large public mental health outpatient facility in New York City. Most clinical staff who provided an opinion indicated screening was useful, feasible and helpful; most clients did not mind screening. Facilitators to program implementation included administrative support and ease of use. Barriers included consent, misperceptions, and concerns regarding potential liability. It is feasible to implement a suicide-screening tool in a public outpatient clinic. However, even experienced clinicians harbor unfounded myths. Effective large scale use will require vigorous training and oversight.

Keywords

public mental health system; risk screening; suicide prevention

INTRODUCTION

Preventing suicide has become an expressed national priority during the past decade, with resolutions from both Houses of Congress (U.S. Congress, 1997, 1998), the Surgeon General's Call to Action (U.S. Public Health Service, 1999), the National Strategy of Suicide Prevention (U.S. Department of Health & Human Services, 2001), the report of the President's New Freedom Commission (2003), and the Garrett Lee Smith Act (2004).

A challenging problem is the detection of suicidal intent among individuals who suffer serious mental disorders, where many of the so-called "risk factors" for suicide are present.

It has long been clear that having a defined, serious condition raises the longer-term probability of suicide. Nonetheless, suicide remains a relatively rare event even among individuals with several mental disorders, and accurately identifying individuals with imminently increasing risk from those with serious but relatively stable conditions remains as challenging as with the general population.

The purpose of this study was to develop the means and test the feasibility of screening for factors that may reflect heightened risk for suicidal ideas or behaviors among clients with serious mental disorders. In this paper we present qualitative findings, which have implications for developing the clinical infrastructure for a screening process; in a companion paper (this issue) we present quantitative findings.

METHODS

The New York State Office of Mental Health (OMH) Central Office/Research Foundation for Mental Hygiene, Inc. IRB approved the project. By design, we merged the informed consent and HIPAA authorization into one form, referred to as the “consent.” We used the OMH incident reporting system, operated by the OMH Bureau of Quality Management, to monitor participants for any increase in attempts or suicides at SBPC. In the event the number of suicide-related incidents increased beyond what would be expected based on averages during previous reporting periods, we planned to stop the project.

Site

The target site was South Beach Psychiatric Center (SBPC), which has the largest outpatient population among the OMH state-run facilities. Its adult outpatient department of 10 locations serves 1,550 adult clients weekly, or approximately 3,350 annually, in western Brooklyn and Staten Island. Although it is the largest provider, SBPC has among the lowest rate of suicides and suicide attempts in the OMH system. This project complemented the implementation of suicide risk screening for outpatients as a quality improvement initiative.

Procedure

Implementation was in three steps: 1) site assessment, 2) risk screen development, and 3) screening pilot period. Additionally, we also identified implementation barriers and facilitators for screening. For the site assessment, we gathered anonymous qualitative data from staff on perceived factors that contribute to the service system effectiveness and relatively low rates of suicidal behavior. These data were collected via a secure intranet with email invitations to participate. During development, we reviewed the literature, reviewed existing screening and assessment tools, consulted with experts, and acquired feedback from clinicians, leaders and consumers. Since the ultimate goal was to determine the feasibility and utility of routine screening we expected that such feedback would be a critical tool in later program development.

Given our overall goals and the nature of the target patient populations, we focused the screening tool on *dynamic risk factors* (e.g., changing mood and thoughts, or recent stressors) that had the potential to forewarn the clinician about a client’s increased risk at that specific time. Although we included a brief history section (e.g., family history of suicide; childhood emotional, physical or sexual abuse), and an assessment for a positive screen, we excluded items about non-modifiable risk factors or significant presenting features that were noted in the past (e.g., substance use status and ongoing medical conditions), as these clinicians had established clinical relationships with their clients. Assessment of first-time clients would require a much broader array of inquiries that would not be suitable for ongoing outpatient sessions. We also included a clinician report regarding

impressions and treatment actions following the screening and clinical session. The suicide risk screen, assessment, and clinician report were computerized on the SBPC internal website for administration by the clinician, with HIPAA-compliant password logons for clinical staff. Clinicians could print out a summary for each client's chart.

Consistent with plans to embed screening tools into standard practice, the tool was administered as a clinical procedure to all SBPC clients. Later in the session a request was made *only for randomly selected clients* to obtain informed consent-authorization to release de-identified data. In this manner, the authorization request would not interfere with the clinical session, particularly in the event where a client might associate any discussion of suicide with a research project and refuse to discuss it with the clinician. If the client refused authorization, the client's data were not extracted for analysis, although the clinician was able to use the client's screening information, and could still report (anonymously) his or her feedback. We also allowed clinicians to reorder the items; they were asked to record any adaptations on their clinician reports which were used as a means of further assessing and developing the tool.

Each participating SBPC clinician (psychiatrists, psychologists, social workers, nurses, rehabilitation counselors, and student interns under the supervision of a licensed clinician) received a list of five randomly selected clients from their case-load. Selection criteria included: at least age 18 years or older, outpatient status, and session frequency of monthly or more often. Each clinician was asked to screen each of their selected clients approximately once per month over a 6-month period. Clinicians had the option to screen more frequently if needed. Clinicians could provide feedback on the screening process and the instrument during the 6-month pilot period. Additionally, clinicians and clients could provide feedback on the clinician report.

Two initial training sessions were provided. The first was a general presentation on incidence, screening, and assessment of suicidal behavior by a recognized expert. The second was an extended session on the protocol for use of the routine paper and pencil versions of the instrument, including consent for release of research data.

Participants

A total of 153 SBPC outpatient clinicians received a list of 5 or fewer randomly selected clients depending on caseload size. A pool of 719 clients was randomly selected for routine screening during a 6-month pilot period that commenced in December 2006 through May 2007. For the prior calendar year, the SBPC adult outpatient client demographic profile was: 56% female, 44% male; 78% White, 17% Black, 5% Asian; with 18% of Latino heritage.

RESULTS

Site Assessment

Feedback was obtained from 158 SBPC staff on perceived factors contributing to low client suicide/attempt rates at the facility. Text responses were coded in categories, and multiple reasons were frequently reported; thus, percentages exceed 100%. The top three macro-level factors identified were: 1) team approach and staff cohesion (48%); 2) coordination/continuity of care, and good relations with co-providers (34%); and, 3) communication between providers, patient and treatment team (25%). The top 3 micro-level factors pertaining to clinician characteristics that contributed to low client suicide/attempt rates were 1) clinician skill, training, and experience (76%); 2) being calm, assuring, caring, genuine concern, commitment to improving clients' problem-solving skills, with the belief that treatment is helpful (21%); and, 3) avoiding work in isolation and utilizing team/supervisory input (6%).

Risk Screen Development

Our biggest hurdle in tool development was to balance the large number of known predictors found in the literature, contained in other measures, and recommended by experts and clinical staff with practicality and potential usability in a clinical session. The first draft contained 86 items. After several iterations, our final pilot test screening instrument contained seven items pertaining to recent (past 30 days) symptomatology, feelings, thoughts (e.g., felt overwhelmed, hurt, agitated, low-self esteem, hopelessness) and recent stressor(s), ending with an inquiry on hurting or killing self. A positive response to the last item (hurting or killing self), or client ambivalence, or clinician discretion lead to an additional eight items that focused mainly on intent, means, ability, lethality, and the client's perceptions of options other than suicide.

In addition to the screening and assessment items, we created a clinician report which was completed after each screening session. This report contained four sections of check boxes regarding history of suicidality, recent suicidality, outcome (clinician's assessment of client risk, and treatment actions), and process feedback. The clinician's assessment of risk (low, moderate, high or extreme) was used in preliminary analysis of the screening items.

Pilot Feedback

A total of 1,671 screenings were performed (ranging from 1 to 8 times) for 471 (66%) of 719 potential clients. Quantitative results are included in a companion paper (published in this issue). Of the clients screened, 82% (N=386/471) provided authorization to release their individual level screening data and feedback comments for program evaluation. Of the 153 potential participating clinicians, 116 (76%) took part. Of these, 83 (72% of the 116) provided 309 comments; we also received 166 comments from 105 (27%) of the 386 consenting clients. For the majority of the clients who declined authorization to release data, their clinicians indicated that the client "did not want to be a part of any study," or "wanted to get paid."

As shown in Figure 1, and detailed in Table 1, 60% of clients had firm convictions regarding screening for suicide risk. Of those, two-thirds were positive (e.g., "it is good to screen," "everyone should do this," "this can save lives," "this is a good thing," "it helps my therapist know what is going on," "I felt better afterward by letting my therapist know," etc.). A few clients added that it is important to screen for risk around the holidays, while two believed screening around the holidays "could trigger it [suicide]." One-third of client comments were negative (e.g., "this is not helpful," "not comfortable with this," "don't like these questions," "are you going to send me to the hospital?" etc.). Many of the negative comments pertained to screening being irrelevant, and one client mentioned that screening should be done only with "suicidal" clients. Neutral client comments were largely additional information about themselves with no opinion about screening, or general comments (e.g., "it was okay," "I don't care either way," etc.).

Most of the clinicians' comments were neutral, or they included additional information regarding the client or screening system. Forty percent of the clinicians who provided comments had firm convictions about screening; of those, three-quarters were positive (e.g., "feasible," "useable," "easy," "concise," "useful," "helpful," "facilitated dialogue," etc.). Several added that screening led to productive conversations during the session, or further exploration of issues that would not otherwise be disclosed. Few provided feedback on the frequency of screening. Five clinicians and one client indicated that monthly screening was too frequent. Four clinicians suggested that the frequency of screenings should be associated to the occurrence of any client stressors.

One-quarter of clinician comments were negative (e.g., “not feasible,” “not useful,” etc.). In many cases where the clinician had a negative comment, the client’s comment was negative and similar, and nearly all negative comments were associated with what we came to call “clinician dissenters,” specific individuals who expressed strongly held views opposed to any screening process (described more fully in the next section). Central to their negative comments were concerns about obtaining consent, personal liability, and the potential for screening to stimulate *de novo* thoughts of suicide among susceptible clients.

Factors Facilitating or Impeding the Implementation of Screening

Overall, the implementation of routine risk screening went smoothly, and was embraced by the majority of stakeholders. They provided valuable input regarding the screening process. Three factors were most notable in facilitating implementation—SBPC leadership enthusiasm, participant enthusiasm, and ease of use of the screening tool and its related report. Given the coincidence of interests between developing plans for clinical screening and the ideas involved in developing the tool, there was powerful synergy.

The majority of clinicians voiced enthusiasm for the suicide prevention initiative and screening tool. Many were eager to be a part of the process and they clearly wanted to contribute feedback. Some did so immediately regarding the screening tool and the wording on specific items. One site that specializes in Latino populations compiled a workgroup and translated the screening, the assessment, and the clinician report into Spanish. Feedback from six clinicians revealed that they uncovered valuable information that they had not been aware of prior to screening. Spreading knowledge of such experiences provided valuable informal support. Clinicians appreciated the format and ease of use of the screening tool, with its check boxes and summary report for the client chart.

Involving clients at the outset and during the process was beneficial. For example, one client occasionally called the lead researcher to “see how it’s going,” and during the months that followed he served as an information conduit from his involvement with peer groups. He and his peers believed that “loneliness,” “a lack of social supports,” and “holidays and significant anniversaries,” were important factors that clinicians should routinely check. In addition to a feedback mechanism through the clinician report for clients, client advocates as messengers proved most helpful.

Even as the initiative can be viewed—overall—in positive terms, there were several significant barriers to implementation. Several clinicians, who described themselves as “not very computer savvy,” preferred a paper and pencil version, which was accommodated but required the additional burdens of photocopying and data entry—additional tasks that were not well received by clinicians. In retrospect, use of scannable forms would have mitigated this somewhat. Several clinicians noted their busy workload and stated they did not have time to read emails, memos, or notices, which caused some difficulties in notifying them of the study, trainings, visits and other important information.

Among the 153 eligible clinicians, 37 (24%) ultimately did not conduct screening on any of their clients. Of the 116 who did take part, 15 (13%) clinicians did not follow the protocol exactly, as discussed below.

Concerns about screening involved three themes: First, some clinicians indicated that discussing suicidal thoughts or plans might sway suggestible-but-not-currently-suicidal individuals to consider suicide. Second, they worried that seeking consent for release of de-identified data might stoke clients’ fears or enflame paranoid thinking. Third, they expressed marked concerns that their own liability to litigation would be greatly increased because of screening—either for “screen-positive” clients if sufficient actions were not taken in

response to a change in clinical conditions, or for “screen-negative” individuals if someone killed him/herself during the days and weeks following screening.

Fifteen clinicians actively expressed their concern and belief that suicide risk screening was unethical or treatment-contraindicated. Many of these concerns were related to the notion that asking about suicide will cause a suggestible client to perceive that the clinician was advocating suicide as an option. Some opined that screening “was inappropriate, unless the client was suicidal,” “would certainly upset the client by planting the idea,” “was unnecessary and contraindicated particularly for clients who have trauma histories or paranoia,” “was unethical and the [clinicians] as the experts know what is best for their clients.”

In this context the 15 clinicians opposed implementation of the screening process. These clinicians reported increased client “paranoia” involving 19 clients. In every instance, the clinicians had chosen not to follow the protocol of the study. Rather than administer the screening as a clinical procedure followed by seeking consent for sharing de-identified results, they reversed the order that was set forth, seeking consent for screening with the clear input that this was solely for research. In all but one instance the reported “paranoia” focused specifically on the consent process or the mention of a research study, and was not associated with the risk screening itself. According to the involved clinicians, their clients refused to be screened or assessed for suicide risk, and the clinicians claimed they could no longer even discuss suicide because the client associated the topic with research.

The third expressed barrier was fear of liability. Several clinicians were fearful over the inclusion of the clinician report—which summarized the results of the client risk screening, history and recent suicidality, clinician’s assessment of risk, treatment actions taken and process feedback—in the client chart. The major reported concern related to feared liability if they recorded *any* level of risk for a client, followed by an attempt or death, whether hours, a day, a week, a month, or even years after the screening. Many claimed that their clients were “chronically suicidal,” and that some “threatened suicide every day.” Some reported that they would have to “hospitalize everyone,” to protect themselves from potential litigation if something happened in the immediate or distant future. A few, anonymously reported that “it is better to follow the ‘don’t ask, don’t tell’ philosophy,” strictly for liability reasons; and they were quite angered at the requirement to document screening results.

Mitigating Concerns

We undertook several actions to address these concerns voiced by a minority of clinicians, including additional visits and trainings by the first author that involved presentation of additional research findings, particularly those that dispel the belief that asking about suicide will provoke suicidal behavior (Gould, Marrocco, Kleinman, et al., 2005). However, it was clear that despite our 2-hour initial training for the project kick-off and several site visits for additional training, a more comprehensive training program was necessary. To this end, we hosted a full day mental health provider training. This training, titled *Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals*, was developed by staff from the SAMHSA funded Suicide Prevention Resource Center (SPRC) and the American Association for Suicidology (AAS) (SPRC, 2006). In order to accommodate schedules and a large number of clinicians (N=600), we presented six 1-day training sessions across the region during the fourth month of the initiative roll-out, and invited several hundred community providers in New York City.

Desire among clinicians for such training appears to be widespread. During the training cycle and over the month that followed, we received nearly 500 email requests and phone

calls from providers across the States of New York, Connecticut, and New Jersey to sponsor a repeat (or “similar”) event at their facility or in their community. Our conversations and observations with participants revealed that many well-trained professionals shared the belief that asking about suicide would trigger the behavior on the part of the client. We also encountered numerous worries about documentation and liability. These were not concerns isolated to SBPC. In fact, our discussions with workshop leaders from SPRC and AAS stated to us that many clinicians across the country were “shocked” that trainers advocated direct inquiry about suicide risk.

DISCUSSION

Among the clinicians providing feedback about this pilot effort, most reported that screening for factors associated with suicide was useful, feasible, and helpful. Most of their clients—individuals with serious mental disorders—did not object to screening and some saw great value in the effort. A small number of clinicians voiced strong, dissenting views; it was among their cases where we encountered the vast bulk of reported adverse reactions and negative comments from clients. It is possible that adverse reactions and negative comments from clients prompted legitimate clinician concerns. We cannot attribute directionality or causality from our observations. Administrators, clinical directors, accreditation organizations, researchers, and IRBs must carefully consider and accommodate such clinician and client concerns. Our approach involved redoubling educational efforts and allowing a full airing of differing views.

SBPC represented an excellent site for the pilot project, given the administration’s dedication to best practices activities towards suicide prevention, its advanced technology capabilities, and its willingness to partake in trials for the improvement of client care and staff knowledge. Nonetheless, we encountered some difficulties.

Conducting the pilot project reinforced our view that working to build clinician consensus for suicide prevention (of which screening is only one component) is a key element, grounded on repeated, in-depth education. One of our most striking findings was that trained clinicians are not immune from societal-level misinformation. Buttressing clinical skills is an essential element, and in our project the full-day training during the fourth month served to facilitate increased frequency of screening. Additionally, client advocates or peer messengers could be very useful in the education and awareness component of the campaign.

It is noteworthy for future efforts that several clinicians reported that much of the language that was required by our IRB was confusing to many clients (e.g., “... randomly selected which means every client had an equal chance of being chosen,” “... Information provided to the research team will become part of the research records and will no longer be covered by the HIPAA Privacy Regulations. However, all information that identifies you will be removed from the research files,” “Only this authorization form with your signature will have your name on it which will be kept in your chart.”). For such research to be compatible with consumers’ abilities to provide informed consent, it will be essential to work with IRBs to develop language that is readily understood by the subjects involved. This will not be an issue in the future at SBPC, as suicide screening, subsequent to the pilot, has been adopted as a regular clinical practice and is considered protected health information under HIPAA.

Another important finding was the significant impact on clinicians in documentation of suicidal risk and treatment actions taken. Since the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has established suicide prevention as a national patient safety goal (JCAHO, 2007), clinicians have serious and relevant questions about liability

and accountability. Healthcare organizations need to provide clear protocols based on best practices where suicide risk exists based on screening and assessment. It is unreasonable to expect that clinicians can predict precisely what might occur in the future, or to hold clinicians liable and accountable for dynamic conditions in their patients. Instead, best-practice guidelines should recognize the dynamic nature of suicidality and encourage clinicians to routinely screen their clients for increased risk.

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FIGURE 1.
Client and Clinician Comments Regarding Routine Suicide Risk Screening.

TABLE 1

Percentages of Positive and Negative Comments by Clinicians and Clients After Factoring our Neutral Comments

Clinicians		
Positive	31	76%
Negative	10	24%
Neutral	59	
Clients	41	68%
Positive	19	32%
Negative	40	
Neutral		