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Patient Opinions About Screening for Suicide Risk in the Adult Medical Inpatient Unit

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Abstract

As hospital clinicians and administrators consider implementing suicide risk screening on medical inpatient units, patient reactions to screening can provide essential input. This post hoc analysis examined patient opinions about screening for suicide risk in the medical setting. This analysis includes a subsample of a larger quality improvement project designed to screen medically hospitalized patients for suicide risk. Fifty-three adult medical inpatients at a clinical research hospital provided opinions about suicide risk screening. A qualitative analysis of responses to an opinion question about screening was conducted to identify major themes. Forty-three (81%) patients supported screening medical inpatients for suicide risk. Common themes emphasized asking patients directly about suicide, connection between mental/physical health, and the role of screening in suicide prevention. Adult medical inpatients supported screening for suicide risk on medical/surgical inpatient units. Behavioral health clinicians are uniquely poised to champion suicide detection and intervention in the general medical hospital setting. Patient opinions can be utilized to inform thoughtful implementation of universal suicide risk screening in the medical setting.

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Introduction

Individuals with medical illnesses are at elevated risk for suicide.^{1–4} Diagnoses such as cancer, diabetes, HIV/AIDS, lung disease, and gastric ulcers have been associated with increased rates of suicidal thoughts, behaviors, and death by suicide.^{5–11} Symptoms and psychosocial effects of medical illnesses, such as uncontrolled pain, poor prognoses, poor social support, and physical and cognitive impairments, are also correlates of suicidal thoughts and behaviors.^{12–14} Furthermore, death registry studies reveal that individuals who have killed themselves often visit their medical providers months before their death.¹⁵ Therefore, settings that treat medically ill patients represent an important venue for suicide detection and prevention.

In 2010, the Joint Commission (JC) issued a Sentinel Event Alert highlighting the need to detect suicide risk in nonbehavioral health patients in medical settings.¹⁶ Over the past 18 years, nearly 1300 inpatient deaths by suicide have been reported to the JC. Most striking, approximately 25% of these deaths occurred in nonbehavioral health settings such as the emergency department and inpatient medical units.¹⁷ Although the JC has made recommendations to screen medical patients at elevated risk, the specific implementation of suicide prevention strategies has been left up to the discretion of hospitals.

In light of the JC recommendation to broaden screening for suicide risk to include nonbehavioral health patients, determining patient acceptability of screening is a critical next step. Studies have shown that pediatric patients in the emergency department favor suicide risk screening;^{18, 19} however, it is not known how adult patients hospitalized for medical reasons will react to questions about suicide, particularly in the context of medical treatment. The objective of this paper is to describe patients' opinions and reactions to universal screening for suicide risk in an inpatient medical hospital setting using qualitative analysis. Data were obtained from a larger quality improvement project (QIP), Ask Suicide-Screening Questions to Everyone in Medical Settings (asQ'em), which examined suicide risk screening in adult medical inpatients.²⁰ The use of open-ended questions allowed for identification of themes which can be used to assess feasibility and inform how hospitals can implement suicide risk screening and other behavioral health initiatives.

Methods

Patient population

The current findings represent a subanalysis of data collected from the asQ'em QIP.²⁰ The QIP, which incorporated the suicide risk screen into standard of care, was determined to be "exempt" from IRB review by the NIH Office of Human Subjects Research. A convenience sample of 56 adult medical/surgical patients, age 18 years or older, who were admitted to one of three select inpatient units at the National Institutes of Health (NIH) Clinical Research Center (CRC) during a single week in January 2012, were included in this subanalysis. The NIH CRC is a 200-bed clinical research hospital. Patients were excluded if they were unable to communicate fluently in English, were cognitively impaired, or were experiencing acute worsening medical status.

Procedure

As part of the provision of standard care, nurses administered the asQ'em, a two-item suicide risk screening tool, and a patient feedback survey to newly admitted patients on one of three selected inpatient units (oncology, general medical/surgical, and infectious disease). The screening was embedded into the nurses' initial intake assessment; no patients declined answering the two screening questions. The asQ'em was composed of the following items: (1) "In the past month, have you had thoughts about suicide?" (Yes/No) and (2) "Have you ever made a suicide attempt?" (Yes/No). If patients answered yes to either of these two questions, a follow-up question was asked to assess acuity, "Are you having thoughts of suicide right now?" (Yes/No). Of note, the asQ'em tool is not yet a validated assessment instrument; the multisite validation study is underway. The purpose of this analysis was to describe the opinions of medically ill adults about suicide risk screening. A 15-item feedback survey was given verbally by the asQ'em data collector to all patients who participated in the QIP. The following two questions are the focus of this subanalysis: (1) "Do you think all medical/surgical patients in a hospital should be asked about suicide; why or why not?" and (2) "Do you have any additional comments?" Further methodologies and the quantitative results of asQ'em have been described elsewhere.²⁰

Qualitative data analysis

Responses to these open-ended questions were transcribed verbatim and uploaded into NVivo 9.2 qualitative software for coding and content analysis. A group composed of a masters-level clinical social worker (DJS), a research assistant (EL), and an advanced doctoral clinical psychology student (EDB) used grounded theory and open coding, a technique of naming and categorizing phenomena, to analyze the responses.²¹ Two members of the team (DJS and EL) used the open coding procedure to code the comments and to identify themes that emerged from the responses. A constant comparison method was used to refine the codes into larger themes. A third coder (EDB) reviewed the responses and discussed with the team to further refine themes. Eleven themes were established. Interrater agreement was 90.5%. All discrepancies were resolved by discussion and consensus.

Results

Overall, 56 patients ranging in age from 18 to 89 were screened. Three patients were excluded due to emergent medical status changes or early discharge from the hospital. Fifty-three patients (95%) completed the feedback survey and were included in this subanalysis (see Table 1). Patients were 66% female and 62% white; average age was 48.3 years (± 19.5 years). Patients were recruited from the following units: 45% general medical/surgical, 38% cancer, and 17% infectious disease. Four of the 53 patients in this sample screened positive for suicide risk necessitating follow-up mental health evaluation.

Of note, 98% of patients reported the experience of being screened for suicide risk as either positive (79%) or neutral (19%). Only one patient reported the experience as negative; this patient screened positive on the asQ'em screen. The remaining three patients who screened positive did not report the experience as negative. Further, 81% of patients reported that they believed all medical/surgical patients in a hospital should be screened for suicide risk; 9.5%

disagreed, and another 9.5% reported they “don’t know.” Reactions to being screened for suicide risk in this subsample are presented in Table 2.

The three most common themes that emerged from the qualitative analysis included the following: (1) patients should be asked directly about suicide; (2) mental health should be an integral component in the delivery of medical care; and (3) importance of intervening, protecting, and keeping patients safe in a hospital setting. Descriptions of the themes as well as quotes from the patients follow.

Patient reactions to screening for suicide risk: major themes

The most commonly identified response was the importance of asking patients directly about suicide in order to detect a problem which might otherwise have remained hidden ($N=39$; 74%). Comments indicated that patients may not spontaneously offer information about suicidal thoughts or behaviors unless asked openly.

“The questions will help you help them. You can’t read a person’s mind. You don’t know what they are thinking until you ask.”

– *an 89-year-old man admitted to the oncology unit*

“I think anyone should be asked. You never know who has thoughts. [You] don’t want to miss one. You could save a life by asking.”

– *a 20-year-old man admitted to the medical/surgical unit*

“It’s never crossed my mind, but you have to ask for people who may be hiding something.”

– *a 45-year-old woman admitted to the oncology unit*

Another major theme that emerged from this analysis was the notion that mental health should be an integral component in the delivery of holistic care to the medical patient in a hospital setting ($N=31$; 59%). Patients recognized that medical illness can significantly impact not only physical well-being, but also psychological well-being. Many patients felt that both physical and emotional functioning should be monitored in the hospital setting.

“I think it’s such an emotional strain to be in a situation where you are vulnerable. Hospitalization is when you feel the most vulnerable and scared.... If you are predisposed [to suicidal thoughts], it could tip the scale and ... this could be the kind of intervention that helps.”

– *a 48-year-old woman admitted to the medical/surgical unit*

“It’s important that it is coming from a health care professional. If they are in this setting [hospital] they are very ill. Facing death, mortality. Asking and honesty are key.”

– *a 43-year-old woman admitted to the infectious disease unit*

“Medical patients may be stoic.... With all of the emotional stuff going on ... patients may feel like they have to keep it together....”

– *a 48-year-old woman admitted to the medical/surgical unit*

Patients also expressed their belief that asking suicide screening questions could lead to intervention, protection, and safety ($N=24$; 42%).

“Because I think that we know risk for suicide is a chronic illness. In a hospital, patients are more likely to be depressed. It’s an opportunity for intervention.”

– a 32-year-old woman admitted to the medical/surgical unit

“Because I think that anyone should be asked. You never know who has thoughts. You don’t want to miss one. You could save a life by asking.”

– a 20-year-old man admitted to the medical/surgical unit

“It’s hard to generalize, but it can’t hurt to ask. If there is a 1/1000 chance that you catch somebody, it’s worth a little awkwardness.”

– a 63-year-old man admitted to the oncology unit

“When you are in a hospital, people are there to help you.”

– a 64-year-old woman admitted to the oncology unit

Related to this intervention theme, several patients alluded to the responsibility the health care system would have after asking about suicide.

“When asking these kinds of questions, you have to make sure you have the help once you open the door.”

– a 40-year-old woman admitted to the oncology unit

Additional findings

In addition to these major themes, other topics were less frequently reported. Nine patients (17%) mentioned in their responses that they knew someone who died by suicide. One patient suggested that mental illness and suicide can be hereditary and repetitively seen in families thus requiring additional oversight and monitoring.

“I watched my cousins’ children after he died by suicide [because] I have learned that it [runs in families].... medical patients... may need someone to check in with them.”

– a 48-year-old woman admitted to the medical/surgical unit

Eight patients (15%) connected suicide risk screening to stigma around mental health. Patients mentioned concerns related to the rising rates of mental disorders, particularly with regard to military personnel returning from active duty overseas. Several patients commented that while suicide has been traditionally seen as a “taboo” topic, there appears to be growing national awareness around the rising problem of suicide. They noted that this has helped to de-stigmatize mental illness more generally and suicide in particular.

“Twenty years ago people didn’t want to talk about cancer [and we’ve come a long way since then]. Hopefully, the same could be true in 20 years for suicide.”

– a 63-year-old woman admitted to the oncology unit

“Several patients touched on the importance of screening for suicide not only in the adult setting, but in children and extending to the entire family as well.”

“[Suicide screening] would be good for little kids. It strikes all ages and [screening] would open up a dialogue in the family and has a ripple effect.”

- a 64-year-old woman admitted to the oncology unit

Concerns about screening for suicide risk

Five patients (9%) did not agree with universal suicide risk screening. Four suggested that screening may not be relevant for all patients, stating that it “depends on the case.” One patient remarked about the timing of screening: “People feel fragile waiting for serious surgery and that would not be the time to ask.” Additionally, three patients had concerns about being stigmatized or treated “differently” by staff if they screened positive for suicidal ideation. Specifically, one patient who screened positive for suicide risk stated it “made me feel as though [the medical team] would put me in a different category than the person not having these difficulties. They are going to think I’m cuckoo.” Some patients felt that screening for suicide risk should occur only in those cases where there was a “warning sign” or some clinical indication in the form of behavior, expressed thoughts, clinical history, or certain risk variables like low levels of social support. One stated: “It was not expected. Am I here for my lungs or my mental health?”

Discussion

In a qualitative analysis subsample of a larger QIP, adult medical inpatients supported screening for suicide risk during a medical hospital stay. When asked to elaborate on their opinions about screening, patients highlighted the importance of directly asking about suicide. As a second theme, they emphasized the link between physical and mental health as part of comprehensive hospital care. Lastly, the importance of connecting screening to suicide intervention and prevention efforts was underscored. These responses provide further support for asking about suicide in medical settings, if implemented carefully and thoughtfully.

In the first identified theme, patients reported that if medical patients are not asked directly about suicide, they may not talk disclose these thoughts to the healthcare providers. This theme supports findings from prior research that psychiatric symptoms often go unrecognized and untreated in medically ill populations^{1–4} as well as research recommending the development of suicide risk screening instruments for the medically ill.^{22, 23}

Raising awareness and comfort about mental health screening is not only important for patients with medical illness, but also critical for health care professionals. As part of the implementation of the asQ'em QIP, in-service trainings with nurses, social workers, and physicians, provided by multidisciplinary members of the behavioral health team, were vital for raising awareness and increasing knowledge about suicide risk in the medical setting (see Horowitz et al., 2013). Furthermore, a carefully scripted paragraph introducing asQ'em was

created to reduce discomfort both with the patient participants and the nursing staff who administered the risk of suicide screening questions (see Fig. 1).

Another major theme that emerged was the notion that medical illness and mental health are inextricably linked and as such should be integrated into the holistic care of the hospitalized medical patient. It is common for patients to present to their primary care providers with somatic complaints that may be a marker for psychological distress like depression, anxiety, and suicidal thoughts.²⁴ In fact, there has been a growing trend in hospitals and primary care settings to identify socio-behavioral problems such as screening for depression and distress, domestic violence and alcohol use or dependence.^{25–30} Therefore, identification of suicide risk could be incorporated into comprehensive care for medically hospitalized inpatients.

Patient opinions highlight the importance of suicide risk screening in order to intervene and provide safeguards for patients who might be harboring suicidal thoughts and behaviors. As stated by the patients, once the “door is opened” to talk about suicide, health care providers will have the responsibility to respond. In the case of acute suicidal risk, this may include an emergent assessment by behavioral health staff, including possible one-to-one observer status or psychiatric hospitalization. If an assessment indicates a more chronic risk of suicide, linking the patient with outpatient mental health resources may be more appropriate. Of note, medical patients at elevated risk for suicide may require additional assessment and attention after major medical procedures or events, such as communication of a new diagnosis or poor prognosis. Guidelines around suicide risk assessment and care have been published^{31–33} and likely need modification for use in medical settings.

Limitations of this analysis include the fact that data was collected using a small convenience sample of patients from a single setting as part of a QIP. Furthermore, as this setting is a clinical research hospital, it is important to recognize that participants who enroll in clinical trials represent a self-selected subsample of medical patients. Responses may not generalize to other nonresearch settings. In addition, non-English-speaking patients were excluded; this is an important population to assess opinions of in future studies. Lastly, the qualitative analysis was conducted on open-ended responses to a single question, and responses were often brief. Further qualitative analyses using more in-depth interviews or focus groups may have elucidated additional themes.

Conclusions

Qualitative findings suggest that adult hospitalized medical patients support suicide risk screening. The importance of asking directly the connection between physical and mental health as well as the critical role of follow-up interventions were emphasized. Patient opinions lend further support for the implementation of universal suicide risk screening and prevention strategies in medical hospital settings.

Implications for Behavioral Health

With support from medical patients for suicide risk screening, hospital systems can begin to take the next steps in acting on the Joint Commission’s recommendation for screening in the general medical setting.¹⁶ Risk of suicide screening will create opportunities for behavioral

health clinicians to work collaboratively with nonpsychiatric staff on inpatient medical units in several ways. Targeted education about the importance of early detection and training on how to respond to positive screens may reduce discomfort in managing suicide risk in the general medical setting. Effective implementation of suicide risk screening will require coordinated effort with key hospital-based stakeholders including behavioral health nursing, social work, and psychiatry. Behavioral health nurse champions can help bridge relationships between nursing administration and staff nurses in regards to mental health concerns. Hospital-based behavioral health clinicians can position themselves to take an active role in the evaluation of patients who screen positive and to manage acute psychiatric needs. Furthermore, linking at risk patients with community mental health resources will require a coordinated effort with behavioral health staff taking the lead.

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Please say to the patient: “We are working to improve patient safety in the hospital. Sometimes, people with medical illnesses experience emotional distress and even have thoughts of ending their own life that they keep to themselves. We, as healthcare providers, believe we can help. Therefore, the next set of questions has to do with the sensitive topic of suicide. We are asking you these questions because of a new patient safety initiative and are currently asking these questions of all newly admitted patients on this unit.”

Figure 1.
The script for nurses who administered the asQ'em²⁰

Table 1

Demographics of QIP patients

Pilot patients	
Demographics	<i>N</i> (%) [total = 53]
Diagnosis	
General med/surg	24 (45%)
Cancer	20 (38%)
Infectious disease	9 (17%)
Age, mean (SD)	48.3 (19.5) years
Range	18–89 years
Gender	
Female	35 (66%)
Race	
Caucasian	33 (62%)
African-American	13 (25%)
Other	7 (13%)

Table 2

Overall reactions to suicide screening in an inpatient hospital setting in subsample used in qualitative analysis

Overall, how would you rate your experience of being screened for suicide: positive, neutral or negative? <i>N</i> (%)	
Positive	42 (79%)
Neutral	10 (19%)
Negative	1 (2%)
Do you think all medical/surgical patients in a hospital should be asked about suicide?	
Yes	43 (81%)
No	5 (9.5%)
Don't know	5 (9.5%)