Published in final edited form as:

Jt Comm J Qual Patient Saf. 2018 January ; 44(1): 1–3. doi:10.1016/j.jcjq.2017.11.001.

Universal Suicide Risk Screening in the Hospital Setting: Still a Pandora's Box?

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Suicide is a global public health concern. More than 44,000 Americans die by suicide every year, making it the 10th leading cause of death in the United States.¹ Screening for suicide risk in general medical health care settings is likely to be an essential component of effective suicide prevention efforts, for multiple reasons. For example, more than 80% of suicide decedents had contact with a health care provider in the year prior to their death.² Suicides occurring within hospitals, while relatively rare in absolute terms, are the fourth most frequently reported sentinel event to The Joint Commission and are properly considered “never events.”³ In addition, youth may present to a health care setting with occult suicide risk before having any known history of mental health problems.

Physical illness is a commonly overlooked risk factor for suicide. Medical patients often experience significant stressors, such as feeling like a burden to family; having concerns such as potential loss of employment or medical bills; or feeling alone and isolated. These powerful stressors can increase suicidal thoughts in vulnerable patients, particularly individuals who have a history of suicidal thoughts or behaviors. Thoughts of suicide are important to assess, especially in patients without known mental health disorders. For

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Disclaimer. The views expressed here are those of the authors and are not necessarily those of the National Institute of Mental Health, the National Institutes of Health, or the federal government.

Conflicts of Interest. All authors report no conflicts of interest.

example, the vulnerability for suicide risk among individuals with cancer is highest in the first month after diagnosis,⁴ highlighting the critical need for early detection.

Sentinel event data reveal that about a quarter of hospital suicides reported to The Joint Commission through 2010 occurred on nonbehavioral health units such as medical/ surgical units, the ICU, and the emergency department (ED).⁵ In 2016 The Joint Commission issued *Sentinel Event Alert* 56, which recommends that health systems consider evaluating suicide risk in all patients and all settings.⁶ Without existing evidence-based guidelines for implementation of suicide risk screening protocols, hospital systems have been hesitant to proceed. A faulty screening program could lead to either underdetection or overdetection, resulting in over-taxing already strapped and often scarce mental health resources.

The article “Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System”⁷ by Kimberly Roaten and colleagues, in this issue of *The Joint Commission Journal on Quality and Safety*, is timely and exemplary. Roaten et al. report how Parkland Health and Hospital System (PHHS; Dallas) effectively implemented universal suicide risk screening housewide in a large, urban safety-net hospital.

Interestingly, the impetus for PHHS to start suicide risk screening began with a Joint Commission accreditation survey citation. A patient with a substance use disorder was not given an adequate suicide risk assessment—an infraction of National Patient Safety Goal (NPSG) NPSG.15.01.01, Element of Performance (EP) 1, which requires evaluation of suicide risk among all patients in psychiatric hospitals, and among psychiatric patients in general hospitals.⁸ This focus excludes individuals with occult suicide risk, including those with no prior history of psychiatric issues, which may be particularly relevant for youth, as well as patients who may have a history of psychiatric concerns that are not readily observable by clinical staff at the time of presentation and triage. NPSG.15.01.01, EP 1, has been challenging for hospitals to navigate because mental health/substance use disorders are not always known or easy to detect without screening. Some clinicians may not even recognize substance abuse as a “mental health disorder.” PHHS should be applauded for its forward, patient-centered thinking that, as Roaten et al. describe, “exceed” NPSG.15.01.01, EP 1, in planning to expand the screening to all medical patients, providing an excellent model for hospitals across the United States.

Roaten et al. report that the screening initiative at PHHS began with overcoming roadblocks such as concerns from hospital administrators “that it would be an overwhelming undertaking.”⁷ (p. **) With support, vision, and commendable commitment from senior leadership, PHHS convened a leadership committee to gather information and develop plans to educate staff. Following a standard quality improvement (QI) methodology, the PHHS team was able to implement an effective, carefully planned process for a system that manages more than one million patient encounters a year.

Roaten et al. offer preliminary data that can be used to combat one of the biggest barriers to screening—the worry of excessively high positive screen rates that the hospital system would not be able to manage. This fear of “opening Pandora’s box” was not realized. Overall, 96% of the patients screened were negative for suicide risk. Positive screen rates

varied by setting, with approximately 1% on the inpatient unit, 2% in the outpatient clinics, and 6% in the ED. Anecdotal evidence suggests that the screening was not disruptive to hospital work flows, which is consistent with published data on screening in primary care,⁹ and that it linked thousands of individuals with much-needed mental health care.⁷

Often, a major hurdle for hospitals to implement screening is the concern regarding lack of resources for patients who screen positive. PHHS hired additional resources to manage the positive screens. Although some hospitals may face budgetary and/or logistical barriers to hiring mental health specialty staff for psychiatric evaluation of positive screens, there may well be a net economic benefit for health systems and payers in doing so—in terms of provider satisfaction (as, indeed, Roaten et al. report), more effective and cost-effective patient disposition, and improved risk management. These are important areas for future investigation.

One key insight of PHHS's experience is that a positive primary screen did not necessarily lead to involuntary detainment and acute safety precautions as the default. Screening would be infeasible if every positive primary screen were placed in a "safe room" or required a "constant observer." For example, the most potent risk factor for suicide is past suicide attempt.^{9,10} Data revealed that about one third of the patients screened positive for past suicidal behavior.⁷ The brief safety assessment that follows screening would determine if the past behavior requires further follow-up during the visit. Treating all positive primary screens as requiring psychiatric hospitalization is a common misinterpretation of a primary screening instrument that hampers screening programs. As Roaten et al. advise, the primary screener should be very brief and designed to flag patients requiring further assessment. A key element of the PHHS approach was a secondary safety assessment conducted by social workers, which confirms risk and guides next steps. This stepped approach is critical for effectively managing positive screens without disrupting treatment work flows.

Roaten et al. highlight education as a critical part of the implementation for all disciplines, including nurses, physicians, and other clinical staff. For example, social workers initially had significant concerns about bearing the responsibility for independent evaluation of patients who screen positive but became very comfortable after participating in the training. Also, as Roaten et al. describe, an important technique that helped ensure nursing compliance with screening involved embedding the screening instrument into the electronic health record (EHR), which allowed the screening program to be seamlessly integrated into nursing work flows. This was of paramount importance, as it made screening more feasible and user-friendly. Many of the larger EHR vendors are currently working on integrating validated suicide risk screeners into their platforms.¹¹

Perhaps this PHHS initiative could mirror other successful mental health detection projects, such as the Perfect Depression Care program, which started from ground zero in the Department of Psychiatry at the Henry Ford Health System because of need and is now a nationally utilized evidence-based model for depression treatment and suicide prevention in health care settings.¹²

There are two limitations of the Roaten et al. study to consider. First, the patients were not divided by chief complaint (that is, medical versus psychiatric), which does not allow for a calculation of the true prevalence of medical patients with occult suicidal thoughts; nevertheless, we can assume that it would have been lower than the reported rate of 4%, which included patients with psychiatric chief complaints. Second, while PHHS had the resources to add “enough social workers to meet the clinical needs of the patients identified by the screening process,”^{7(p. 22)} most institutions may not. However, reorganizing to manage positive screens and treat mental health concerns with the same dedication as physical concerns is imperative to reducing the increasing suicide rate.

The suicide risk screening task force at PHHS should be recognized as trailblazers in suicide prevention in the medical setting. The PHHS experience suggests that universal suicide risk screening is feasible in a large, diverse public hospital, with the potential of saving many lives, and does not represent the opening of a Pandora’s box. PHHS heeded a critical call to action, increased its mental health resources to manage additional positive screens, and efficiently coordinated the disposition of patients. Further studies with prospective follow-up data will be important to provide additional evidence regarding the logistics and effectiveness of screening.

Reducing the suicide rate is a national imperative that requires proactive methods for identifying and treating individuals at risk. Current practice generally misses those with occult risk—that is, who may only disclose suicidal thoughts/behaviors if they are asked directly. PHHS has taken an important step in documenting the feasibility and value of adding universal suicide risk screening in the inpatient, outpatient, and emergency care settings, allowing for identification of such occult cases. In doing so, PHHS provides an exemplary model that other health systems could follow to increase the chance that individuals who are struggling in silence may be recognized and treated.

Acknowledgments.

The authors thank Eliza Lanzillo for her assistance with manuscript preparation.

Funding. The writing of this editorial was supported (in part) by the Intramural Research Program of the NIMH.

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