



Suicide risk among urban children

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ABSTRACT

Objective: This study examines how socio-demographic and clinical characteristics influence suicide risk among a large, urban sample of children (ages 12 and younger) receiving Psychiatric Emergency Services (PES).

Methods: Bivariate and binomial logistic regression analyses were employed to analyze data for a sample of 951 urban children presenting for pediatric PES.

Results: Approximately 17.2% of patients presented had a history of suicidal thought and behavior. Despite the larger number of black children presenting for PES, we found no significant difference in suicide risk across ethnic group, though the prevalence rates were increasingly higher in Whites, Latinos, and Black respectively. Of those presenting with suicidality: 65.1% were diagnosed with a behavioral disorder, 26.3% were diagnosed with a mood disorder, 3.8% with a psychotic disorder, and 4.8% with another disorder. About one in ten suicidal cases admitted to prior child abuse. Furthermore, patients admitted to the hospital for suicidality were more likely to be female, to have a mood disorder, and to be appropriately discharged to an inpatient setting following initial hospital care. **Conclusions:** The study points to the importance of screening publically insured (Medicaid) urban children experiencing psychological distress regardless of ethnicity and age for suicide risk. Clinicians should consider these findings when working with children in psychiatric crisis.

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1. Introduction

Suicide is surprisingly prevalent among preadolescents. According to the Centers for Disease Control and Prevention (2016a, 2016b), suicide was the sixth leading cause of death for children aged five to 12 (Centers for Disease Control and Prevention, 2016a). Moreover, the most recent data on suicide rates for children aged five to 14 shows a steady increase from 2008 to 2013 where this group experienced a rate of change of 100% from 2008 to 2013 (Xu, Murphy, Kochanek, & Bastian, 2016). Additionally, the CDC fatal injury reports shows another increase in suicide rate for children aged five to 12 with a rate of change from 2013 (0.31) to 2014 (0.36) of about 16% (Centers for Disease Control and Prevention, 2016b). This is alarming in and of itself but also because suicide risk increases with age where suicide is now the third leading cause of death for children ages 10 to 14 (Heron, 2016). Furthermore, recent research on the suicide rate for children under age 12 reveal a markedly higher and statistically significant 86% increase

in suicide among Black children in contrast to whites and Latinos (Bridge et al., 2015). Yet, there is little empirical data to explain ethnic differences in children's suicide risk.

The importance of understanding the risk of suicide during childhood is essential given the well-documented link between childhood suicidality and suicidal behavior in adolescence, (Borchardt & Meller, 1996; Jackson & Nuttall, 2001; Lewinsohn, Rohde, & Seeley, 1994; Pfeffer et al., 1994) and the link between childhood suicidal ideation and adult psychosocial functioning (Steinhausen & Metzke, 2004). For instance, stressful life events are correlated with both pediatric non-fatal suicide attempts (Fergusson, Woodward, & Horwood, 2000) and suicide (Beautrais, 2001; Brent et al., 1993; Gould, Fisher, Parides, Flory, & Schaffer, 1996; Marttunen, Aro, & Lönnqvist, 1993). In particular, physical abuse during childhood increases the risk of suicide (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999; Johnson et al., 2002; O'Leary et al., 2006) and sexual abuse during childhood increases suicidal behavior (Johnson et al., 2002; Silverman, Reinherz, & Giaconia, 1996) when controlling for other risk factors (Fergusson, Horwood, & Lynskey, 1996). It has been found that in an urban sample of children, suicidal ideation was also associated with exposure to or witnessing of violence and distress (O'Leary et al., 2006).

The research on children's non-fatal suicidal behavior is growing, but studies with urban samples and ethnic minority populations are seldom. A prior study with an urban sample of Latino and Black children

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found that self-reported depressed mood is linked to future suicide attempts, (O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004; Guiao & Esparaza, 1995) particularly for females (Ialongo et al., 2004). Furthermore, risk-taking and aggressive behaviors can predict pediatric suicidal behaviors (Price, Dake, & Kuchareqski, 2001; Garrison, McKeown, Valois, & Vincent, 1993). This literature, however, includes few subjects under age 12, is often based on small samples (<60 subjects), and tends not to include Black or Latino children. A closer examination of the children's suicide literature expose notable shortcoming often due to small sample size, omission of ethnic minority children, dated scholarship, and studies including too few variables known to be associated with suicide risk. Specifically, there is a dearth of knowledge about Black and Latino children suicide risk factors and estimates of their pattern of non-fatal suicidal behaviors (Joe, 2008). This study seeks to address these noted gaps in the children suicide literature and present data for children using a large urban clinical sample.

We examine the non-psychological (e.g., demographic) and clinical diagnostic profile of suicidal and non-suicidal Black, White, and Latino children presenting at an urban pediatric psychiatric emergency (PES) service in a mid-Atlantic city.

2. Methods

2.1. Setting

The Albert Einstein Medical Center's Crisis Response Center (CRC) is the only center designated by the county office of mental health in Philadelphia to provide PES to children and adolescents. The CRC remains a comprehensive PES, providing triage, assessment for psychiatric and drug/alcohol problems, crisis treatment, referral services, and linkage follow-up. It is not bounded by catchment area and is open 24-hours a day, 7-days a week. About 78.4% of the children and adolescents seen are covered by county-funded medical assistance insurance. This study focused on the 981 children (ages 12 or younger) presenting to the CRC during a one-year period (October 1, 2001 and September 30, 2002).

2.2. Sample

Data for this study of ethnic group differences in the patterns and risk of suicidal behavior was restricted to 951 CRC patients who were Black, White, or Latino and under 12 years of age. Asians and other minorities totaled to <30 and were not included in the analyses, because including them in subgroup analysis would yield unreliable estimates. All patients were parent or self-identified as Black (i.e., African American), White, or Hispanic/Latino. The medical record data for each visit was abstracted and the personal identifier removed. To avoid duplication, analyses included only data for patients' first visit among those who had multiple CRC visits during the study period, to reduce the potential adverse effect of clustering or non-independence of visits within patients.

2.3. Measures

The demographic information abstracted from patient records included age (continuous and categorical groups), gender, ethnicity (Black, White, Latino, and other), and a proxy for socioeconomic status (whether the patient had public, private, or no insurance). In addition the patient's history of physical and sexual abuse, presence of substance abuse, and discharge plan was noted.

2.3.1. Suicide risk outcomes

The patient's suicidality was noted in the chart and coded for this first set of analyses as a dichotomous variable consisting of visits that were suicide-related (e.g., a current or past suicide attempt, suicide planning, suicide ideation w/no plan) or non-suicide related. The

notes for suicidality refer only to the initial visits of children that had multiple visits. If a suicide attempted was currently active or there was any history of a past serious attempt, it was noted in the medical chart, thus included in the data. Other information regarding follow up visits after the index visit to the CRC was not documented in this data set. The suicide risk level outcome was constructed from the initial visit medical records and was coded as an indication of suicide risk on a five-point scale from no suicide risk, to ideation with or without a plan, to a history of suicidal behavior (i.e., serious past or present attempt). All clients included in the current analysis had at minimum a recent history of suicidal ideation, so the recoded scale had a four-point range from suicidal ideation (0) to serious past or present attempt (Centers for Disease Control and Prevention, 2016b).

2.3.2. Arrival status & time

Arrival status refers to whether a patient presented on a voluntary or involuntary basis. Voluntary patients presented with their caregivers in the absence of legal force, while involuntary patients presented due to the application of some legal force. In Pennsylvania, a person may be subject to involuntary psychiatric examination and treatment if he/she presents with a severe mental illness such that a clear and present danger to harm self or others exists (PA Mental Health Procedures Act 143, 2014). The physician must examine a patient who is brought in under an involuntary commitment petition within 2 h. During this time, the physician must decide whether to uphold the petition, in which case the patient will be involuntary committed to an inpatient facility or not uphold the petition, in which case the individual is discharged and may be referred to treatment in the community.

2.3.3. Psychiatric diagnoses

Diagnostic variables were based on the patient's recorded Axis I DSM-IV diagnoses (American Psychiatric Association, 2000) as determined by the evaluating psychiatrist and were collapsed into the following categories: psychotic disorders, mood disorders, (e.g., major depressive disorders, bipolar disorders) behavioral disorders (e.g., conduct, impulsive, oppositional, attention deficit/hyperactivity), alcohol/substance abuse disorders, and other disorders/problems (e.g., anxiety disorders adjustment disorders). The category "other disorders/problems" included developmental disorders (e.g., autism), and V codes for relational disorders, learning disorders, abuse, and miscellaneous problems, which accounted for a small number of cases. The other eight diagnostic categories were separated out because they may require more clinical discretion and have been examined in previous studies on racial/ethnic disparities in diagnostic and disposition decision-making. The medical record notation of comorbid DSM-IV diagnoses was incomplete, precluding the use of comorbid diagnoses in the analysis. Patient GAF score was also recorded to measure psychological, social and occupational functioning and severity of impairment (American Psychiatric Association, 2000). Although the GAF rating criteria are often described in nine broad categories, researchers have combined GAF scores into fewer categories (Moos, Nichol, & Moos, 2014). Accordingly, we classified patients by using three categories of GAF scores: 1 to 40, pervasive impairment; 41 to 60, serious impairment; 61 to 90, moderate to low impairment.

The Albert Einstein Medical Center and the University of Pennsylvania Institutional Review Boards granted approval of the protocol for medical records review. Because this is a retrospective review, the clinicians had no knowledge of the study at the time the evaluation information and diagnostic and disposition decisions were recorded. Data were derived from PES databases designed for billing, monitoring quality outcomes, and other standard procedures.

2.4. Statistical analysis

Bivariate and logistic regression analyses were employed to analyze data to document the incidence and patterns of suicidal behavior and

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