



The development and implementation of a brief intervention for medically admitted suicide attempt survivors[☆]



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ABSTRACT

Objective: The current study endeavored to establish the feasibility and acceptability of a brief intervention for medically admitted suicide attempt survivors.

Method: Fifty patients admitted to a Level 1 trauma center were recruited following a suicide attempt. The first 10 patients provided information on what constituted usual care, which in turn informed the creation of the intervention manual and research design. The next 10 patients informed refinement of the intervention and research procedures. The final 30 patients were randomized in a pre-post research design to receive the teachable moment brief intervention plus usual care or usual care only. Patients were assessed prior to randomization and 1 month later by blinded research assistants. Outcomes included patient satisfaction, readiness to change problematic behaviors, reasons for living, and suicidal ideation.

Results: Patients rated the brief intervention as “good” to “great” on all items related to client satisfaction. Significant group \times time interactions were observed for readiness to change ($\beta=9.02$, S.D.=3.73, $P=.02$) and reasons for living ($\beta=29.60$, S.D.=10.22, $P=.004$), suggesting greater improvement for those patients who received the brief intervention.

Conclusions: Patients admitted to an acute inpatient medical setting may benefit from a brief intervention that complements usual care by focusing specifically on the functional aspects of the suicide attempt in a collaborative, patient-centered manner.

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1. Introduction

The National Action Alliance for Suicide Prevention has set a goal of reducing suicide attempts and suicide deaths in the United States by 20% in 5 years and 40% in 10 years [1]. To achieve this goal, prevention strategies must be realistic and sustainable. Interventions intended for high-risk populations [2] must take into account patient, provider, and setting level contextual factors, where new skills are expected to be quickly learned and adopted by care providers, valued by patients, and fit within the culture of specific clinical settings [3]. One such high-risk population is suicide attempt survivors hospitalized in acute care inpatient medical settings, which represent approximately 317,000 hospital admissions and \$3.5 billion in total medical costs annually [4]. Previous research suggests significantly elevated rates of suicide (Odds Ratio=56) [5] and subsequent hospitalizations for self-directed violence (Relative Risk=175) [6] for those previously hospitalized for injuries sustained during a suicide attempt. Information is lacking on the emotional impact of treating suicide attempt survivors in hospital

settings. Previous studies do indicate that general hospital staff often view patients admitted for self-directed violence in a negative manner compared with clinicians in psychiatric hospital and community settings [7]. As elucidated in a review of emergency staff reactions to suicidal and self-harming patients, implementation of evidence-based approaches may assuage clinician anxiety and negative perceptions when interacting with suicidal patients [8].

The population of suicide attempt survivors treated in acute inpatient medical settings is heterogeneous in nature, ranging from those who made a non-lethal attempt with little intent to die to others treated for a serious, premeditated suicide attempt meant to result in death. As such, discharge planning will vary based upon multiple factors, including medical coverage, resource allocation, and patient motivation and insight to engage in mental health services. While patients stabilize physically, care providers could take advantage of the time (median=4 days) [9] spent on medical/surgical floors by engaging them in a brief intervention targeting their suicidal ideation. The timing of such an intervention matches behavioral medicine research supporting a sentinel event effect (i.e., teachable moment), where patients demonstrate greater openness to new information and elevated motivation to reduce problematic health behaviors when engaged shortly after a cueing event [10,11]. As purported by Boudreaux and colleagues [10], the factors associated with short-term behavior change following a

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cueing event may differ to varying degrees from those factors associated with more distal gains. Following a suicide attempt, proximal factors may include fostering self-acceptance, insight, restoring hope for the future, and increasing motivation to engage in evidence-based treatment to acquire new skills to address the issues that uniquely underlie their recent attempt and suicidal ideation. The distal factors may consist of maintaining adherence to an outpatient suicide-specific treatment plan, strengthening social bonds, and enhancing self-efficacy to create one's future.

Previous research has applied the conceptualization of a teachable moment to non-suicide related phenomena, such as smoking cessation [11], where the cueing event may be a visit to the emergency department for an exacerbation of a child's asthma, which in turn leads a parent to forgo future smoking after facing the impacts of second hand smoke. As described by McBride and colleagues [11], a cueing event is associated with a multi-faceted interpretation, which may in turn lead to greater desire to initiate changes in order to reduce problematic health behavior. This conceptual framework can readily be applied to a suicide attempt, which has the potential to increase an individual's emotional state, sharpen perceptions regarding risks and positive outcomes associated with personal choices, and add clarity to social role and self-concept, such as "I am a spouse, father, and/or son." The overall perceived impact of the suicide attempt is associated with elevated motivation, hope, insight, and acceptance, which may prove effective in reducing proximal risk during a particularly lethal window of time for suicide when patients are being admitted to inpatient psychiatry units and/or returning to the community [12]. Acquiring new skills through outpatient treatment, enhancing self-efficacy through recovery, and deepening and expanding social connection are theorized to prolong remission from self-directed violence. Thus, intervening on medical/surgical floors may lead to more effective use and engagement in subsequent inpatient and outpatient mental health services to prevent subsequent suicide attempts and emergency services.

The current study aims were informed by the Phase 1a/b treatment development framework described in Leon, Davis and Kraemer [13] wherein we sought to refine and pilot a treatment manual and adherence measure, while also measuring the feasibility and acceptability of screening, recruitment, randomization, and assessment procedures. Additionally, we sought to examine trajectories across 1 month on outcomes of interest between patients who received the brief intervention and those who did not.

2. Material and methods

2.1. Participants

Fifty patients medically admitted to a medical/surgical floor of a Level 1 trauma center were recruited following a suicide attempt. Patients admitted for self-directed violence without intent to die (i.e., unintentional overdose, non-suicidal self-injury) or who denied making a suicide attempt were excluded from the study. To better understand usual care for suicide attempt survivors in acute inpatient medical settings prior to beginning the intervention development phase, the first author completed immersive-observation of 10 suicide attempt survivors for up to 8 h per day for two days, which involved separately interviewing patients and their psychiatric care providers. Findings from this initial phase suggest that hospital providers prioritized: a) assessing risk of suicide while in the hospital and during the immediate post-hospitalization period, b) determining whether inpatient psychiatric admission is needed, c) conducting a clinical interview to determine diagnosis and relevant treatment options, and d) providing suggestions on short-term risk management strategies, including medications and behavioral approaches. Notably absent was direct intervention regarding the unique factors underlying and leading up to the recent suicide attempt, such as their beliefs about unburdening others, feelings of isolation, and potential vulnerability to

extreme emotion dysregulation. Short-term risk management strategies utilized focused more on keeping the patient safe than addressing what was actually making them suicidal.

The next 10 patients informed the refinement of the initial treatment protocol, adherence rating measure, and study procedures and were not included in the analyses. The next 30 patients were randomized to receive the teachable moment brief intervention plus usual care or usual care only to assess feasibility of the randomization procedure [13], not with the intention of measuring efficacy of the intervention. All study procedures were approved by the University of Washington Institutional Review Board. The study is registered with ClinicalTrials.gov (NCT01355848).

2.2. Measures

2.2.1. Suicidal ideation and behavior

The Scale for Suicide Ideation is a 19-item assessment used to evaluate the current intensity of the patient's specific attitudes toward, behavior, and plans to commit suicide. The measure has been the primary outcome measure in several trials targeting suicidal patients and has evidence of strong psychometrics ($\alpha = .88$) [14]. The Suicide Attempt Self-Injury Count is a brief two-page instrument for determining the first, most recent, and most severe suicide attempt or non-suicidal self-injury. The Suicide Attempt Self-Injury Count also collects information on the date of attempt/self-injury, method used in index and previous attempts according to the definitions of Linehan et al. (e.g., using definitions of self-inflicted injuries which include situations of actual tissue damage and situations where tissue damage would have occurred except for outside intervention or sheer luck [e.g., firearm jammed]) [15], intent to die (i.e., intent to die, ambivalent, no intent to die), highest level of medical treatment received, and lethality [16]. The Reasons for Living Inventory is a measure that rates the importance of different reasons why people choose not to kill themselves. We used the 32-item adolescent version as we attempted to recruit participants as young as 15 years of age, but were unable to consent a minor for the study. Should we have recruited a minor, we believed the adolescent version would have been more appropriate while still providing meaningful information about adults. The measure has shown strong internal consistency and test-retest reliability [17].

2.2.2. Motivation to change

The Stages of Change Questionnaire is an 18-item measure based on the original, 32-item scale created by McConaughy, Prochaska, and Verlicer [18]. The measure has shown acceptable levels of internal consistency in an adult sample ($\alpha = .75-.87$) and predictive validity of response to treatment [19].

2.2.3. Satisfaction ratings

The 8-item Client Satisfaction Questionnaire (CSQ) is a general measure of individual satisfaction with health and human services that takes 3–8 min to complete. It has been shown to have good internal consistency ($\alpha = .83-.93$) and good predictive validity [20,21]. Patients are asked to use a 4-point Likert scale (1=poor, 2=fair, 3=good, 4=excellent) to rate each item.

2.2.4. Demographic characteristics

The Demographic Data Survey was used to collect demographic information, including gender (male, female, and transgender), sexual orientation, marital status, income, ethnicity, and number of family members located within a 50-mile radius [22].

2.3. Intervention: teachable moment brief intervention

The Teachable Moment Brief Intervention (TMBI) is informed by two evidenced-based approaches to suicide prevention: a) the therapeutic philosophy of the Collaborative Assessment and Management of

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