To Ask or Not to Ask? Opinions of Pediatric Medical Inpatients about Suicide Risk Screening in the Hospital

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Objective To describe opinions about suicide risk screening in a pediatric medical inpatient sample.
Study design As part of a larger instrument validation study, 200 pediatric medical inpatients (ages 10-21 years) were screened for suicide risk. Participants completed demographic self-report forms and were asked their opinions about suicide risk screening. Patient responses were recorded verbatim by trained research social workers. Qualitative data was analyzed using thematic analysis.
Results The majority of adolescents who participated had not been previously asked about suicide (N = 101; 62.3%) and were supportive of suicide risk screening (81.0%). Five salient themes emerged from the qualitative analysis of patient opinions: prevention, elevated risk, emotional benefits, provider responsibility, and lack of harm in asking.
Conclusions The majority of youth screened for suicide risk on medical inpatient units were supportive of suicide risk screening. Opinion data have the potential to inform screening practices and assure clinicians that suicide risk screening will be acceptable to pediatric patients and their parents. Given the lack of screening in these patients' past experiences, the medical setting is a unique opportunity to capture youth at risk for suicide. *(J Pediatr 2016;170:295-300)*.

Adolescent suicide is a significant public health problem in the US. In 2011, suicide became the second leading cause of death among youth ages 10-24 years, accounting for more than 5000 deaths nationwide.[1] Nonfatal suicide attempts are more prevalent, affecting as many as 5%-8% of children and adolescents annually.[2-5] To date, the majority of suicide risk screening and prevention research with youth focuses on individuals who are diagnosed with mental health disorders or takes place in psychiatric treatment settings.[6,7] A number of studies indicate that the majority of youth who die by suicide may not be in mental health treatment at the time of death; yet, the majority of youth who die by suicide had contact with a medical professional 3 months prior to their death.[8-11]

Early detection of patients at elevated risk for suicidal thoughts and behaviors is a critical suicide prevention strategy.[9,12,13] A growing body of evidence suggests that medical inpatients are at increased risk for suicide.[14-17] Joint Commission data reveal that at least one-quarter of the hospital suicides occur on nonbehavioral health care units, indicating that a substantial portion of medical inpatients may have unmet mental health needs that go undetected by healthcare providers in medical settings.[18-21]

The majority of research on the feasibility of, acceptability of, or opinions about suicide risk screening in pediatric populations has been conducted in emergency departments or primary care settings.[22-27] Although the majority of research on patient opinions indicates that the majority of patients reported pro-screening attitudes, little is known about the opinions of children and adolescents hospitalized on medical inpatient units.

The purpose of this report is to describe opinions about universal screening for suicide risk in a sample of pediatric medical inpatients. Findings from this research will inform implementation of universal suicide risk screening strategies for pediatric patients in medical settings.

Methods

As part of a larger multisite instrument validation study, a total of 200 pediatric medical inpatients were recruited to participate in a suicide risk screening instrument validation study. Participants included patients between the ages of 10 and 21 years who were hospitalized for a minimum of 12 hours on 1 of 3 inpatient medical-surgical floors at a large urban pediatric tertiary care hospital. Inclusion criteria for age were selected based on previous studies conducted by the investigators.[22,23,28,29] Exclusion criteria included: (1) acute medical symptoms that precluded participation; (2) presence of severe developmental delays, cognitive impairment, or communication disorder such that the patient was not able to comprehend questions or communicate their answers; (3) primary reason for hospitalization is a psychiatric disorder and are "boarding" while awaiting an inpatient psychiatric bed; and (4) parent/guardian or consenting participant was non-English speaking. Patients were recruited between the hours of 2 p.m. and 8 p.m. Monday

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This project was supported in part by the National Institutes of Health Intramural Research Program (NCT02050867, Protocol ID 14-M-N044). The authors declare no conflicts of interest.

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http://dx.doi.org/10.1016/j.jpeds.2015.11.052

through Friday. Study enrollment occurred between August and December of 2013.

Institutional review boards at both the host institution and National Institute of Mental Health approved this study. Written informed consent was obtained from participants age 18 years and over and from parents/legal guardians of participants ages 17 and younger. Written assent was obtained from all participants ages 17 and younger. All interviewers were doctoral trained licensed clinical social workers.

After obtaining informed consent/assent, parents/guardians of the patient were asked to leave the patient's treatment room prior to administration of the interview. Participants were notified that if the interviewers had any safety concerns, then their parent/guardian and medical team would be notified and they would receive appropriate psychiatric follow-up care. Participants were administered a battery of screening measures for suicide risk and depression, and a questionnaire inquiring about demographics, previous healthcare utilization, and history of psychiatric/medical illnesses. Participants were also asked the following open-ended questions: "Do you think nurses should ask kids about suicidal thoughts while they are in the hospital? Why or why not?" Interviewers were instructed to note participant responses verbatim.

Qualitative Analyses

Responses to the questions "Do you think nurses should ask kids about suicidal thoughts while they are in the hospital? Why or why not?" were analyzed using thematic analysis.[30] First, superordinate categories of "pro-screening" and "patients not in favor of screening" were divided into separate groups based on a participant's response to the question: "Do you think nurses should ask about suicide?" A team of 2 doctoral trained social workers independently categorized survey responses to the "Why or Why not?" within each of these superordinate categories. The coding team using open coding to generate a series of initial themes from participant responses. The coding team met with the larger study team to refine the codes using constant comparison methodology[31] and a final list of 6 themes was generated. A third master's level social work researcher then independently coded the data based on the themes generated by the coding team. After a first round coding pass, the 3-person coding team recalibrated any differences in interpretation of the initial themes and codes; the coding team then made a final coding pass. As the primary aim of the larger study was to validate a brief suicide screening instrument, sample size was determined based on the number of participants needed to power the validation study and thematic saturation was reached.

Quantitative Analyses

Descriptive statistics are reported as proportions and means with SDs (Table I) when applicable. Demographic characteristics are described, including age, race/ethnicity, sex, and insurance status (Table I). Age is reported using categories employed in previous research with adolescents about suicide risk screening. All data were collected via self-report with the exception of insurance status, which was obtained via medical record review.

Table I. Patient demographics by opinion on screening

	Overall (N = 196)*	Yes (N = 162; 81.0%)	No (N = 34; 17.0%)
Mean age, y (SD)	15.52 (2.84)	15.59 (2.74)	15.15 (3.23)
10-11	15 (7.7%)	8 (4.9%)	7 (20.6%)
12-17	129 (65.8%)	115 (71.0%)	14 (41.2%)
18-21	50 (25.5%)	38 (23.5%)	12 (35.3%)
Unknown	2 (1.0%)	1 (0.6%)	1 (2.9%)
Race/ethnicity	N (%)	N (%)	N (%)
White	133 (67.9)	109 (67.3)	24 (70.6)
Hispanic/Latino	26 (13.3)	21 (13.0)	5 (14.7)
Black	17 (8.7)	15 (9.2)	2 (5.9)
Mixed	12 (6.1)	10 (6.2)	2 (5.9)
Asian/Pacific Islander	3 (1.5)	2 (1.2)	1 (2.9)
Other/unknown	5 (2.5)	5 (3.1)	0
Sex			
Female	114 (58.2)	101 (62.4)	13 (38.2)
Male	81 (41.3)	60 (37.0)	21 (61.8)
Unknown	1 (0.5)	1 (0.6)	0
Family constellation			
Married	110 (56.1)	91 (56.2)	19 (55.9)
Divorced	45 (23.0)	38 (23.4)	7 (20.6)
Never married	31 (15.8)	24 (14.8)	7 (20.6)
Other/unknown	10 (5.1)	9 (5.6)	1 (2.9)
Insurance status			
Private	116 (59.2)	95 (58.6)	21 (61.8)
Public	61 (31.1)	51 (31.5)	10 (29.4)
Public and private	8 (4.1)	6 (3.7)	2 (5.9)
None	1 (0.5)	1 (0.6)	0
Unknown	10 (5.1)	9 (5.6)	1 (2.9)
Psychiatric treatment			
Yes	121 (61.7)	106 (65.4)	15 (44.1)
No	74 (37.8)	55 (34.0)	19 (55.9)
Unknown	1 (0.5)	1 (0.6)	0
Ever asked in any setting			
Yes	75 (38.3)	61 (37.7)	14 (41.2)
No	121 (61.7)	101 (62.3)	20 (58.8)

*Four patients did not definitively respond "yes" or "no" but still provided qualitative responses to the question.

Results

Overall, 200 of 248 medical inpatients agreed to participate with an enrollment rate of 81% in the larger study. Nearly all participants (n = 196, 98%) answered the question of interest definitively (ie, yes or no). Four did not respond and were excluded from this analysis. Demographic data for the sample definitively answering the questions of interest are presented in Table I. Approximately 83% (162/196) of patients interviewed reported that nurses should ask youth about suicide risk on medical floors. Of the 162 participants, all but 2 reported reasons for this opinion. All of the participants not in favor of screening offered reasons that were analyzed. Notably, 62% (121/196) of the sample reported that they have never been asked questions about suicide before in any setting.

Qualitative Results

For deriving themes, there were few coding discrepancies,[7] each of which was resolved by discussion until consensus

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