

Comparison of Self-Administered Post Traumatic Stress Disorder Tool vs. Researcher Administered Tool in the Emergency Department

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Abstract: Background: Recent studies have shown that there is a high rate of post traumatic stress disorder in the inner city.

Objective: The purpose of this study was to determine whether patients in the Emergency Department would use a post traumatic stress disorder (PTSD) assessment. Additionally, did the type of administration of the PTSD tool impact the usage of PTSD services?

Methods: The sample population was taken from patients, 12 years or older, who presented with a non psychiatric illness. This study was done at a level one inner city adult and pediatric Emergency Department. The PTSD validated survey, was randomized between being self or research fellow administered. Half of the patients completed the survey on their own and half were administered by a research fellow. Those who screen positive on the tool were contacted one week later. This was done to determine if they have scheduled an appointment or were seen for a follow-up appointment. This study was IRB approved.

Results: A total of 299 participants completed the survey. Half (149) of which used a PTSD tool that was self administered. The total amount of participants who tested positive for PTSD was 35% (105). There was a significant difference (0.01) between those who self administered the tool 26% (40) and those who had the tool administered 12% (18). This was seen in relationship to who was more likely to follow up with behavioral health referrals.

Conclusions: These results reveal that 35% of the participants tested positive for PTSD. The majority of those that screened positive and used follow up services had self administered the tool. This indicates that they are more likely to seek out services based on their results.

Keywords: Emergency medicine ■ Post traumatic stress syndrome ■ Self administer ■ Follow up

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INTRODUCTION

The aftermath of traumatic experiences can be seen in a range of populations. These experiences can affect a person physically and psychologically and impact their overall use of health care services.^{1,2} A range of responses to such events are often displayed. They include: fear, grief, changes in appetite or sleeping or depression.¹ If these behaviors continue after six months, according to Spoon et al. and Feldon et al. the individual

might be suffering PTSD. This could indicate a diagnoses with post-traumatic stress disorder (PTSD).^{1,2}

Yet, PTSD is often under recognized by medical practitioners. Thus patients with post traumatic stress are not offered the effective treatments that are available.

Recent studies however have shown that there is a high rate of post traumatic stress disorder in the inner city.³⁻⁵ This is due to the endemic rates of violence witnessed and experienced within the United States which had disproportionately affected African American youth.^{6,7} Thus violence has become a significant public health problem. The federal Centers for Disease Control and Prevention has reported that 30% of U.S. inner city youths are affected by post-traumatic stress disorder.⁶ This population experienced a high rate of severe trauma. For example, in Chicago there were more kids killed between 2003 and 2011 than Americans were lost in Operation Enduring Freedom in Afghanistan.⁶ Children who are exposed to repeated high levels of violence often suffer from a range of psychological issues. These can include: difficulties with attachment, regressive behavior, anxiety and depression, and aggression and conduct problems.^{6,7} This can lead to behaviors like avoidance and heightened awareness and hyper vigilance.⁶⁻¹⁰ According to Corbin et al. symptoms like hyper vigilance may lead victims of violence to feel vulnerable and engage in behaviors, like weapon carrying, that increase the risk and likelihood of re-injury.⁸ Early identification and treatment for PTSD among African American males who have been exposed to violence may reduce the incidence of future violence and injury.⁹⁻¹¹

Other studies by Schwartz et al. and Post et al., have found similar results.^{12,13} They looked at children and teens that have been exposed to and or live in areas of high levels of violence. Schwartz et al., using the PTSD symptom survey, found that forty-three percent of children were found to have PTSD.¹² Similarly, Post et al., using a different PTSD PCL symptom scale found 49% of youth surveyed tested positive for PTSD.¹³

The key to trauma informed care is to identify and refer patients to behavioral health services in the community. Yet, the assessment and referral for this disorder is lacking. Prior studies have shown the emergency department is an appropriate environment to assess and

refer patients with undiagnosed mental illness.¹⁴ A self-assessment and referral tool has been developed. This could enable patients to self-screen and self refer for posttraumatic stress disorder. The Primary Care PTSD Screen (PC-PTSD) can be used in a variety of medical settings.^{15–17} It is different than other PTSD assessment tools. It does not connect screening positive to specific and inclusive list of traumatic events. Instead it a concise tool that only measures the respondents physical and psychological impact of exposure to the traumatic events.^{15–18}

The benefit of self administered mental health assessment tools have been shown in numerous studies. Ferri et al. showed that use of such tools can impact ways to addresses mental health disparities.¹⁹ Its use can make access to a range of assessment tools that lead to better outcomes, such as use of referrals, which was especially beneficial to marginalized groups and people for whom English was not a first language.¹⁹ Dwinells study also found the use of patient administered assessment surveys beneficial for patients and providers.²⁰ They found an increase use in referrals within the group that self administered their assessment survey.²⁰ This indicates the effectiveness and potential use for mental health self administered surveys especially within populations that do not necessarily know they are at risk for such illnesses.

A respondent using the PC-PTSD tool screens positive if they answer yes to any of the three out of four survey questions.¹⁶ A positive screening for PTSD using this tool does not mean that a patient has PTSD.^{15–17} It does indicate that they are at risk. Thus, they should be confirmed by a secondary assessment with a mental health professional.^{16,17} It is however, a screening that could be done by patients in the Emergency Department waiting areas with results given to them during their assessment.

There have been few studies on whether or not those that are screened positive will use follow up or referral services. Several studies have done within high risk communities for other health issues. They have found that environmental factors do impact how people understand the issue. It also determines how they see level of risk and if they seek treatment.^{17,18} Liebschutz et al. found that institutional mistrust, foreshadowing, and self reliance and logistical issues all impact on patients.¹⁸ This is seen in relationship to usage of follow up service usage.¹⁹ Thus a mixture of cultural and environmental factors could impact what if any services are seen as needed and thus used.

The purpose of this study was to determine whether patients in the Emergency Department would use a post-traumatic stress disorder (PTSD) assessment. Additionally,

whether the way the survey was administered would result in an increase in usage of PTSD services.

MATERIALS AND METHODS

This study included a sample of consenting and medical stable 299 patients, 12 years and older, who presented to the ED with a non psychiatric related diagnosis. They were given either a self-assessment and referral tool (see Appendix 1) while in the Emergency Department. Patients 12 years of age and over were enrollment in the study. Patients between the age of 12 and 17 years of age, who were accompanied by a parent or guardian, were asked to assent. The research fellows randomized distribution of the tool to patients for self-reported completion versus the other half which would be administered. A review of the medical chart was done to examine demographics, treatment, meds, and mode of arrival, triage score, and related treatment data elements.

Patients with positive screens were self-referred to behavioral health for adults or pediatrics for further evaluation and possible treatment. Those who screen positive on the tool were contacted one week later to determine if they had scheduled an appointment or were seen for a follow-up appointment. A secondary confirmation of follow up appointment was also done by looking up the patient in the medical system. An ANOVA analysis was done to determine what if any differences there were between the two groups with regards to screening positive and use of referrals. This study was IRB approved.

RESULTS

A total of 299 participants completed the survey, half of which were self administered. A total of 350 were approached and 299 completed the study for a response rate of 89%. The top reason for declining to take part in the study was feeling too sick. The population was closely split between males 47% (141) and female 53% (158). The majority 75% (224) of participants were African American, with 17% (51) Hispanic, 7% (20) Caucasian and 1%³ other. The ages ranged as follows: 12–21 years old 12% (36), 22–24 11% (34), 25–34 23% (68), 35–44 20% (62), 45–54 (16% (49), 55–64 12% (35), 65 plus 5%.¹⁵ The educational levels were also varied. This was in part, due to the younger age range in the study. Thus, 27% had some high school, 40% completed high school/GED, 24% some college, and 5% college and 3% graduate education. The top six presenting diagnoses were as follows: musculoskeletal 33% (99), gastrointestinal 15% (46), general 13% (38), respiratory 7% (21), dermatology 8% (23), and cardiovascular 4%.¹³

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