Published in final edited form as:
Clin Pediatr Emerg Med. 2013 March ; 14(1): 20–27. doi:10.1016/j.cpem.2013.01.001.

Asking Youth Questions About Suicide Risk in the Pediatric Emergency Department: Results From a Qualitative Analysis of Patient Opinions

Elizabeth D. Ballard, PhD,
Postdoctoral Fellow, Division of Child and Adolescent Psychiatry, The Johns Hopkins University, Baltimore, MD 21205, eballar3@jhmi.edu, W: 410-955-8596

Ian H. Stanley, BA,
Postbaccalaureate IRTA Fellow, Office of the Clinical Director, National Institute of Mental Health, NIH, stanleyih@mail.nih.gov, W: 301-451-2114

Lisa M. Horowitz, PhD, MPH,
Staff Scientist / Pediatric Psychologist, Office of the Clinical Director, National Institute of Mental Health, NIH, horowitzl@mail.nih.gov, W: 301-435-6052

Maryland Pao, MD,
Clinical Director, Office of the Clinical Director, National Institute of Mental Health, NIH, paom@mail.nih.gov, W: 301-435-5770

Elizabeth A. Cannon, MA, MS, and
Research Associate, Center for Innovation in Pediatric Practice, Nationwide Children's Hospital, Elizabeth.Cannon@nationwidechildrens.org, W: 614-581-7546

Jeffrey A. Bridge, PhD
Principal Investigator, Center for Innovation in Pediatric Practice, Psychiatry and Community Behavioral Health, Nationwide Children's Hospital, Jeff.Bridge@nationwidechildrens.org, W: 614-722-3066

Abstract

The emergency department (ED) is a promising setting to screen youth for suicide risk. Patient reactions to questions about suicidal thoughts and behaviors during their ED visit have implications for how screening is introduced, developed, and implemented. The current study is a qualitative investigation into patient opinions about screening for suicide risk in the pediatric ED. As part of a subset of a multisite study, 165 participants, 10 to 21 years old, were included in this sub-analysis. Ninety percent (148/165) of participants supported suicide risk screening. Reasons youth support screening included prevention of suicide, detection of at-risk youth, and a lack of other social support. Overall, pediatric patients agreed with suicide risk screening in the ED, citing similar reasons as in a previous investigation, further demonstrating acceptability of suicide risk screening in this setting. A small subset of youth (10%; 17/165) did not support screening for

Corresponding Author Lisa M. Horowitz, PhD, MPH, Staff Scientist / Pediatric Psychologist, Office of the Clinical Director, National Institute of Mental Health, NIH, horowitzl@mail.nih.gov, W: 301-435-6052.

Disclosures
The opinions expressed in the article are the views of the authors and do not necessarily reflect the views of the Department of Health and Human Services, the Centers for Disease Control and Prevention, or the United States government.

reasons that included a desire to focus on their chief (i.e., nonpsychiatric) presenting concern and fear of iatrogenic risk. Understanding patient opinions, including those in support of and in opposition to screening, can inform implementation practices. Further education about the importance of suicide risk assessment may be a helpful first step in instituting universal screening efforts.

Keywords

suicide; screening; emergency department; patient opinion; youth; children

Screening for suicide risk in the pediatric emergency department (ED) is a burgeoning area of research.(1–3) Identifying adolescents at increased risk for suicidal behavior is a particular concern, as suicide is a leading cause of death in youth(4) and 7.8% of high school students report having made a suicide attempt in the last year.(5) In response, in 2012, the United States Surgeon General and the National Action Alliance for Suicide Prevention issued the National Strategy for Suicide Prevention (NSSP), which advocated the development and implementation of suicide risk screening measures, particularly highlighting the need for screening in the ED.(6) Such universal screening has the ability to identify the most vulnerable, at-risk youth and connect them with mental health resources and treatment.(7–8)

Asking youth about suicidal thoughts and behavior, particularly when the child or adolescent did not present to the ED for a mental health reason, can evoke concerns in the patient, parents, and staff. Thus, the NSSP emphasized the need for patients to feel “safe” when disclosing their suicidal thoughts.(6) While screening for suicide risk is not associated with iatrogenic risk of inducing suicidal behavior,(9–10) the important question emerges of how children and adolescents will respond to being asked about suicide during an ED visit.

Investigations into the feasibility and acceptability of suicide risk screening in the pediatric ED are essential before measures are widely disseminated. Past research has demonstrated that universal suicide risk screening in the pediatric ED is feasible, in that it is nondisruptive to ED workflow and is supported by young patients and their parents/guardians (hereafter referred to as “parents”).(11–12) In a separate study of patients and their parents, participants supported screening for suicidal thoughts and behaviors, with adolescents rating suicide risk screening as significantly more important than screening for other mental health problems.(13)

Qualitative reviews of patient responses can complement the aforementioned studies and provide rich insight into *why* patients find screening to be acceptable or unacceptable. In 2012, Ballard and colleagues published a qualitative investigation of patient opinions about suicide risk screening.(14) The five most salient themes that emerged from open coding responses of patients who supported suicide risk screening were: 1) identification of at-risk youth; 2) a desire for clinicians to know and understand their situation; 3) connection of youth with mental health help and resources; 4) prevention of suicidal behavior; and 5) lack of other individuals to speak with about these issues. These responses emphasized the importance of suicide risk screening, highlighting its potential to link patients to mental health treatment. However, this analysis was conducted on patients in a single urban pediatric ED in Washington, DC, of whom 66.7% were black, 14.7% were white, 56.4% were female, and 51.9% were on public insurance. The generalizability of these findings would be further strengthened by examining patient opinions from another ED with different demographic characteristics. Furthermore, focusing on responses that describe how to ease

comfort and safe disclosure when screening for suicide risk would benefit future implementation strategies.

The purpose of this paper is to describe opinions on screening for suicide risk in a second sample of pediatric ED patients ages 10–21 years from Columbus, OH, using the abovementioned themes. This paper also further examines opinions of a small subset of youth who were unsupportive of screening.

METHODS

Participant Population

These data were collected as part of a multisite study that developed and validated a suicide risk screening instrument, the Ask Suicide-Screening Questions (ASQ), for pediatric EDs.(3) Participants were part of a convenience sample of ED patients, ages 10 to 21 years, inclusive, seeking care at Nationwide Children's Hospital, which is an urban pediatric ED associated with a tertiary care teaching hospital and has an annual census of over 79,000 ED visits. Study enrollment occurred between September 8, 2009 and January 5, 2011, during which trained bachelor's and master's level research associates approached patients with both psychiatric and nonpsychiatric presenting concerns. This study was approved by the Nationwide Children's Hospital institutional review board (IRB) and the National Institutes of Health (NIH) Combined Neuroscience IRB. After approached for enrollment, participants ages 18 years and older gave written informed consent. Participants under the age of 18 years gave written assent to participant and written informed consent was obtained from their parent.

Procedure

Participants were interviewed in examination rooms as they were waiting to see their doctors. Data collection occurred without the presence of legal guardians, but participants were informed that if they responded in any way that made the data collectors concerned about their safety, their guardians and doctors would be notified. Participants were asked a series of suicide risk assessment questions and items concerning demographics and health service utilization. Additionally, participants were then asked if they had been screened for suicide risk in the past. The final question was: "Do you think ER nurses should ask kids about suicide/thoughts about hurting themselves…why or why not?" Open-ended responses to these questions were transcribed verbatim.

Qualitative Analysis

NVivo9.2, a qualitative research software package, was used for data analysis.(15) Two raters, a doctoral level clinical psychologist and a bachelor's level research assistant, coded the data using the same themes drawn from a previous analysis.(14) Inter-rater agreement for these themes ranged from 88%–100%. Additionally, the raters used open coding procedures for other themes that emerged from the data. All discrepancies were resolved by discussion and consensus.

RESULTS

During the study period, 170 of the 271 (63%) eligible patients approached in the pediatric ED agreed to participate. Three participants had missing data for the question of interest (i.e., "Do you think ER nurses should ask kids about suicide/thoughts about hurting themselves… why/why not?"). Two additional participants answered with "I don't know," limiting qualitative inquiry. Thus, the sample for the current study consists of 165 patients.

The sample was 72.1% white, 15.2% black, 58.6% female, and 51.5% had private insurance. Demographic data are presented in Table 1.

Consistent with previous findings, the majority (90%; 148/165) of participants agreed that nurses should ask kids about suicide, with no significant differences in age, gender, race, reason for visit, or insurance status. More than half (57%; 94/165) of participants had not been asked questions about suicide in the past. After adjusting for age, sex, race, and insurance status, psychiatric patients were more likely to have been asked about suicide than nonpsychiatric patients (adjusted odds ratio [OR] = 0.24; 95% confidence interval [CI], 0.11–0.53; $p < .001$) and females were more likely to have been asked than males (adjusted OR = 0.48; 95% CI, 0.24–0.98; $p < .05$). There were no differences in age, race, or insurance status for being asked about suicide before the index ED visit.

Reactions to Screening for Suicide Risk

The five most common themes from patient responses in support of screening are presented in Table 2. Several responses were coded as more than one theme. The most frequent theme, identified by 26% (42/165) of the sample, was **identification**: screening for suicide risk in a pediatric ED would identify youth who are at risk for suicide and who would otherwise have not disclosed their thoughts and/or feelings. At the core of this theme is the belief that youth will not volunteer to discuss suicide, and that specific probing for suicidal thoughts and behavior by a nurse or another clinician is necessary.

"If you don't ask, you'll never know."

- An 18-year-old female nonpsychiatric patient

"Because if you don't ask, they would never know why they are feeling the way that they do."

- A 13-year-old male nonpsychiatric patient

The next most common theme, identified by 16% (26/165) of participants, was **prevention**: suicide risk screening is an important first step in the prevention of suicidal thoughts and behaviors. Responses indicated that participants believe screening practices are necessary to thwart the trajectory from suicidal thoughts to behaviors or even death.

If nurses ask, then they can catch it before doing it."

- An 11-year-old male nonpsychiatric patient

"So less accidents like that would happen."

- An 11-year-old male non-psychiatric patient

Further, 14% (23/165) of participants expressed **connection** as an important theme: a valuable and therapeutic interpersonal connection is created between a nurse and the patient when the nurse asks questions about suicide risk. Subthemes included the need to be listened to, acknowledged, or understood by a clinician.

"Give them a chance to say how they feel and have hope."

- A 14-year-old male psychiatric patient

"That way they can talk about it and maybe feel a whole lot better about it."

- A 12-year-old male nonpsychiatric patient

Fourteen percent (23/165) of participants identified a theme of **linkage**: screening would provide an opportunity for youth to be connected with appropriate mental health resources to help them with their distress.

"Good for [nurses] to know so they know where to take it from here."

- A 12-year-old female psychiatric patient

"So you know how much you need to keep an eye on them."

- An 11-year-old male psychiatric patient

Additionally, 10% (17/165) of participants reported that youth may feel alone (**isolation**) and that they have no one else to talk with about suicidal thoughts, and a medical professional would be an objective, caring resource.

"Kids need someone to talk to about suicide who knows things about it."

- A 16-year-old male non-psychiatric patient

"Kids open up more to nurses and doctors because they are helping them."

- A 16-year-old female non-psychiatric patient

Non-support of screening—Although the majority of youth supported screening for suicide risk in the ED, several youth expressed their disagreement with universal screening. Because slightly more participants disagreed with screening in this sample (10%; 17/165) when compared to the DC sample (4%; 7/156; χ^2=3.92, df=1, p=0.048), further analyses of the negative responses were conducted and categorized into three themes; several responses were coded into more than one theme (see Table 2). The majority (10/17) of participants who opposed screening stated that screening was not relevant to their presenting concern. These participants reported that they would feel irritated and uncomfortable by screening, in part because their chief complaint was medical in nature, and they felt that screening was a distraction from their more salient concerns. They reported their beliefs that nurses were overstepping their boundaries by asking mental health questions in a medical setting.

"Would drive me crazy—would be irritating to someone who doesn't have those thoughts."

- An 18-year-old male nonpsychiatric patient

"Might be focused on something else, hard enough while in here now."

- A 12-year-old male nonpsychiatric patient

Some (5/17) participants disagreed with universal screening, but offered conditions in which screening would be acceptable. These participants felt that nurses could use their clinical judgment in determining who to screen.

"Maybe ask younger kids, not teens."

- A 15-year-old female psychiatric patient

"Because people are just here for what they're here for, so don't ask unless they see it as [possible."

- A 13-year-old male nonpsychiatric patient

Finally, a small minority of participants (4/17) reported a fear that screening conferred iatrogenic risk.

"Because it just makes people more stressed, they get the idea of suicide."

- A 12-year-old female psychiatric patient

"[They] might try it."

- A 12-year-old male nonpsychiatric patient

Other Findings: Family Involvement

Several (14/165; 9%) youth highlighted the unique role of families in the suicide risk screening process. Of these 14 patients, 12 were in the ED for a non-psychiatric reason. One youth identified more than one theme relating to family. Five percent (8/165) of participants reported a theme of **isolation related to family**, suggesting that screening by nurses is important because patients may feel unable to discuss these matters with family members. Reasons included fear of being "grounded," apathetic or absent parents/guardians, or simply discomfort speaking about this sensitive topic.

"Because I think some kids go through it and are too scared to tell parents and should have someone to go to."

- A 17-year-old female nonpsychiatric patient

"A lot of people's parents really don't care. And some just don't have parents."

- An 18-year-old female nonpsychiatric patient

In addition, 2% (3/165) of participants explicitly noted that **parental presence** during screening is something to consider, either as a positive factor (i.e., parents/guardians can provide potentially useful collateral information) or as a negative factor (i.e., parental presence could prevent a patient from telling the truth).

"Should ask parents too. Kids might not want to say. If you're here you must have something. People think they don't need help."

- A 12-year-old male psychiatric patient

"As long as the parent is not in the room, so [the patient] can get help."

- An 18-year-old female nonpsychiatric patient

Another 2% (3/165) of participants noted their belief of a link between familial **abuse** and suicide, stating that asking about suicidal thoughts and behaviors may help to identify children who are being abused.

"Because they don't know if why they're coming in is due to if a parent is doing something to them. Maybe being mentally abused."

- A 16-year-old female nonpsychiatric patient

Finally, two participants mentioned that suicide has a painful impact on the entire family.

"If they seem depressed, the nurses could help—tell them it won't help to commit suicide. Your family would be sad."

- A 10-year-old female nonpsychiatric patient

DISCUSSION

The majority of pediatric ED patients presenting with psychiatric and nonpsychiatric complaints supported universal screening for suicide risk. After qualitative analysis of youth opinions about screening, five top themes emerged: detection and identification of suicide risk, prevention, mental health resource linkage, lack of other outlets for social support, and a desire to be understood. These themes were similar to those found in a previous study utilizing opinions from another pediatric ED sample with differing demographics; the theme of **prevention** was mentioned more often in this current sample. This replication lends further support to the acceptability of suicide risk screening efforts in the pediatric ED.

The replication of these findings from the previous study highlights important components of screening for suicide risk. First, responses related to detection suggested that adolescents will not report suicidal thoughts and behaviors unless asked directly. Therefore, trusting adolescents to spontaneously report suicidal thoughts or behaviors, or relying on presenting complaint data, may not be an effective strategy for identification of at-risk youth in the ED.(8) Second, data from both quantitative and qualitative responses demonstrate that a significant number of these patients do not recall being asked about suicide in other settings and may feel **isolated** from friends and family. Consequently, for some children and adolescents, the ED may be their only contact with a clinician who can connect them with mental health resources.(6–7) Lastly, many of the participants emphasized the importance of connecting patients who screen positive for suicide risk with preventative interventions, which is a major concern in the suicide prevention literature.(8, 16)

Understanding reasons why a small minority of patients disagreed with screening may also be helpful in implementing universal ED screening for suicide risk. The myth of iatrogenic risk from suicide assessment persisted in this sample, highlighting the need for further psychoeducation about screening being an important and safe component of suicide prevention efforts. Other patients stated that they did not want to be asked about suicide if they were in the ED for nonpsychiatric reason, describing the experience of being screened as potentially uncomfortable and “irritating.” The comments echo other ED research studies,(12) in which a minority of patients and parents raised concerns about screening, including privacy, added time, non-psychiatric reasons (e.g., asthma, abrasions, or vomiting) for their ED visit, or that mental health screening is potentially upsetting.(13) Such responses further highlight the need for thoughtful planning and careful implementation in order to mitigate discomfort and irritation associated with screening.

There were varying opinions about the role that family members play in suicide screening. Some participants stated that youth may not be able to discuss suicide with their parents and that family should not be present during the screening process. Others stated that parents could provide important collateral information and could be important protective factors for suicide. Notably, parents may not be asking their children about suicidal thoughts simply because they do not know how to ask; parents often feel relief when a clinician assesses their child for suicide risk.(17) Regardless of opinion, if an adolescent is identified as having suicidal thoughts in the ED, parents are often informed about their child’s suicide risk as an issue of safety.(11) These responses about family involvement emphasize that when ED clinicians screen for suicide risk, the adolescent’s desire to share thoughts about suicide with an outside provider will have to be balanced with an understanding of parental rights to know about factors that affect their child’s safety. Further work evaluating the impact of familial presence at each point in the screening process, from the actual assessment to communication of results, is warranted to aid clinicians in implementing suicide risk screening in EDs.

There are several potential limitations to this study. While this study sought to replicate findings from another patient sample with different demographics, both EDs were in primarily urban settings and generalizability may be limited. Only one open-ended question was used, which limits the amount of qualitative data that was collected. Lastly, participants had already assented or consented to take part in a study on suicide risk screening, so they may have been predisposed to agree with suicide risk screening efforts. Nevertheless, these findings mirror results from other ED patient samples,(12–13) which did not have similar recruitment biases, suggesting that such screening is generally supported by pediatric ED patients.

CONCLUSION

Pediatric ED patients support universal suicide risk screening. With thoughtful and careful implementation, screening can provide youth the opportunity to speak with a trusted clinician about distressing thoughts. In turn, nonpsychiatric clinicians can link young patients with needed mental health resources. Conceivably, such a bridge can prevent suicidal behavior and related ED visits in the future. In the words of one 16-year-old psychiatric participant, who presented to the ED with suicidal ideation: “If people would’ve asked me when [I was] younger, I might not have these problems now.”

Acknowledgments

Funding /Support

The research in this article was supported by the Intramural Research Program of the National Institutes of Health and the National Institute of Mental Health. Dr. Bridge was supported by institutional research funds from The Research Institute at Nationwide Children’s Hospital, CDC grant R01 CE-002129, and NIMH grants K01 MH-69948 and R01 MH-93552.

REFERENCES

1. King CA, O’Mara RM, Hayward CN, et al. Adolescent suicide risk screening in the emergency department. Acad Emerg Med. 2009; 16:1234–1241. [PubMed: 19845554]
2. Wintersteen MB, Diamond GS, Fein JA. Screening for suicide risk in the pediatric emergency and acute care setting. Curr Opin Pediatr. 2007; 19:398–404. [PubMed: 17630602]
3. Horowitz LM, Bridge JA, Teach SJ, et al. Ask suicide-screening questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012
4. Centers for Disease Control and Prevention National Center for Injury Prevention and Control. [Accessed 11-4-2012] Web-based injury statistics query and reporting system (WISQARS). Available at: http://www.cdc.gov/injury/wisqars/index.html.
5. Centers for Disease Control and Prevention. [Accessed 11-4-2012] Youth risk behavior surveillance —United States, 2011. Available at: http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf.
6. US Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance For Suicide Prevention. 2012 national strategy for suicide prevention: goals and objectives for action. Washington, DC: HHS; 2012 Sep.
7. Knesper, DJ. Continuity of care for suicide prevention and research: suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Education Development Center, Inc; 2010. American Association of Suicidology & Suicide Prevention Resource Center.
8. Pena JB, Caine ED. Screening as an approach for adolescent suicide prevention. Suicide Life Threat Behav. 2006; 36:614–637. [PubMed: 17250467]
9. Gould MS, Marrocco FA, Kleinman M. Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. JAMA. 2005; 293:1635–1643. [PubMed: 15811983]
10. Mathias CW, Furr M, Sheftall AH, et al. What’s the harm in asking about suicidal ideation? Suicide Life Threat Behav. 2012; 42:341–351. [PubMed: 22548324]
11. Horowitz L, Ballard E, Teach SJ, et al. Feasibility of screening patients with nonpsychiatric complaints for suicide risk in a pediatric emergency department: a good time to talk? Pediatr Emer Care. 2010; 26:787–792.
12. Williams JR, Ho ML, Grupp-Phelan J. The acceptability of mental health screening in a pediatric emergency department. Pediatr Emer Care. 2011; 27:611–615.
13. O’Mara RM, Hill RM, Cunningham RM, et al. Adolescent and parent attitudes towards screening for suicide risk and mental health problems in the pediatric emergency department. Pediatr Emer Care. 2012; 28:626–632.
14. Ballard ED, Bosk A, Snyder D, et al. Patients’ opinions about suicide screening in a pediatric emergency department. Pediatr Emer Care. 2012; 28:34–38.

15. NVivo Qualitative Data Analysis Software. QSR International Pty Ltd. Version 9. 2010
16. Asarnow JR, Baraff LJ, Berk M, et al. An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment. Psychiatr Services. 2011; 62:1303–1309.
17. Horowitz LM, Wang PS, Koocher GP, et al. detecting suicide risk in a pediatric emergency department: development of a brief screening tool. Pediatrics. 2001; 107:1133–1137. [PubMed: 11331698]

Table 1

Demographics of study participants. ($N = 165$)

Sex	n (%)
Female	95 (57.6)
Male	70 (42.4)
Mean Age (SD), y	14.92 (2.42)
10–11 y, n (%)	10 (6.1)
12–17 y, n (%)	129 (78.2)
18–21 y, n (%)	26 (15.7)
Race or Ethnicity	
White	119 (72.1)
Black	25 (15.2)
Mixed/Other	18 (10.9)
Hispanic/Latino	3 (1.8)
Insurance status	
Private	85 (51.5)
Public	58 (35.2)
None	22 (13.3)
Presenting complaint	
Nonpsychiatric	119 (72.1)
Psychiatric	46 (27.9)

Table 2

Overall reactions to suicide screening in a pediatric ED.

		Total (*n* = 165)	**Nonpsychiatric patients (*n* = 119)**	**Psychiatric patients (*n* = 46)**	**Odds Ratio***	**95% Confidence Interval**
Have you ever been asked about suicide before?	Yes	71 (43)	40 (34)	31 (67)	0.24	0.11–0.53
Do you think it is a good idea for nurses to ask kids about suicide?	Yes	148 (90)	106 (89)	42 (91)	0.95	0.28–3.26

Note: Values are n (%).

*Adjusted for age, sex, race, and insurance status

Table 3

Most common themes from patient responses about nurses screening for suicide risk in the ED.

	Total (*N* = 165) n (%)	**Nonpsychiatric patients (*n* = 119)**	**Psychiatric patients (*n* = 46)**
Top Themes in Support of Screening			
Identification of at-risk youth	42 (26)	34 (29)	8 (17)
Prevention of suicidal behavior	26 (16)	17 (14)	9 (20)
A desire for clinicians to know and understand their situation	23 (14)	15 (13)	8 (17)
Connection of youth with mental health help and resources	23 (14)	13 (11)	10 (22)
Lack of other individuals to speak with about these issues	17 (10)	15 (13)	2 (4)
Themes in Opposition to Screening			
Not relevant to presenting concern	10 (6)	8 (7)	2 (4)
Conditional screening	5 (3)	3 (3)	2 (4)
Fear of iatrogenic risk	4 (2)	3 (3)	1 (2)

Note: Themes in support of screening are replicated from Ballard and colleagues.(14) Several participants identified more than one theme.