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TREATMENT RECIDIVISM IN ADOLESCENTS WITH MENTAL ILLNESS: A FOCUSED APPLIED MEDICAL ETHNOGRAPHY

Chukwudi C. Ekwemalor

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TREATMENT RECIDIVISM IN ADOLESCENTS WITH MENTAL ILLNESS: A
FOCUSED APPLIED MEDICAL ETHNOGRAPHY.

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF DOCTOR OF PHILOSOPHY IN NURSING

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

SCHOOL OF NURSING

BY

CHUKWUDI EKWEMALOR, PhD(c), MBA, MSN, RN-BC

August, 2016

Approval Form D-3

The University of Texas Health Science Center at Houston
School of Nursing
Houston, Texas

May 31, 2016
Date

To the Dean for the School of Nursing:

I am submitting a dissertation written by Chukwudi C. Ekwemakor and titled "Treatment Recidivism in Adolescents with Mental Illness: A Focused Applied Medical Ethnography". I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing.

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Thank you and God bless you all.

Abstract

Chukwudi Christopher Ekwemalor, PhD(c), MBA, MSN

Treatment Recidivism in Adolescents with Mental Illness: A Focused Applied Medical
Ethnography

August, 2016

Background

Treatment recidivism, described as frequent unplanned relapse readmissions, is a national problem predominant in adolescents with mental illness with significant socioeconomic consequences. Adolescents living with mental illness are a sub-culture of adolescence, the critical growth period of developmental and social transition from childhood to adulthood. The main triggers of treatment recidivism in this population are not fully understood from previous studies.

Purpose

The study purpose was to explore treatment recidivism with the following aims:

1. To illuminate treatment recidivism from the perspectives of recidivist adolescents with mental illness.
2. To describe the main factors that contribute to treatment recidivism and how best to minimize them from the perspectives of these adolescents.
3. To describe the interaction of the recidivist adolescents with mental illness with the medical culture.

Methods

The design was a focused applied medical ethnography that involved face-to-face interviews of 16 purposively selected recidivist adolescents that met the eligibility criteria who were on inpatient readmission in the study hospital. Individual and group interviews were conducted until data saturation was achieved. Participants also were unobtrusively observed and demographic information was extracted from their medical records.

Interview transcripts and other data were organized with NVivo 11 Pro software during data analysis to derive repetitive patterns and themes that revealed the perspectives of the participants.

Findings

The 16 participants were near unanimous that the “additional stressors” of problematic parental relations and school bullying were the main triggers of treatment recidivism. They suggested that these main triggers were responsible for treatment recidivism over and above their “routine stressors” of adolescence and mental illness and needed to be addressed to minimize the problem. The participants had a mixed perception of treatment recidivism and described their interaction with the medical culture as mostly positive.

Conclusion

Further research is needed on larger samples to determine the impact of parental relations and school bullying on recidivism in adolescents with mental illness.

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Summary of Study

Treatment recidivism, conceptualized as frequent unplanned relapse readmissions, is a national problem, predominant in adolescents with mental illness. Frequent inpatient hospital readmission in adolescents with mental illness is varied, but higher than reported in most other populations. Arnold et al. (2003) estimate readmission at 19% in six months for adolescents after initial inpatient psychiatric unit discharge. Bobier and Warwick (2005) reported a 65% readmission rate in a 12-month period post discharge. Goldstein, Frosch, Davarya, and Leaf (2007) reported that 19% of child and adolescent psychiatric patients were readmitted to emergency services in a six-month follow-up period. Fontanella (2008) estimates that 24 to 38% of adolescents were readmitted to a psychiatric unit one-year after inpatient discharge.

Treatment recidivism is a significant social and economic problem considering the adolescents' burden of mental illness, decreased school and job performance, disruption of lives of patients' families, and the inevitable contribution to the increasing cost of healthcare. It could dramatically impact adolescent lives and lead to chronic adult mental illness, criminality, and risky behaviors such as suicide, alcohol, and substance use among others. It has been reported that about 20% of adolescents have diagnosable mental illness (CDC, 2014; Schwarz, 2009), but less than half of that percentage actually receive treatment (Costello, He, Sampson, Kessler & Merikangas, 2013). Cost implications could not be easily ascertained, but can be imagined from the cost estimates of inpatient hospitalization. Fontanella (2008) reported that inpatient services accounted for about 33% of the total mental health expenditures for children and adolescents in the United States.

Culture has been defined in terms of the beliefs, values, and behavior characteristics of a particular social, ethnic, illness or age group as well as society (Dictionary.com, 2015; Engebretson, 2011). Adolescents living with mental illness are a sub-culture of adolescence, the critical growth period of developmental and social transition from childhood to adulthood. Adolescence is a sub-culture of the broader societal culture, because of beliefs, values, and behavior aspects of that growth period (Erickson, 1968; Steinberg, 2011).

Treatment recidivism has persisted and even increased since the time of managed-care despite various efforts to address it (James et al., 2010; Garrison & Daigler, 2006). The factors that influence recidivism in adolescents with mental illness are multiple, but not yet fully understood. Previous efforts to address treatment recidivism or frequent readmission have evaluated the effectiveness of aftercare services (James et al., 2010; Carlisle, Mamdani, Schachar & To, 2012) and factors such as patients' clinical status, treatment models, family and environmental characteristics (Fontanella, 2008; Barker, Jairam, Rocca, Goddard & Matthey, 2010) with mixed and sometimes conflicting results. The current effort of the Affordable Care Act (ACA, 2010) to address treatment recidivism or frequent readmission is limited to certain categories of patients' conditions that do not yet include adolescents with mental illness.

A review of the literature revealed a dearth of research studies on treatment recidivism in adolescents with mental illness compared to their adult counterparts, despite the fact that treatment recidivism is more prevalent in the adolescents with mental illness (Bobier & Warwick, 2005; Barker et al, 2010; James et al, 2010). Moreover, most of the previous studies were quantitative and did not sufficiently seek the views of the recidivist

adolescents with mental illness on treatment recidivism. The purpose of this study was to qualitatively explore treatment recidivism from the perspective of these adolescents with mental illness. The aims of this study were:

1. To illuminate treatment recidivism from the perspectives of recidivist adolescents with mental illness.
2. To describe the main factors that contribute to treatment recidivism and how best to minimize them from the perspectives of these adolescents.
3. To describe the interaction of the recidivist adolescents with mental illness with the medical culture.

Methods

Design

Focused applied medical ethnography, a type of qualitative method used to seek the understanding of a subcultural group on a specific issue (Engebretson, 2011; Muecke, 1994; Richards & Morse, 2013) was used to gain a better understanding of treatment recidivism from the perspectives of purposively selected recidivist adolescents on admission in an urban southwestern United States psychiatric hospital. This focused applied medical ethnographic study was done through audio-recorded individual and group interviews to ensure that the interpretation of the participants' perspectives of their experience was well described (Engebretson, 2011; Polit & Beck, 2012; Richards & Morse, 2013; Silverman, 2014; Thorne, 2008). The interviews were complemented by information from their electronic medical records and the non-participant field observations of the participants' interaction among themselves and with others in the hospital unit.

Setting and Sample

The study setting was a large inpatient psychiatric hospital, in an urban city in the southwestern United States. The hospital has a dedicated 20-bed general child/adolescent psychiatric unit frequently used by adolescents from the surrounding communities with a whole spectrum of mental illnesses. A purposive sampling method was used to recruit 16 recidivist adolescents who met the eligibility criteria and who were articulate enough to provide adequate perspectives. Sixteen participants made up of nine female and seven male adolescents were recruited and interviewed before data saturation was achieved. It was anticipated that 10-20 participants would be needed to reach saturation and redundancy in this type of qualitative study (Polit & Beck, 2012, Richards & Morse, 2013; Thorne, 2008).

Inclusion and Exclusion Criteria

Inclusion of participants was based on the following:

- i. Adolescent aged 13 to 17 years,
- ii. Admitted to the study hospital at the time of recruitment,
- iii. Diagnosed with at least one mental illness, based on the DSM-IV (APA, 2000 & 2013) criteria and documented in participants' medical records,
- iv. A history of at least one previous inpatient admission and discharge from a psychiatric hospital for which the present admission is due to relapse,
- v. Ability to read and speak English at 6th grade level or more.

Exclusion of participants was based on the following:

- i. Presence of intellectual disability and communication disorders,
- ii. Presence of any serious medical condition for which the patient had been hospitalized at least twice in the last 6 months before recruitment.

Recruitment and Data Collection

Institutional Review Board (IRB) approval was obtained before the study commenced. The principal investigator (PI) met with parents/guardians of identified potential participants, explained the study to them, and asked for their consent to allow their adolescents participate in the study. Adolescents whose parents/guardians consented were approached, the study explained to them, and their assent requested to be in the study. The consents and assents were obtained at the study facility with forms approved by the IRB. The consent and assent documents prepared in two original sets were signed by both the parents and the participants and witnessed by the PI and any unit nurses present. One set of the signed documents was then given to the parents/guardian while the other set was retained for the study in the PI's locked cabinet.

The parents and participants were approached within one week of the participants' admission to the hospital to allow time for a reduction in potential increased anxiety level of the parents and for stabilization of the participants from their acute precipitating admission condition. The nurses confirmed that the adolescents were stable enough to be recruited and interviewed and the PI also verified participants' stability in the course of explaining the study to obtain assents after parental consents. The participants were promised and given a \$25 Walmart gift-card in appreciation of their

time and effort in successfully completing the study interviews. The gift-cards were deposited with the hospital and released to the participants on discharge.

The recruitment and data collection phase concluded with the achievement of data saturation and redundancy after the recruitment and interview of a total of 16 participants. Data collection involved the interview, non-participant unit observation of the participants, and the extraction of demographic information from the participants' electronic medical records (see Table. 1). All participants were interviewed individually at first and later in groups when three of them were present at the same time in the unit. The individual and group interviews were conducted by the PI in the study hospital unit office rooms that were assigned for that purpose by the charge nurses. All unit office rooms used for the interviews provided enough privacy to allow the participants to confidently share their perspectives on the aims of the study. The face-to-face oral interviews were conducted using the topic guide and sample questions shown in Appendix A and B respectively. The sample questions were modified, dropped, or new questions introduced as necessary during the actual interviews based on the participants' responses and information from their medical records in line with ethnographic methodology (Kvale & Brinkmann, 2009; Richards & Morse, 2013; Spradley, 1979). The questions asked addressed the content of the four topic guide categories aligned with the aims of the study.

The interviews were taped with a digital audio-recorder. The individual interviews were initially done in two to three segments until it was clear that the participants said whatever they wanted to say in one segment and sufficiently addressed all aspects of the study aims. Thereafter, the remaining interviews were done in only one

segment for each participant. Three group interviews were conducted with three participants previously interviewed individually. The three group interviews were done with three different participants in each group so that no participant was involved in more than one group interview. Not all participants were involved in the group interviews as some were discharged before that process. The three group interviews were also audio-taped. Non-verbal observations of the participants were jotted down during or immediately after both the individual and group interviews.

The demographics information shown in Table 1 was extracted from participants' electronic medical records. Field notes of the PI's non-participant observation of the participants as they interacted in the milieu were jotted down to better understand the adolescents and their interview responses. The recruitment, interview, observation and extraction of information from participants' medical records lasted about seven weeks when the PI suspected that data saturation had been achieved with 14 participants. Data saturation was further confirmed with the recruitment and interview of an additional two participants for a total of 16 participants which was within the range of 10-20 participants proposed and considered adequate for a study of this kind (Polit & Beck, 2012; Richards & Morse, 2013; Thorne, 2008).

The parents of the participants were not formally interviewed, but provided necessary information during the interaction with the PI in the course of obtaining parental consents. The PI also followed up with some parents after their adolescents' interviews during family visitation when necessary. This information was jotted down in the field notes and used to verify participants' interview and electronic medical records data where necessary. Most of the parents/guardians of the participants requested to be

informed about the outcome of the study while giving consent, and provided their telephone numbers to the PI for that purpose.

Data collection was concluded when data saturation was achieved with both individual and group interviews. The data saturation assessment was confirmed by the qualitative method expert and the chair of the dissertation committee who listened to a series of the audio recorded individual and group interviews of the participants and read the transcripts.

Data Management and Analysis

The interviews were transcribed verbatim by a professional transcriptionist. The PI validated the transcriptions and edited as necessary. The edited transcripts were used in data analysis together with the study memos, observation and other field notes, and extracted medical records information of the participants. Unique codes were used to de-identify participants for confidentiality and the code sheet was safely secured by the PI in a locked cabinet.

To further confidentiality, information from the study was only shared with the study advisors and the professional transcription organization with a track record of confidential handling of medical research data. The study advisors vetted the entire process and guided and debriefed the PI. Some of the original interview audio-records, original verbatim transcripts and the edited versions were sent to the chair and qualitative method expert of the dissertation committee of this study for review and confirmation of the level of agreement.

Data analysis was done concurrently and almost simultaneously with data collection. Interview transcripts were formatted to enable the transcripts to be used in the NVivo 11 Pro (QSR International, 2013) data management software. The PI commenced data analysis by reading and re-reading the transcripts uploaded into the software to immerse and familiarize himself with the data (Kvale & Brinkmann, 2009; Saldana, 2013; Thorne, 2008) before coding and categorizing the data. Broad-brush coding was first used in the categorization process which followed the study topic guide categories. Detailed coding then followed with the creation of hierarchies of sub-codes under the categories that aligned with the aims of the study. Participants' perspectives that addressed the aims of the study were derived from the repetitive patterns and themes revealed in the detailed coding process. The coding process was discussed with the qualitative method expert and the chair of the dissertation committee as it progressed clarifying the process and reflexivity.

The four stage ethno-nursing (Leininger, 2005) and thematic (Saldana, 2013) analysis methods were used to guide the analytic process. The first stage of the ethno-nursing analysis involves collection, description and recording of data; the second stage involves, the identification and categorization of descriptors of data about the domain; the third stage involves the identification of patterns in the context of the environment and the fourth stage involves the identification of major themes, presenting findings, and making recommendations for future research based on insights revealed by the study. The identified repetitive patterns and themes from the analytic process were the basis of the reported study findings.

The PI made reasonable efforts to achieve rigor and meet the quality criteria of credibility, authenticity, criticality, integrity, explicitness, vividness, creativity, thoroughness, and congruence (Whittemore, Chase & Mandle, 2001). These efforts included that an operational manual approved with the proposal was strictly used in the conduct of the study and that participants' interviews were audio-recorded and transcribed verbatim. The use of purposive sampling method ensured that the recidivist adolescents selected were those capable of effective contribution to the study and the participants were informed not to discuss their responses with others except during the group interviews. The three group interviews were constituted with three different groups of participants, so that no participant took part in more than one group interview. The comparison and verification of participants' interview responses with data from their electronic medical records, parents, clinical staff and field observation notes provided a level of triangulation. Finally, the data collection and analytic processes were continuously discussed with the qualitative method expert member and chair of the study dissertation committee for debriefing and critical feedback.

Findings

Overview

The 16 participants in this study included six Black, four Hispanic and six White recidivist adolescents who were in the age range of 15-17 years (13 out of the 16 participants). The majority of the participants in this study were from low socioeconomic families (11 out of the 16 participants). A slight majority of the participants were females (nine out of the 16 participants) and most were diagnosed with psychiatric or combined

psychiatric disorders (14 out of the 16 participants) rather than combined psychiatric and substance use disorders (Table 1). None had substance use disorder alone. The psychiatric disorders noted were mostly bipolar disorder (eight out of the 16 participants) and mood or attention deficit hyperactive disorder (each with five out of the 16 participants). The other psychiatric or substance use disorders were each less than 20% of the total. Beyond the above variations, the participants were near evenly spread in other demographic data explored in this study.

The participants described a mixed perception of treatment recidivism. They voiced dislike for their frequent inpatient hospital readmission, but believed it was necessary. They were emphatic that the “additional stressors” of problematic parental relations and bullying in schools were the major contributors to treatment recidivism over and above the “routine stressors” of adolescence; psychiatric diagnosis, medication compliance issues, and aftercare follow up. The participants mostly described a positive perception of their interaction with the medical culture.

General Perception of Treatment Recidivism

All of the 16 participants had mixed perceptions of treatment recidivism, but said that they had no special name for it other than readmission or relapse. Though the participants were not comfortable with their frequent return to the hospital, they considered it necessary to manage an acute escalating situation that could not be handled well at home, especially as the home was a main part of the problem. A 15 year old female participant put it this way: *“Well, it is bad to come to the hospital again and again. But, at the same time, it’s good, because you needed the help. It’s better to be back*

than the alternative". Another 15 year old female agreed: *"Well, I think it's good when you are here and you learn. But, I think it's bad that you are here because you shouldn't be here often"*. A 13 year old male participant said this: *"I didn't want to come to the hospital, but I had to come because I needed help"*. Similar views ran across the rest of the study participants. Another 15 year old male participant added: *"I believe that what's needed is needed and if you have to come back then you should come back, then it's in your best interest that you do"*.

Main Contributing Factors to Treatment Recidivism

The analysis of data from the 16 participants revealed the two main themes of "problematic parental relations" and "bullying" in schools as the main contributors to their treatment recidivism. However, they acknowledged the presence of "routine stressors". A model integrating the contribution of the major "additional stressors" of problematic parental relations and bullying in school found in this study with the "routine stressors" of adolescence, psychiatric diagnosis, medication compliance issues, aftercare follow up issues, to treatment recidivism in adolescents with mental illness is illustrated in Figure. 1.

Problematic parental relations.

The participants were emphatic that the "additional stressor" of problematic parental relations derived from the repetitive patterns of conflicts or not getting along with their parents described in various forms such as "conflict with my parents", "my parents do not understand me", "my mom makes me mad", "dad should stop all the insults", and similar others was a main trigger of treatment recidivism that underlie the

complaints of suicidal ideation and threats, non-suicidal self-injuries/self-cutting, anger, aggression, fighting, acting out, truancy, and depression that led to their frequent readmission. They believe the above listed signs and symptoms manifested their feelings of isolation, alienation, loneliness, desperation, not being loved and wanted, distrust, and worthlessness mostly due to the underlying trigger of problematic parental relations.

The participants were unequivocal that the additional stressors of problematic parental relations was a major trigger of treatment recidivism, but they also acknowledged the contribution of some obvious factors previously noted in the literature such as their psychiatric diagnosis, medication non-compliance, lack of aftercare services follow-up, neighborhood and family circumstances. However, they viewed these as “routine stressors”, more like the “hygiene factors” in Herzberg’s motivational theory (Herzberg, 1968; Herzberg, Mausner & Snyderman, 1959). They thought that though they could function reasonably with the routine stressors which could nevertheless cause readmission, but not as much as the additional stressors which triggered frequent readmission or treatment recidivism. One 15 year old female participant said this about problematic parental relations trigger: *“Most of the time I hear from other teens that their parents brought them here because they were having problems with their parents rather than at school or at work”*. A 16 year old male talking about his mother added: *“I try to be calm but then she does everything in her power to get me mad”*. A 15 year old female participant said: *“Just that I feel like my parent, my family doesn't love me for me, and I feel like they don't accept me. Since I admitted that I was gay and my mom didn't take it so well”*. Yet, another 15 year old male participant put it in a different way: *“I believe*

that the parents in the way they treat their child and the way they interact, how much they're willing to help them are factors that play roles in coming back to the hospital”.

Bullying in schools.

Bullying in schools has been variously defined, but essentially as unwanted aggressive physical or verbal behavior due to some power imbalance that is likely repeated over time with the intention of excluding the bullied from the group (Bullying Definition, n.d.). “Bullying” in schools derived from the repetitive patterns of difficult interpersonal relations with school mates described variously as “bullying”, “how the students interact with each other”, “they say all sorts of things to get you”, and “guys sometimes fake illness to avoid going to school because of other kids”, which appear to align with the above definition of bullying. They believed that bullying was just as problematic parental relations a major trigger of treatment recidivism that underlies the complaints of suicidal ideation and threats, non-suicidal self-injuries/self-cutting, anger, aggression, fighting, acting out, truancy, and depression usually documented as reasons for their readmission. They voiced that the above listed signs and symptoms manifested their feelings of isolation, alienation, loneliness, desperation, not being loved, distrust, and worthlessness mostly due to the underlying trigger of bullying.

On bullying in schools as a main trigger of treatment recidivism, a 16 year old male responded: *“I think school plays a major part, because of bullying and peer pressure”*. Another 15 year old female replied: *“Most of the time the kids are depressed because they’re students in a school where they get bullied”*. One 14 year old male participant added: *“We may start faking illness just not to go to school and experience*

bullying". Another 15 year old male simply replied to main triggers: *"It's problems from school and from home, but mainly home"*. A 17 year old female participant blamed bullying thus: *"Sometimes, it could be because of bullying. That's just bullying or people just saying stuff just to get to you, some stuff like that"*.

Suggestions to Reduce Treatment Recidivism

The participants suggested that addressing the additional stressor triggers of problematic parental relations and bullying in schools could reduce treatment recidivism. They also envisaged that the routine stressors such as ensuring medication compliance, follow-up with aftercare treatment and counselling services, and neighborhood issues should be maintained to complement the effort. The suggestions came in different but related forms. One 15 year old female participant said while talking about parental interaction: *"Um, talk it out, like, instead of always forcing me to do things to meet me halfway, at least, you know? Instead of never asking my opinion, ask it. To hear me out on some things"*. Another 15 year old male participant advised: *"The interaction should be very healthy interactions. It needs to be very healthy interactions, very positive interactions. Such that a parent at the very least, pretends that he or she cares about how the child is doing, such as asking them how their day was or making sure they're well fed, asking if they're feeling okay, that kind of stuff"*. Another 15 year old female participant has this to say on parents: *"The parents can try to become closer to their kids. My parents—we're close, but we're just not, like—I don't know how to explain it"*. Another 15 year old female was even more conciliatory: *"Because sometimes parents don't understand their kids half of the time. They're still learning how to raise a kid themselves"*.

On how to address bullying in schools to make the recidivist adolescents feel safe and less stressed in school, a 16 year old female participant indicted school administrators saying: *“Most schools tend to just not care”*. She advised school administrators: *“To actually watch, just like watch more and listen more. Look for signs, you know? Just help kids speak out. Let the kids know that they don’t have to be scared”*. Another 15 year old female participant said: *“The way I see it is for them to set up a club for those who are bullied, those who want to seek refuge. Like, if you're being chased by somebody inside the schools go to the library and seek refuge in there”*. Yet another 14 year old male participant advised: *“When someone says that there is bullying going on, they should accept it. They should not consider it as a tattletale”*. He further added: *“I want more staff in the hallways.....so I think we should get more security to supervise the schools”*. Similar suggestions ran through the transcripts in different forms with a 17 year old female participant advocating for school counselling: *“School counseling, I think it helps because I go to school counseling and I know. I see a therapist three times a week at school, whenever I need it. I think that helps”*.

On a general level, one 16 year old male participant chipped in a media related suggestion that could help: *“I think that instead of having these commercials that have bad influences, with all the negativity, we can start creating things to inspire. Create a commercial that tells you, you are important, instead of saying you need to come and visit the dark side. Come visit the light side. Start saying and having more people offer extra support; that will have positive influence on everybody else”*.

Perception of the Interaction with the Medical Culture

The 16 participants described the perception of their interaction with the medical culture as mostly positive and satisfactory. They however made suggestions on different areas they want to see some adjustments to make it even better. A 17 year old female participant said: *“I see it’s worked, from what I’ve seen, I think everything is working pretty good. I see that the kids like it here. I mean, everybody’s getting the help they need and the medical help is good here. Everything I like it. They’re helping me and I’ve been good so far”*. While a 15 year old female believes: *“It’s very organized, but I see that admissions process—well, but it’s usually very long and kind of painful”*, another 15 year old male stated: *“I feel like the things the hospital is doing are things needed within the hospital’s environment, such as keeping a structured, organized schedule throughout the day making it a safe environment all that is perfectly fine”*. Yet another 15 year old female participant said: *“Well, it’s very organized, and as Ricky Martin said, life is crazy. So having a schedule, a structured place, like this, can be very easy I guess on yourself. And then when you go back to the world, it’s like so crazy, you want to go back in, into your little turtle hut”*.

Some of the participants’ suggestions included allowing more time for doctor and patient interactions, assisting them with school work so that they will not be behind when they get discharged and go back to school, incorporating more activities to reduce boredom and take their mind off their problems, and allowing more supervised social interaction between the male and female teens.

Discussion

The adolescents' acknowledgement of the routine stressors/factors associated with readmission underscore the significance of their perspective that problematic parental relations and bullying especially in schools were the main triggers of treatment recidivism. Even though they acknowledged the routine stressors are part of their lives, they were only mentioned when the participants were asked to think of any other factors that could lead to rehospitalization.

The findings that problematic parental relations and school bullying were the main triggers of treatment recidivism appear to have support in both the ecological transactions model (Bronfenbrenner, 1979; Gonzales, 2009; O'Connell, Boat & Warner, 2009) and systems theories and models (Bertalanffy, 1968; Neuman & Young, 1972) which postulated that humans live in an ecological system, interact with and are influenced by their environment which they also influence. The findings also appear to have support in the stress theories (Lazarus & Folkman, 1984) that emphasized the influence of stressors on physiological, emotional, mental and physical behaviors of humans.

Thus, the mere grouping of problematic parental relations with the broad family characteristics or bullying in schools with the broad environmental factors may conceal the specific nature of these triggers and diminish the level of clarity revealed by this finding. The specific clarity of isolating the main triggers could help in early identification of those at risk and aid the search for focused interventions that could reduce treatment recidivism. Based on anecdotal evidence of the PI's interaction with

families in the adolescent units of different psychiatric facilities, parents tend to “medicalize” their teen’s situations and get frustrated that the hospitals “failed to provide the quick and permanent fix” for their troubled teens. Parents over medicalization of all their teens’ problems may be overly simplistic. It is not certain which of these two main triggers has more influence on treatment recidivism, but anecdotal evidence of psychiatric nurses experiences including that of the PI in the study hospital points to increased admission when schools are in session than during holidays suggesting possible higher influence of bullying. However, the exact nature and level of influence for these triggers is uncertain because of the complex relationship that could exist between them and would only be ascertained through mixed method studies on the subject in the future.

The above finding highlights the need for possible adjustment to the “content” of the present family meetings and family therapy in the hospitals to go beyond mainly “sharing of information with patients and families on available resources and encouraging compliance with aftercare follow up” to accommodate more of “adolescent parental relations and parenting skills” especially for parents of troubled teens. The implementation of this highlighted need could be extended to religious and societal organizations where parents are encountered in large numbers. It should be noted that the previous opportunities of the informal socialization of parenting skills have been eroded by the circumstances of our changing society (Marcosi, 2015; Bumpass, 1998). Therefore, stakeholders may need to investigate new avenues for teaching these skills to address the present inadequacy. As one participant put it while talking on parents, “.....but it’s like they don’t understand either. Because sometimes parents don’t

understand their kids half of the time. They're still learning how to raise a kid themselves. They've never raised a kid before. They're still learning".

The findings of this study also further spotlight the recognition that bullying has become a major problem in schools, different from the routine pressures of school work. Judged by the grade level at school, responses of participants and parents, it appears that a sizeable number of these recidivist adolescent participants were getting along enough with their school work. The above supports the response that they were capable of being in school and functioning reasonably notwithstanding the routine stressors of adolescence and mental illness, except for the additional stressors of bullying and/or problematic parental relations. School work stress is a constant that affects all adolescents whether they live with or without mental illness. Recent studies have not only supported the traumatic and harmful effects of bullying, but even associated bullying with higher probability of developing a mental illness later in life (Sourander et al, 2009). The overwhelming stress that bullying brings to bear on adolescents with mental illness, that causes them to relapse, snap and be hospitalized again could only be imagined. The participants did mention that the bullying in school was not peculiar to them or related to their mental health issues as they claimed that most of their school peers were not aware of their psychiatric diagnosis and that bullying was rampant across board. The immediate impact of bullying was probably felt more by these adolescents with mental illness because they were already "stressed" relative to other students due to presence of their routine stressors discussed above.

Again stakeholders would need to redouble efforts on the menace of bullying in schools. While bullying may occur outside the schools, most occurs in schools. Bullying in schools has been recognized as a serious societal problem, but current efforts to address it are not adequate as the participants revealed. The participants, though from different schools, very easily attested to its existence in their various schools. Their suggestions that more opportunities be created for them to speak out without being afraid and for schools to have trained personnel that will proactively be on the lookout for signs of bullying should be considered. Schools should evaluate implementing visible and deterrent interventions on those caught engaging in bullying to protect and assure other students. Schools should not only be safe, but should be seen as such by the students, so that their anxiety is limited to school work. The above suggestions should be in addition to current interventions which may benefit from re-evaluation and necessary adjustments to make them not only effective but also efficient.

Their mixed perception of treatment recidivism should not come as a surprise, because adolescents should have more important “adolescent activities” to do outside the hospitals such as learning, growing and interacting than being in the hospital. But the overwhelming anxiety created by the identified additional stressors makes their illness relapse and render them unable to effectively participate in those adolescent activities and so they settle for the inevitable option of going back to the hospital. Their positive perception of the medical culture should be expected, because they see the hospitals as the last resort. The order, structure, caring, listening ear, respect, non-judgmental interactions in the hospitals provide what they desired but could not get in the outside world of the home and school. The participants had some recommendations to improve

their interaction with the medical culture such as improving food quality and allowing freer interaction between the boys and the girls. Such suggestions have been made in the past, but have not had wholesale implementation by the hospitals. Full implementation such as the unhindered interaction between the boys and the girls could make adolescent patients lose focus of their treatment, make more safe havens of the hospitals, and possibly lead to unintended consequences.

The fact that near equal number of female and male participants was noted adds to the existing controversy in the literature as to which is the more recidivists of the two genders. Though it was planned to have about equal representation, it just happened without getting to the point where the effort was needed to achieve it. The supplemental finding that most recidivists had combinations of psychiatric diagnoses than combined psychiatric and substance use diagnoses was also revealing. However, this finding has to be considered against the background that a lot of these adolescents use substances at various levels that may or may not meet diagnostic criteria (CDC, 2014) at their time of hospitalization. Another supplemental finding was that a majority of the participants were from low socioeconomic families; low socioeconomic status determined on the basis of participants' receipt of free meal in school. Though this finding has support in previous studies that found association between negative health outcomes and low family socioeconomic status, it could be associated with the fact that the study hospital serves a good number of the indigent families. However, it could also be a mirror of the disparity that exists in that direction that still needs to be addressed to improve health.

Limitations of the Study

The major limitations of this study include that it was conducted in one inpatient psychiatric hospital that served mostly the indigent population in one region of the United States and focused only on the perspectives of a relatively small number of purposively selected recidivist adolescents with mental illness. Furthermore, non-English speaking participants were excluded and the study included a broad rather than narrow classification of mental illnesses.

Conclusions

Though the above findings represent only the perspectives of the recidivist adolescents with mental illness, they are both insightful and well-articulated. The findings could further the efforts towards focused assessments of adolescents with mental illness and help with early identification of those at risk which would support well targeted interventions to address treatment recidivism in that sub-culture.

There is the need to follow this study with large multicenter studies that could span regions and/or countries to rule out the effects of the limitations noted above while verifying the findings of this study. Such studies could be inclusive of other perspectives such as those of parents and/or healthcare providers, employ methodological diversity, and benefit from multidisciplinary teams considering the nature of the issues raised in the findings of this study.

Even though generalization was not intended for the findings of this study as with most qualitative studies, the verification of these findings could improve their possible applicability to other similar settings with necessary modifications.

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Table 1

Participant demographics and other characteristics

Participant	Age	Gender	Race	# of Re- Admits	DSM- IV Axis I Dx	Status	Living Status	Family SES	Family - Structure	Family Psych Hx
1	15	F	W	≥ 2	B/D, PTSD SUD	NS/NW	CPS	L	CPS	Psych + SUD
2	16	M	B	≥ 2	B/D	S = 10 th	Family	L	Single parent	N/A
3	15	F	W	≥ 2	MDD	S= 10 th	Family	L	Dual parent	N/A
4	16	M	H	≥ 2	B/D, ADHD	S = 8 th	Family	L	Dual parent	N/A
5	15	F	W	≥ 2	MDD	S = 10 th	Family	M	Dual parent	Psych Dx
6	13	F	B	≥ 2	B/D, ODD	S = 7 th	Family	L	Single parent	N/A
7	13	M	B	≥ 2	B/D	S = 7 th	Family	M	Dual parent	N/A
8	17	M	H	≥ 2	M/D, ADHD	S = 9 th	Family	L	Single parent	Psych Dx
9	17	F	H	≥ 2	B/D	S = 11 th	Family	L	Dual parent	N/A
10	15	F	B	≥ 2	B/D, PTSD	S = 9 th	Family	L	Single parent	Psych Dx
11	16	F	W	≥ 2	D/D	S = 10 th	Family	M	Dual parent	Psych + SUD
12	16	F	B	≥ 2	M/D, ADHD	S = 9 th	Family	L	Dual parent	Psych + SUD
13	15	M	H	≥ 2	M/D, ADHD	S = 9 th	Family	L	Single parent	N/A
14	15	F	B	≥ 2	B/D, ADHD	S = 8 th	Family	L	Dual parent	Psych Dx
15	16	M	W	≥ 2	M/D, C/D, SUD	S = 10 th	Family	M	Single parent	Psych + SUD
16	14	M	W	≥ 2	M/D, I/D	S = 10 th	Family	H	Dual parent	N/A

Note. B=Black; H=Hispanic; W=White; N/A= Denied/not seen in record; N/S=Not schooling; N/W=Not working; S=Schooling; B/D=Bipolar D/O; C/D=Conduct D/O; D/D=Depressive D/O; I/D=Impulsive D/O; M/D=Mood D/O; MDD=Major Depressive D/O; ODD=Oppositional Defiant D/O; SUD=Substance Use Disorder.

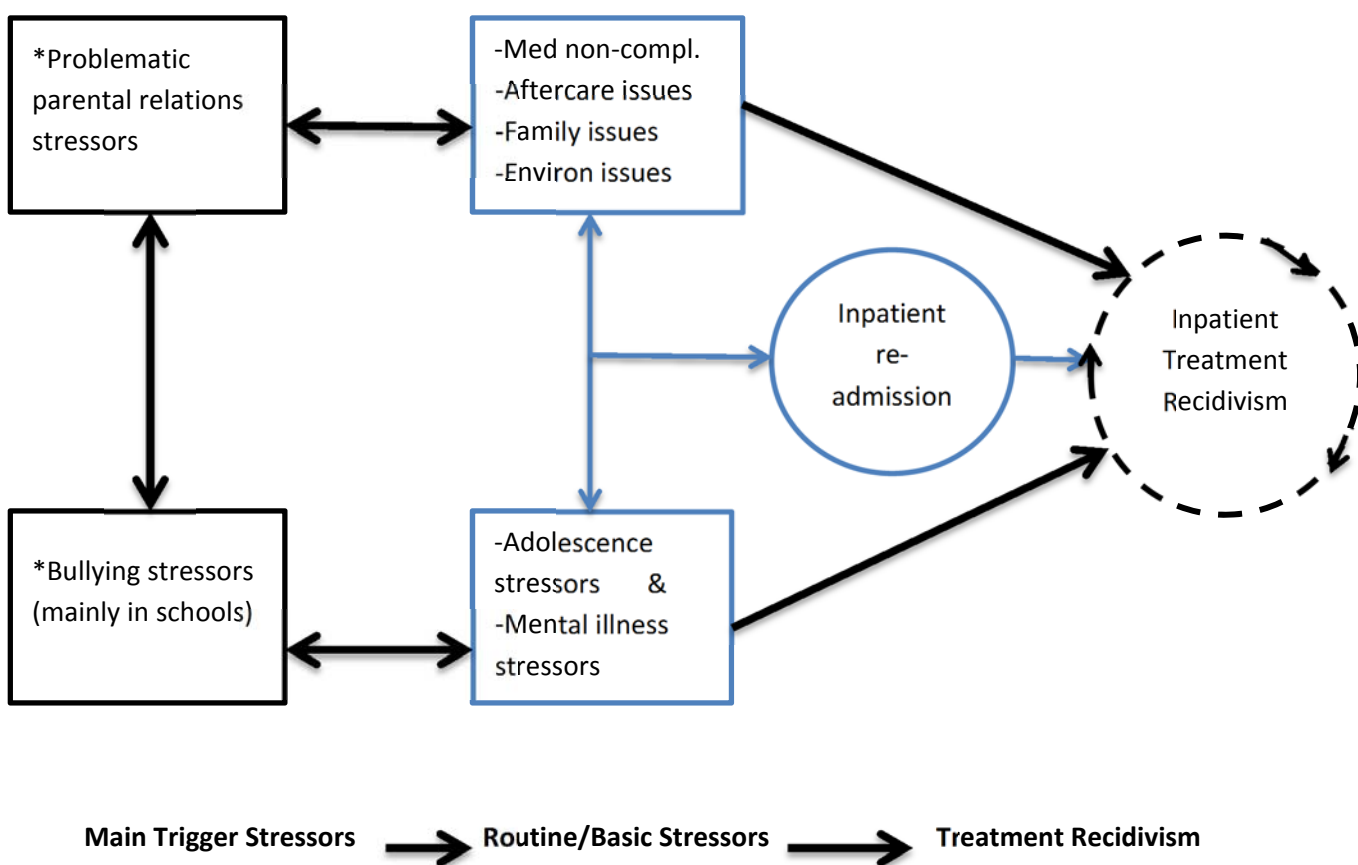


Figure 1. Model of Triggers of Readmission and Treatment Recidivism

Appendix A

Topic Guide for the Interview

Appendix A

1. Treatment recidivism and its meaning to the recidivist adolescents,
2. What factors the recidivist adolescents consider as contributors to recidivism in relation to the under listed,
 - 2a. Contributions of patients if any,
 - 2b. Contribution and nature of their problem condition,
 - 2c. Contributions of their families and immediate environment if any,
 - 2d. Contributions of hospitals and treatment team if any,
 - 2e. Contributions school and/ or work and that environment if any,
 - 2f. Participants' other thoughts not included in the above listed,
3. Recidivist adolescents' suggestions on the way forward if they consider it necessary with respect to the under listed,
 - 3a. Contributions of patients if any,
 - 3b. Contribution and nature of their problem condition,
 - 3c. Contributions of their families and immediate environment if any,
 - 3d. Contributions of hospitals and treatment team if any,
 - 3e. Contributions school and/ or work and that environment if any,
 - 3f. Participants' other thoughts not included in the above listed.
4. Participants' perspectives and attitudes to the medical culture.

Appendix B

List of Typical/suggested Questions for the Interview

Appendix B

1. Hi John, please tell me a little about yourself and your likes and dislikes (John is an example, to show how to address patient by name).
2. What was the issue that brought you to the hospital this time?
3. How many times have you been admitted to the hospital in the last 12 months?
4. Have you been previously admitted outside the last 12 months?
5. Think about your very first admission and what were the issues at that time?
6. In your readmissions in the last 12 months, could you recall what happened?
7. Tell me your thoughts about being admitted to the hospitals again and again.
8. How do you see this? (As a problem or solution and what makes you think about it that way?)
9. How does your family see this? How do they talk you about it?
10. How did your school and/or work, teachers and classmates see this? How did the hospitals and the treatment team, specifically- doctors, nurses, social workers, therapists, chaplain and other patients see this? How did they talk to you and others about it?
11. If you see it as a problem, what do you think can be done to reduce it?
12. If you do not see this as a problem, what other suggestions do you have about it?
13. Would you talk about other things related to this that we have not covered, but you remember and consider important?
14. What are your perspectives and attitude to the medical culture?

List of Typical Questions used in the Interviews

APPROVED PROPOSAL

Treatment Recidivism in Adolescents with Mental Illness: An Ethnographic Study

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Specific Aims

Treatment Recidivism conceptualized as frequent unplanned relapse readmissions is a national problem, predominant in adolescents with mental illness. Arnold et al. (2003) estimate readmission at 19% in six months, and 44% in 10.3 years for adolescents after initial inpatient psychiatric unit discharge. Blader (2004) reported a 34% rehospitalization rate in a one year period for children 5 to 12 years after inpatient psychiatric treatment. Goldstein, Frosch, Davarya, and Leaf (2007) reported that 19% of child and adolescent psychiatric patients were readmitted to emergency services in a six-month follow-up period. Fontanella (2008) estimates that 24 to 38% of adolescents were readmitted to a psychiatric unit one-year after inpatient discharge while Bobier and Warwick (2005) reported a 65% readmission rate in a 12-month period post discharge.

Treatment recidivism is a significant social and economic problem considering adolescents' burden of mental illness, decreased school and job performance, disruption of lives of patients' families, and the inevitable contribution to the increasing cost of healthcare. Its cost implication can only be imagined from the cost estimates of inpatient hospitalization. Davis (2014) reported that about \$10.9 billion was used to provide some type of mental health services to 9.3% of children and adolescents 5-17 years old during a two-year period. Fontanella (2008) reported that inpatient services accounted for about 33% of the total mental health expenditures for children and adolescents in the United States. Current efforts to address treatment recidivism have investigated the effectiveness of aftercare services (James et al., 2010; Carlisle, Mamdani, Schachar & To, 2012) and issues based on patients' clinical status, treatment models, family and environmental

characteristics (Fontanella, 2008; Barker, Jairam, Rocca, Goddard & Matthey, 2010) with mixed and sometimes conflicting results.

Adolescents living with mental illness are a sub-culture of adolescence the growth period of developmental and social transition from childhood to adulthood (Burns, Dunn, Brady, Starr & Blosser, 2009; Centers for Disease Control and Prevention (CDC). (2012); Stuart, 2013). Adolescence also is a sub-culture of the broader societal culture, because of the peculiarities of the period in terms of beliefs, values, and behaviors of that growth period (Erickson, 1968; Steinberg, 2011). Culture has been defined variously depending on disciplinary leanings and the time (Bodley, 2000; Engebretson, 2011; Ferrante, 1992; Kroeber, 1952; Spradley, 1979). In anthropology where the culture was originally and widely studied, society was emphasized (Heath (2001). But more recently, culture has also been defined in terms of the beliefs, values, and behavior characteristics of a particular social, ethnic, illness or age group as well as society (Engebretson, 2011; Dictionary.com, 2015). Adolescents with mental illness are described as a sub-culture to be studied through ethnography follows culture's more recent definition approach.

A major gap in knowledge is that none of the previous efforts to address treatment recidivism sought the perspectives of the adolescents with mental illness themselves in the design or review of current interventions to address it. A better understanding of treatment recidivism from the perspectives of these adolescents with mental illness would help in the search for a solution to treatment recidivism. The purpose of this focused qualitative ethnographic study is to attempt to fill the above gap. Focused ethnography is a type of qualitative method used to seek the understanding of a subcultural group on a specific issue (Muecke, 1994; Richards & Morse, 2013). Expected new insights from this

study could be included in future intervention and services delivery studies in the search for solution to the problem of treatment recidivism.

The specific aims of this study are:

1. To better understand how recidivist adolescents with mental illness in Houston area of Harris County perceive their treatment recidivism.
2. To better understand the perspectives of these adolescents on the factors that contribute to treatment recidivism and how best to minimize them.
3. To describe the interaction of the subculture of adolescents with mental illness with the medical culture.

Research Strategy

Significance

Frequent readmission after discharge from inpatient hospitalization is a national problem. It has become particularly worrisome in this era of fiscal constraints and declining budgetary allocation to the healthcare industry. Reducing treatment recidivism has therefore become a priority of hospitals since the Affordable Care Act (ACA, 2010) established a Hospital Readmission Reduction Program. This program imposes a penalty on healthcare organizations that exceed a certain level of avoidable readmissions for certain disease conditions. However, this program is still limited to certain categories of patients' conditions and does not specifically address the readmission of adolescents with mental illness.

The scope of unplanned readmission is significant. It has been estimated at 25% of all hospital patients admitted in the United States in a 2-year study of 30-day readmission rates between 2006 and 2007 (AHRQ, 2010) and at varying rates in different segments of patient populations and disease conditions. Frequent readmission in adolescents with mental illness is also varied, but higher than reported in most other populations. Estimates have ranged from 19% in 6-month period (Arnold et al., 2003; Goldstein, Frosch, Davarya & Leaf, 2007), to 24% - 38% in a 12-month period (Blader, 2004; Fontanella, 2008), and 44% in 10.3 years (Arnold et al. 2003).

Treatment recidivism has significant social and economic implications, considering the adolescents' increased burden of mental illness and other negative functional outcomes. Such implications include poor school and job performance,

reduction in the nation's supply of productive future workforce, disruptions in the lives of the adolescents' families, and the frustration of healthcare providers. It makes an inevitable contribution to increases in the cost of the healthcare system. It can dramatically impact adolescent lives and lead to chronic adult mental illness, criminality, and risky behaviors such as suicide, alcohol, and substance use among others. It has been reported that about 20% of adolescents have diagnosable mental illness (CDC, 2014; Schwarz, 2009), but less than half of that percentage actually receive treatment (Costello, He, Sampson, Kessler & Merikangas, 2013). Davis (2014) reported that about \$10.9 billion was used to provide some type of mental health services to 9.3% of children and adolescents 5-17 years old, during a two-year period. Fontanella (2008) reported that inpatient services accounted for about 33% of the total mental health expenditures for children and adolescents in the United States. The above give some perspective to the probable cost implications of recidivism in adolescents with mental illness.

Treatment recidivism has persisted and even increased since the time of managed-care despite various efforts to address it (James et al., 2010; Garrison & Daigler, 2006). Previous efforts to address the problem by evaluating interventions based on some identified risks and factors that predict treatment recidivism in adolescents with mental illness have not been very successful. It has been noted that recidivism in adolescents with mental illness is a multidimensional and complex concept like most other human problems (Barker, Jairam, Rocca, Goddard, & Matthey, 2010; CDC, 2012; Steinhausen, Grigoriu-Serbanescu, Boyadjieva, Neumarker, & Metzke, 2008). The factors that influence recidivism in adolescents with mental illness are multifactorial but not yet fully understood. Adolescents with mental illness live in an ecological system and are part of

the interaction and cross-cultural influences in the system that affect every aspects of their development, health and health intervention outcomes (O'Connell, Boat & Warner, 2009). The systems perspective (Bertalanffy, 1968) and the ecological transactional models (Bronfenbrenner, 1979; Gonzales, 2009; Kohrt, Kohrt, Waldman, Saltzman & Carrion, 2004) have long postulated that humans exist in, interact with and are influenced by their environment which they also influence. Some risk factors and predictors of treatment recidivism have been investigated including effectiveness of aftercare or post discharge treatment services, and follow-up (Daniel et al., 2004; James et al., 2010; Carlisle et al., 2012), patients' clinical status, treatment models, family and health system characteristics (Fontanella, 2008, Steinhausen et al, 2008; Barker et al., 2010). But most of these investigations have used quantitative research method and have not sufficiently sought the views of the adolescents with mental illness themselves.

The purpose of this study is to explore an understanding of treatment recidivism from the perspectives of the adolescents who experience this problem. Adolescents with mental illness have not reported experiences with mental illness and readmissions. Their insights could form the basis of future services delivery and intervention research that may lead to adjustment in current practice. Potential changes to practice could improve the lives of these adolescents, their families and communities, satisfaction to healthcare providers, and cost savings to the healthcare industry and the nation.

The study will adopt the Neuman's health care systems nursing model to investigate the revolving door syndrome of treatment recidivism (Neuman & Young, 1972). Neuman's model views the human patient as a complete system in constant struggle for balance with internal and external environmental forces that attempt to

disturb its balance. The systems model recognizes the multi-dimensional nature of interactions that affect various health states and associated problems. Some of the interactions emanate from the patients, patients' treatment and the contexts of the patient. This study focuses on the patient dimension. It will explore the perspectives of recidivist adolescent patients with mental illness in a qualitative ethnographic study to further the search for solution to the problem of treatment recidivism in that population.

Innovation

This proposed study is innovative in three main aspects, namely;

1. Methodology and focus,
2. Timing of study for increased impact,
3. Operational definition of treatment recidivism.

Most previous studies were quantitative and retrospective in nature. But, even the few prospective and/or qualitative studies (Steinhausen, Grigoroio-Serbanescu, Boyadjieva & Metzke, 2008; James et al., 2010), explored treatment recidivism from the perspectives of the parents, healthcare providers and others, but not from the perspective of the adolescents who primarily bear the burden of their disease and the experience of treatment recidivism. This study's use of qualitative, ethnographic methodology to seek an understanding of treatment recidivism from the recidivist adolescents with mental illness and their suggestions on how to better address it is a necessary shift from previous studies. In addition to either supporting or contradicting previous efforts, the findings will bring a new dimension to the discourse on the subject as the search for solution to the problem of treatment recidivism continues.

There is a dearth of research literature on this subject in this population compared to their adult counterparts, despite the fact that treatment recidivism is more prevalent in the adolescents with mental illness (Bobier & Warwick, 2005; Barker et al, 2010; James et al, 2010). Recently, there is increasing public awareness of the problem of treatment recidivism. This is driven by its expected financial impact on the hospitals due to the recent changes in the healthcare laws in the United States. The implementation of the Patient Protection and Affordable Care Act, 2010 (ACA (2010) penalizes certain inpatient hospitals for certain levels of frequent readmissions. The hospitals are thus making concerted efforts to highlight and address treatment recidivism in order to avoid the penalty. The above coupled with the magnitude of treatment recidivism, associated negative functional outcomes, and the cost implication of that problem in adolescents with mental illness justify that the time is ripe for further evaluation of the problem of treatment recidivism in that population.

Treatment recidivism operationalized in this study is defined as two or more readmissions within a 12-month period of an initial inpatient discharge for relapses of previous admission conditions. This definition is a refinement to address the concerns noted in the definition of treatment recidivism in previous studies. Previous studies varied in the nomenclature and operational definition of treatment recidivism. Some called it readmission, rehospitalization or recidivism, and used different time frames that ranged from six months to above 10 years, in calculating the readmission rates. Most of the studies considered only one readmission and failed to account for multiple readmissions within the time frames. They also did not state the nature and reasons for the readmissions, such as whether the readmissions were due to relapse or for entirely new

problems. The above inconsistencies make it difficult to effectively compare, or integrate some of the findings of previous studies, or to fully grasp the import of the problem – the high frequency of readmission in a reasonable time frame.

Approach

Design.

A focused ethnographic study design will be used to explore the perspectives of recidivist adolescents with mental illness in the Houston area of Harris County in Texas. There is a need for better understanding of the emic views of this adolescent sub-group on treatment recidivism as the search for solution to that persistent problem continues. Ethnography is often used to study cultural groups. Focused ethnographic study design is considered appropriate in studying a group of participants who share a common feature of disability similar medical or health concerns (Engebretson, 2011; Richards & Morse, 2013). Recidivist adolescents with mental illness are considered a sub-cultural group in line with the above criteria.

This ethnographic study will be done through individual and group interviews to ensure that the interpretation of the participants' perspectives of their behavior or experience is well described (Polit & Beck, 2012; Thorne, 2008). The interviews will be complemented by non-participant field observations of the recidivist adolescents with mental illness as they interact with themselves and others in the hospital unit. Participants will be adolescent recidivists recruited during inpatient admission in the selected psychiatric hospital. The study hospital was chosen because it has a dedicated general child/adolescent psychiatric unit and it is often used by a number of the surrounding

communities. The hospital is also affiliated to a health science university with a clinical, scientific, and research focus. This affiliation ensures that the hospital environment will be conducive for this study and that the staffs have the orientation and is conversant with research studies.

Methods.

Setting and sampling.

The study setting will be a ±300-bed inpatient psychiatric hospital, in the Houston area of Harris County of Texas in the Southwestern part of the United States. The hospital has a dedicated 20-bed general adolescent psychiatric unit frequently used by adolescents with a whole spectrum of mental illnesses from the surrounding communities. The setting will provide adequate feasibility in terms of access and availability of the participants that will be required for the study. The purposive sampling method will be used to recruit recidivist adolescents that meet the inclusion criteria and who are articulate enough to provide adequate perspectives of this segment of the adolescent population. Purpose sampling is a nonprobability sampling method used by researchers to select the most informative participants for a study (Polit & Beck, 2012). The use of purposive sampling is justified because the nature of the study requires the selection of participants with necessary characteristics to benefit the study. During purposive sampling, reasonable effort will be made to achieve gender and other demographic balance as practicable. Sample size will be determined by data saturation (Polit & Beck, 2012) in the course of the interview process that will proceed almost simultaneously with the recruitment process.

However, a sample size of about 10 to 20 participants is anticipated in line with qualitative tradition (Polit & Beck, 2012, Richards & Morse, 2013), though the actual final sample size will be determined by data saturation. Data saturation will be assessed when further data collection does not offer new insights from what is already collected relative to the study objectives or emergent explanations (Richards & Morse, 2013). Participants' interviews will be conducted in the hospital after recruitment. Effort will be made to interview all participants in the hospital and any participants whose interviews are not commenced or concluded before discharge will be dropped from the study. Any information gathered from such participants before discharge will be discretely discarded and will not be included in reporting the findings of the study. Recruitment will be done within one week of participants' inpatient admission to allow for stabilization from their acute precipitating admission conditions and after their parents have consented for them to participate in the study.

Inclusion & exclusion criteria.

Eligibility will be on the basis of the following:

- i. Being a male or female adolescent aged 13 years or more, but less than 18 years,
- ii. Being admitted to the study hospital, at the time of recruitment,
- iii. Being diagnosed of at least one mental illness, based on the DSM-IV (APA, 2000 & 2013) criteria and documented in participants' medical records,

- iv. Having a history of at least one previous inpatient admission and discharge from a psychiatric hospital for which the present admission is due to relapse,
- v. Ability to read and speak English at 6th grade level or more.

Exclusions will be on the basis of the following:

- vi. The presence of intellectual disability and communication disorders,
- vii. The presence of any serious medical condition for which the patient had been hospitalized at least twice in the last 6 months before recruitment,
- viii. Not meeting the above inclusion criteria.

Procedure and data collection.

Institutional Review Board (IRB) approval will be obtained from the University of Texas Health Science Center at Houston (UTHealth) Committee on the Protection of Human Subjects (CPHS) before commencement of the study. The UTHealth CPHS approval also covers the IRB requirements of the study hospital because of its affiliation with UTHealth. The Principal Investigator (PI) will arrange and visit the study hospital to meet with its relevant authorities and necessary “gate keepers” to introduce himself and the study to the hospital after the UTHealth CPHS approval. The PI will present the UTHealth CPHS approval to the hospital research committee and seek their approval, which is usually given once UTHealth CPHS approval is submitted to them. The PI’s hospital gatekeeper contact will thereafter introduce the PI to the unit staff before the commencement of the study. The PI will thereafter arrange and orient the hospital unit nurses and other staff to the study protocol and recruitment modalities which will enable

them to help in identifying potential participants for the study. The PI will regularly call the hospital unit during the three shifts to inquire and encourage the unit nurses to notify him of potential participants' admission. The PI will approach the parents and their adolescents for participation in the study within one week of admission to the hospital. The time lag is to allow time for a reduction in potentially increased anxiety level of the parents necessitated by the event of their adolescents' inpatient admission and also to allow those adolescents time to stabilize from their acute precipitating admission conditions. The nurses or attending physicians will be asked to confirm that the adolescents are stable enough to be recruited and interviewed. This time allowance will protect the autonomy of the parents and participants as they will be in a better state of mind to understand the study and their expected involvement.

The PI will visit the hospital during the recruitment period to explain the study to the potential participants' parents and to obtain their Informed Consent if they want their adolescents to participate in the study. The PI will subsequently and separately approach and explain the study protocol to potential participants and encourage them to participate in the study after their parents have agreed for them to be in the study and signed the informed consent. The PI will inform potential participants that the outcome of the study could reduce recidivism in the future. The participants will also be informed of the plan to appreciate their effort in the study with a \$25 gift-card for those who successfully complete the study. Potential participants who agree to be part of the study will sign the assent form. The PI will witness both the informed consent of the participants' parents and the assent from the adolescents by attesting his signature at the appropriate places in the forms. The study protocol will be prepared in sets of two and both will be signed by

the participants, their families, and the PI as witness. One set of the signed protocol will be given to each participant and family while the other set will be retained in a secure study folder managed by the PI.

Obtaining the informed consent and assent are intended to protect the autonomy of participants and their families while participating in the study and will include necessary information as required by the UTHealth CPHS format adapted to the study. Such information will include telling the parents and the participants of their right to withdraw from the study at any time if they chose to do so with no negative consequences. This information will also include giving them the UTHealth CPHS and hospital patient advocate phone numbers should they have any complaints against the PI or the study. The data collection process will commence only when the consents and assents have been obtained from the participants and their families. The PI will frequently visit the hospital and on notification of potential participant admission by the unit nurses to continue with new recruitments and the interview and observation of the previously recruited. This process will continue until the recruitment and data collection phase of the study is concluded within the three months allotted to that phase of the study as detailed in the study schedule in Appendix D.

Participants will be provided with privacy in both recruitment and the interviews by discrete selection of a private and quiet location in the unit for that exercise. Private family meeting room, physicians' consultation rooms and unit staff meeting rooms will be rotated for recruitment and interviews. Confidentiality will be maintained by de-identifying and coding all participants' data where possible so that names, medical record

numbers, and other identifying information are not documented. Participants' data will be stored in the PI's study specific laptop which will not be connected to the internet and that will be password protected. The PI will make reasonable effort not to leave the laptop unattended at any time when not locked up in the hospital unit cabinet.

Participants' data will be backed-up in a flash drive that will be secured in the PI's locked cabinet in his study carrel room at the UTHealth School of Nursing building or locked up in his fire proof cabinet at home. Participants' information will be made available to only the professional transcriptionist that will be engaged for the study and the PI's study advisors who are seasoned university professors at UTHealth. Participants' data will be managed in line with the UTHealth CPHS approval requirement to ensure their safety and avoid unauthorized or mistaken disclosure. Participants' data will be erased from the laptop hard drive, back-up flash drive, digital audio tape recorders, and paper hard copies and destroyed as appropriate within the time frame allowed by the UTHealth CPHS approval guidelines.

Participants will be interviewed in the hospital shortly after recruitment, but any participants whose interviews are not commenced or concluded before they are discharged from the hospital will be dropped from the study. Any information gathered from such participants before discharge will be discretely discarded and will not be included in reporting the findings of the study. Participants will be interviewed individually at first, in a location that is safe and comfortable with adequate privacy for the participants to confidently share their perspectives. Focus group interviews will then be conducted thereafter, whenever three or more of the individually interviewed participants are present in the hospital at the same time. Effort will be made to involve all

participants at least one focus group interview. The focus group interviews will complement the individual interviews for more breadth. Such focus group interviews will also be in a place that is safe and private and will be at the convenience of the participants. All the interviews will be audio-tape recorded and parents/participants will be duly informed of this at informed consent/assent stage. The PI will always provide a backup audio-tape recorder during the interviews. The PI will anticipate and deliberately manage possible distractions by dressing appropriately to the level of the participants; using a sophisticated digital audio tape recorder and selecting and arranging the interview location to minimize distractions. Managing distractions will help to reduce reactivity and bias and improve the rigor and credibility of the interview outcomes. The main instrument for this study will be the semi-structured interviews guides, assisted by the audio tape recorders and field notes of the PI.

The Topic Guide shown in Appendix A and the set of sample questions for the semi-structured interview shown in Appendix B will be used to conduct of the interviews. Even though the topic guide and the set of sample questions will be used in interview process, participants' responses and emergent themes will be explored in the course of the interviews and they will determine the eventual scope and overall order of interview questions. The conversational style of interview will be used to make the adolescents who usually sensitive comfortable. In ethnographic studies, participant observation, interview and audio-taping of the interviews are often used to collect data, but the quality of the outcomes of the interview is influenced by the nature of the interview and the experience of the interviewer (Polit & Beck, 2012; Richards & Morse, 2013; Thorne, 2008).

Therefore, deliberate effort will be made by the PI and his advisors to plan and conduct the study interviews to achieve adequate quality.

The interview process will employ broad opening and mostly open-ended questions that will enable the recidivist adolescents to share their perspectives on the subject. Data collection will continue until saturation is achieved or redundancy reached when no further new information is shared by the participants. Interview questioning will be preceded by introductions and exchange of pleasantries before general discussions of the expectations of the study. This is aimed at developing mutual respect and some level of trust with the participants before delving into the semi-structured interviews using the set of sample questions shown in Appendix B. However, these questions will not be asked in any specific order and may not be asked at all depending on the responses of participants to previous questions and new questions may be added based on their responses. A digital audio-tape recorder will be used to tape the interviews and the PI will take detailed field notes during the interviews to capture the contextual and non-verbal observations in the course of the interviews.

The initial interviews will be in one or two segments of about 10 to 20 minutes duration at a time to accommodate the adolescents' attention span and minimize undue burden to them that could influence their responses. Follow-up interviews will be done in further segments as necessary until the sample questions are exhausted and/or based on emergent themes during the process until data saturation is achieved. The interview of each participant will last for about one to three days and will be when it is convenient for the participant. The PI's audio-tape recorder for the interviews will be tested before use

and a back-up will also be provided to manage any potential technical failures of the equipment. Participants will be informed that they will be audio-tape recorded, but that the audio-tape recorders will be camouflaged as much as possible during the interviews to reduce their possible distraction. However, participants will be debriefed about the camouflage of the audio-recorders immediately after the interviews. Interviews will be played back immediately after to ensure that any problems noted are immediately corrected while the encounter is still fresh in the mind of the PI and while the participants are still available. The PI may also speak out his non-verbal and contextual observations to be recorded in the audio-tape recorders immediately after the interviews, whenever he considers it inconvenient or a distraction to the interviews to write copious notes. The PI will also keep a log of his field notes for ease of analysis. Family members and other persons will not be allowed during participants' individual interviews except when specifically requested for by the participants. The possible bias implications of such requests will be explained to the requesting participant and such requests will be documented in the field notes.

Data will also be extracted from the participants' computerized hospital medical records during the records review to document participants' demographic information, psychiatric diagnoses/medical history, previous hospitalization history, and other information relevant to the study as described in the form described in Figure C1, shown in Appendix C. Extraction of participants' data will be limited to what is required for the study to further protect their confidentiality. Participants' parents or responsible family members may be briefly interviewed separately as necessary to corroborate participants' provided information. Participants' parents or responsible family members' interviews

will be limited to one or two occasions as necessary and each interview will last about 10 minutes. This information together with those extracted from participants' hospital records will verify and reconcile participants' interview information. This verification and reconciliation will improve study credibility and the believability of conclusions to be drawn from participants' interview information (Polit & Beck, 2010; Green & Thorogood, 2011).

The PI will visit the study hospital and spend time during recruitment and interviews and at other times that some participants are still in the hospital to informally observe interactions between the recidivist adolescents in the milieu and document the observations in his field notes. The PI will integrate with the unit nurses and other staff in the course of this field observation and will endeavor not to call the attention of the participants during such observation, so as not to interfere or influence the interactions. Informal conversation with the unit healthcare providers, psychiatrists, nurses and psychiatric technicians will also be undertaken in the course of participants' field observation and interviews as part of data triangulation. If required, the PI will seek to get the UTHealth CPHS waiver for obtaining consents/assents from the other persons involved in this informal non-participant observation of the study subjects during submission of the study protocol. Though the interaction of participants with other non-participants and hospital staffs will be observed, only information from the participants will be recorded and reported in the study. This field observation will help the PI to further understand the recidivist adolescents' description of their experiences and form part of data triangulation.

Data management and analysis.

A professional transcriptionist to be engaged by the PI will initially transcribe the audio-tape recorded interview data using agreed transcription conventions (Silverman, 2001) to reduce errors, ensure credibility and repeatability of the process. The PI will validate the transcription by listening to the tape while reading through the professionals' transcription (Polit & Beck, 2012). Coding of data will be done by the PI developing a coding tree with assistance from the methodology experts in his advisory team. Information will be read and re-read to identify clusters of concepts or categories into which data will be coded to derive themes. The study advisors will vet this process intermittently to ensure rigor. The four stage ethno-nursing analysis guide (Leininger, 2005) will be employed in data analysis. The first stage involves collection, description and recording of data; the second stage involves, the identification and categorization of descriptors of data about the domain; the third stage involves the identification of patterns in the context of the environment and the fourth stage involves the identification of major themes, presenting findings, and making recommendations for future research based on insights revealed by this study.

Systematic recording of information and decisions will be done to provide adequate audit and decision trails for confirmability. NVivo 10 (QSR International, 2012) computer qualitative data software or other appropriate software may be used for data management in this process. Data collection and analysis will be done concurrently almost simultaneously as information is generated by the interviews. Data analysis to derive repetitive patterns and themes will be made using mainly the methods of Leininger

(2005) in conjunction with those of Saldana (2013) and others. The PI will ensure reflexivity during the course of this study by bracketing himself from the process to minimize possible bias that maybe related to his goals, professional psychiatric and mental health nursing background, and the long experience with this segment of the adolescent population. The PI's goals, professional training and experience will be explained to the participants at the consent and assent stage, and reinforced during the course of the interview in such a way as not to introduce bias on their own; and will be included in the reporting of findings (Tong, Sainsbury & Craig, (2007).

The PI will seek constant feedback and debriefing from his advisors and other faculty knowledgeable in this research method and clinical area specialists to further reflexivity and achieve the quality criteria outlined in the framework of Whittemore, Chase & Mandle (2001) that includes the primary criteria of credibility, authenticity, criticality, and integrity. The secondary criteria include explicitness, vividness, creativity, thoroughness, and congruence. Final documentation of the data analysis, auditing, reporting, presentation and organization for possible publication of the study will follow the study conclusion. The overall study will follow the schedule shown in Figure D1 in Appendix D.

Study Limitations - Potential Problems and Alternative Approaches

Recruiting enough subjects to participate in the study could be a potential problem. The investigation of the problem in broad range of adolescents with mental illness instead of specific disorders, conducting a pilot study, and the long duration of the study will help to address the challenge of recruiting enough participants. Getting the

recruited participants to talk is another source of potential problem. The PI has taken a qualitative data collection course that will aid him in the interviewing process. This course together with the PI's experience in caring specifically for hospitalized adolescents with mental illness over a three year period will help to address the challenge of getting these adolescents to talk.

Another potential problem will be that some participants may be discharged before the start or conclusion of the interviews. Participants' whose interviews are not concluded before discharge will be dropped from the study and their information will not be reported in the study. Every reasonable effort will be made to ensure the participants are interviewed in the hospital. The study time schedule also has enough leeway built-in to accommodate such eventuality. Though the study hospital selection and participants' eligibility criteria are made to ensure feasibility of the study, any unforeseen circumstances will be addressed with the help of study advisors and resources available to the UTHealth School of Nursing.

This study could be limited by the fact that it is being conducted in one inpatient psychiatric hospital in one region of the United States. But the study is an initial effort, the outcome of which could form the basis for future research studies that may involve a multidisciplinary team. The insight from the perspectives of the recidivist adolescents with mental illness in this study may later be investigated in multiple sites in to assess transferability with a view of eventually modifying services delivery models and interventions in practice. However, this limitation has to be acknowledged in reporting the finding of this study.

Human Subject Participants

UTHealth CPHS approval will be sought before study commencement on this vulnerable population of adolescents with mental illness. Informed consent will be obtained from their parents after a period of not less than one week of the participants' inpatient admission to allow them adequate time to settle down from the anxiety of participants' admission. Thereafter, assent will be independently obtained from the participating adolescents within one week of their inpatient admission to allow them to stabilize enough from their precipitating admission condition. Observation and audio-taping of participants' interview in the psychiatric hospital will be in a unit location chosen to ensure participants' privacy and not portray them differently from other non-study adolescent patients. Effort will be made to mitigate the anticipated minimal risk to the adolescents which may include loss of time and a possible increase in agitation as they recall life experiences and psychological problems due to potential loss of personal data. Interviews will be conducted at the convenience of the participants, privacy will be provided, participants' data will be limited to study requirement, de-identified, coded, and stored in the PI's study laptop that will not have internet access, and be password protected.

If participants get unduly agitated during the interview, the interview will be suspended and the matter will be brought to the attention of the unit nurses for necessary intervention. The data will be backed-up in a flash drive which will be securely locked in the PI's cabinet at the UTHealth School of Nursing study carrel. Data will only be shared with professional transcriber and study advisors who are conversant with confidentiality expectations. The PI will closely secure and guard his laptop, and make reasonable effort

not to leave it unattended. Study data stored in laptop hard drive, back-up flash drive and paper hard copies will be destroyed within the time frame approved by the IRB. The PI has undertaken all relevant CITI and CPHS courses and Boys Scout of America certification for adults dealing with minors. Notwithstanding the planned use of purposive sampling method, every effort will be made in recruitment to achieve gender, race and socioeconomic class representation in the sample. The immediate benefit to participants will be the gift of a \$25 (Twenty-five Dollar) gift-card in appreciation of their time and commitment to the study. The gift-card will be given to them at the time of discharge to avoid possible conflict with others, but they will be informed of this at this at the Assent stage.

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Appendix A

Topic Guide for the Interview

Appendix A

Topic Guide for Interview

1. Treatment recidivism and its meaning to the recidivist adolescents,
2. What factors the recidivist adolescents consider as contributors to recidivism in relation to the underlisted,
 - 2a. Contributions of patients if any,
 - 2b. Contribution and nature of their problem condition,
 - 2c. Contributions of their families and immediate environment if any,
 - 2d. Contributions of hospitals and treatment team if any,
 - 2e. Contributions school and/ or work and that environment if any,
 - 2f. Other participants' thoughts not included in the above listed,
3. Recidivist adolescents' suggestions on the way forward if they consider it necessary with respect to the underlisted,
 - 3a. Contributions of patients if any,
 - 3b. Contribution and nature of their problem condition,
 - 3c. Contributions of their families and immediate environment if any,
 - 3d. Contributions of hospitals and treatment team if any,
 - 3e. Contributions school and/ or work and that environment if any,
 - 3f. Other participants' thoughts not included in the above listed,

Appendix B

List of Typical/suggested Questions for the Interview

Appendix B

Sample Questions for Interview

1. Hi John, please tell me a little about yourself and your likes and dislikes (John is an example, to show you address patient by name, though participant will be informed that coding which will be mentioned before interview will replace name in the records to be transcribed).
2. What was the issue that brought you to the hospital this time?
3. How many times have you been admitted to the hospital in the last 12 months?
4. Have you been previously admitted outside the last 12 months?
5. Think about your very first admission and what were the issues at that time?
6. In your readmissions in the last 12 months, could you recall what happened?
7. Tell me your thoughts about being admitted to the hospitals again and again.
8. How do you see this? (As a problem or solution and what makes you think about it that way?)
9. How does your family see this? How do they talk you about it?
10. How did your school and/or work, teachers and classmates see this? How did they talk to you about it?
11. How did the hospitals and the treatment team, specifically- doctors, nurses, social workers, therapists, chaplain and other patients see this? How did they talk to you and others about it?
12. If you see it as a problem, what do you think can be done to reduce it?
13. If you do not see this as a problem, what other suggestions do you have about it?
14. Would you talk about other things related to this that we have not covered, but you remember and consider important?

Appendix C

Medical Record Data Extraction Form

Appendix C

Medical Record Data Extraction Form

Data Description	Participant #1	#2	#3	#4	#5	#6	#7	#8	#9etc.
Age									
Gender									
Race/Ethnicity									
# of Previous Readmissions									
DSM Axis I & II Diagnosis									
Schooling or Working									
Living with Family/ Foster Care or Residential Facility									
Family SocioecStatus									
Family Structure									
Family History									

Figure C1. Medical Record Data Extraction Form

Appendix D

Proposed Study Schedule

Appendix D
Proposed Study Schedule








Description of Study Activity	Fall 2015					Spring 2016					Summer 2016		
	A u g	S e p t	O c t	N o v	D e c	J a n	F e b	M a r	A p r	M a y	J u n	J u l	A u g
Finalization & Defense of Proposal													
IRB: CPHS Approval /Hospital Research Committee authorization													
Recruitment and Data Collection: Interviews, Observation & Chart reviews													
Data Management & Analysis													
Documentation & Reporting of Findings													
Preparation for Final Defense of Dissertation													
Edits & Preparation for Publication													

Figure D1. Proposed Study Schedule

MANUSCRIPT

16910 Midnight Sky Court
Richmond, Texas 77407
August 01, 2016.

The Editor,
Journal of Child and Adolescent Psychiatric Nursing,
Attention: Kathleen R. Delaney, PhD, PMH-NP, FAAN
Professor, Rush University College of Nursing
600 S. Paulina St.
Suite 1054 A
Chicago, IL 60612
Dear Dr. Delaney,

Submission of Manuscript

Please find attached our manuscript titled “Treatment Recidivism in Adolescents with Mental Illness: A Focused Applied Medical Ethnography” for review to publish in your journal. The manuscript is contained in four attachments – title page, main document, Figure 1, and Tables 1-3.

The research study that produced this manuscript was driven by our desire to contribute to the search for solution to the very serious problem of treatment recidivism in our adolescents with mental health problems. We believe that the publication of this manuscript will contribute to the goal of the journal especially as nursing research has not sufficiently explored this topic in previous studies.

There is no conflict of interest with the manuscript and no letters of permission to reproduce previously published materials or for subject in photographs were obtained because none is applicable in this manuscript.

We look forward to hearing from you. Thank you.

Sincerely,

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Abstract

Problem: Treatment recidivism, described as frequent unplanned relapse readmissions, is a national problem predominant in the subculture of adolescents with mental illness. Because the main triggers of treatment recidivism in this population are not fully understood from previous studies, the purpose of this study was to explore treatment recidivism with the following aims: (i) To illuminate treatment recidivism from the perspectives of recidivist adolescents with mental illness, (ii) To describe the main factors that contribute to treatment recidivism and how best to minimize them from the perspectives of these adolescents, (iii) To describe the interaction of the recidivist adolescents with mental illness with the medical culture. **Methods:** A focused applied medical ethnography was used to study 16 purposively selected adolescents that met the eligibility criteria. Individual and group interviews were conducted until data saturation was achieved. Unobtrusive observation of participants was done in the unit and demographic and clinical information extracted from their medical records. **Findings:** The participants were near unanimous that the “additional stressors” of problematic parental relations and school bullying were the main triggers of treatment recidivism that needed to be addressed over and above their “routine stressors” of adolescence and mental illness to minimize the problem. The participants had a mixed perception of treatment recidivism and described their interaction with the medical culture as mostly positive. **Conclusion:** Further research is needed on larger samples to determine the impact of parental relations and school bullying on recidivism in adolescents with mental illness.

Keywords: Adolescents, Mental Illness, Treatment Recidivism, Perceptions, Contributing factors

Treatment recidivism, conceptualized as frequent unplanned relapse readmissions, is a national problem, predominant in adolescents with mental illness. Frequent inpatient hospital readmission in adolescents with mental illness is varied, but higher than reported in most other populations. Arnold et al. (2003) estimate readmission at 19% in six months for adolescents after initial inpatient psychiatric unit discharge. Fontanella (2008) estimates that 24 to 38% of adolescents were readmitted to a psychiatric unit one-year after inpatient discharge. Bobier and Warwick (2005) reported a 65% readmission rate in a 12-month period post discharge. Treatment recidivism is a significant social and economic problem considering the adolescents' burden of mental illness, decreased school and job performance, disruption of the lives of patients' families, and the inevitable contribution to the increasing cost of healthcare. Cost implications could not be easily ascertained, but can be imagined from the cost estimates of inpatient hospitalization. Adolescents living with mental illness are a sub-culture of adolescence, the critical growth period of developmental and social transition from childhood to adulthood (Erickson, 1968; Steinberg, 2011). Culture has been defined in terms of the beliefs, values, and behavior characteristics of a particular social, ethnic, illness or age group as well as society (Dictionary.com, 2015; Engebretson, 2011). Treatment recidivism has persisted and even increased since the time of managed-care despite various efforts to address it (James et al., 2010; Garrison & Daigler, 2006). The factors that influence recidivism in adolescents with mental illness are multiple, but not yet fully understood. Previous efforts to address treatment recidivism or frequent readmission evaluated the effectiveness of aftercare services (James et al., 2010; Carlisle, Mamdani, Schachar & To, 2012) and factors such as patients' clinical status, treatment models,

family and environmental characteristics (Fontanella, 2008; Barker, Jairam, Rocca, Goddard & Matthey, 2010) with mixed and sometimes conflicting results. The current effort of the Affordable Care Act (ACA, 2010) to address treatment recidivism or frequent readmission is limited to certain categories of patients' conditions that do not yet include adolescents with mental illness.

Sufficient studies do not exist on treatment recidivism in adolescents with mental illness compared to their adult counterparts, despite the fact that treatment recidivism is more prevalent in the adolescents with mental illness (Bobier & Warwick, 2005; Barker et al, 2010; James et al, 2010). Moreover, most of the previous studies were quantitative and did not seek the views of the recidivist adolescents with mental illness on treatment recidivism. The purpose of this study was a focused applied medical ethnography to explore treatment recidivism from the perspective of these adolescents with mental illness with the following aims:

1. To illuminate treatment recidivism from the perspectives of recidivist adolescents with mental illness.
2. To describe the main factors that contribute to treatment recidivism and how best to minimize them from the perspectives of these adolescents.
3. To describe the interaction of the recidivist adolescents with mental illness with the medical culture.

Methods

Design, Setting, and Sampling

Focused applied medical ethnography, a type of qualitative method used to seek the understanding of a subcultural group on a specific issue (Engebretson, 2011; Muecke, 1994; Richards & Morse, 2013), was used to gain a better understanding of treatment recidivism from the perspectives of purposively selected recidivist adolescents on admission in an urban southwestern United States psychiatric hospital. The design involved the use of audio-recorded individual and group interviews, unobtrusive non-participant unit observation and extraction of information from participants' medical records (Polit & Beck, 2012; Silverman, 2014; Thorne, 2008). The study was done in a large inpatient psychiatric hospital, in an urban city in the southwestern United States with dedicated 20-bed general child/adolescent psychiatric unit. Purposive sampling method was used to recruit the adolescents on inpatient readmission who met the eligibility criteria.

Inclusion and Exclusion Criteria

Inclusion of participants was based on the following:

- i. Adolescent aged 13 to 17 years,
- ii. Admission to the study hospital at the time of recruitment,
- iii. Diagnosed with at least one mental illness, based on the DSM-IV (APA, 2000 & 2013) criteria and documented in participants' medical records,
- iv. A history of at least one previous inpatient admission and discharge from a psychiatric hospital for which the present admission is due to relapse,

- v. Ability to read and speak English at 6th grade level or more.

Exclusion of participants was based on the following:

- i. Presence of intellectual disability and communication disorders,
- ii. Presence of any serious medical condition for which the patient had been hospitalized at least twice in the last 6 months before recruitment.

Recruitment and Data Collection

Institutional Review Board approval was obtained prior to data collection.

Informed consents were obtained from the parents and thereafter the assent from each adolescent participant. The parents and participants were approached within one week of the participants' admission to the hospital to allow time for a reduction in potential increased anxiety level of the parents and for stabilization of the participants from their acute precipitating admission condition. The participants were promised and given a \$25 gift-card in appreciation of their time and effort in successfully completing the study interviews.

The participants were interviewed individually at first and some later participated in three group interviews that were comprised of three participants each. Recruitment and data collection concluded with the achievement of saturation and redundancy after the interview of 16 participants. Data collection involved the interview, non-participant unit observation of the participants, and the extraction of demographic information from the participants' electronic medical records (see Table. 1). The interviews were conducted using the topic guide categories and suggested sample questions shown in Tables 2 and 3

respectively, but the sample questions were changed based on the participants' responses (Kvale & Brinkmann, 2009; Richards & Morse, 2013; Spradley, 1979). All participants' interviews were audio-recorded. The parents of the participants were not formally interviewed, but provided necessary information in the course of granting parental consents. Field notes were documented of the non-participant observation of the participants as they interacted in the milieu with themselves and others to better understand the adolescents and their interview responses.

Data Management and Analysis

The interview audio-recordings were transcribed verbatim and edited before analysis together with the non-participant observation field notes, medical chart information, and other study memos. Unique codes were used to de-identify participants in the course of data analysis which proceeded concurrently with data collection. NVivo 11 Pro (QSR International, 2013) data management software was used to organize study data in the analytic process. Initial broad-brush coding was done using the topic guide categories. This initial coding was followed by detailed coding and hierarchies of sub-codes under the categories. Participants' perspectives were derived from the repetitive patterns and themes revealed in the detailed coding process. The four stage ethno-nursing (Leininger, 2005) and thematic (Saldana, 2013) analysis methods guided the analytic process. Efforts to achieve rigor and meet the quality criteria of credibility, authenticity, criticality, integrity, explicitness, vividness, creativity, thoroughness, and congruence (Whittemore, Chase & Mandle, 2001) included the use of an operational manual, audio-recording and verbatim transcription of interviews in addition to cross checking participants' responses with information from their medical records.

Findings

Overview

The 16 participants in this study included six Black, four Hispanic and six White recidivist adolescents who were in the age range of 13-17 years. The majority of the participants in this study were from low socioeconomic families (11 of the 16 participants). A slight majority of the participants were females (9/16 participants) and most were diagnosed with psychiatric or combined psychiatric disorders rather than combined psychiatric and substance use disorders (Table 1). None had substance use disorder alone. The psychiatric disorders noted were mostly bipolar disorder (8/16 participants) and mood or attention deficit hyperactive disorder (5/16 participants). The other psychiatric or substance use disorders were each less than 20% of the total. Beyond the above variations, the participants were near evenly spread in other demographic data explored in this study.

The participants described a mixed perception of treatment recidivism. They voiced dislike for their frequent inpatient hospital readmission, but believed it was necessary. They were emphatic that the “additional stressors” of problematic parental relations and bullying in schools were the major contributors to treatment recidivism over and above the “routine stressors” of adolescence; psychiatric diagnosis, medication compliance issues, and aftercare follow up. The participants mostly described a positive perception of their interaction with the medical culture.

General Perception of Treatment Recidivism

All of the 16 participants had mixed perceptions of treatment recidivism, but said that they had no special name for it other than readmission or relapse. The participants were not comfortable with their frequent return to the hospital, but considered it necessary to manage an acute escalating situation that could not be handled well at home, especially as the home was a main part of the problem. A 15 year old female participant put it this way: *“Well, it is bad to come to the hospital again and again. But, at the same time, it’s good, because you needed the help. It’s better to be back than the alternative”*. Another 15 year old female agreed: *“Well, I think it’s good when you are here and you learn. But, I think it’s bad that you are here because you shouldn’t be here often”*. Another 15 year old male participant added: *“I believe that what's needed is needed and if you have to come back then you should come back, then it's in your best interest that you do”*.

Main Contributing Factors to Treatment Recidivism

The analysis of data from the 16 participants revealed the two main themes of “problematic parental relations” and “bullying” in schools as the main contributors to their treatment recidivism. However, they acknowledged the presence of “routine stressors”. A model integrating the contribution of the major “additional stressors” of problematic parental relations and bullying in school found in this study with the “routine stressors” of adolescence, psychiatric diagnosis, medication compliance issues, aftercare follow up issues, to treatment recidivism in adolescents with mental illness is illustrated in Figure. 1.

Problematic parental relations.

The participants were emphatic that the “additional stressor” of problematic parental relations derived from the repetitive patterns of conflicts or not getting along with their parents described in various forms such as “conflict with my parents”, “my parents do not understand me”, “my mom makes me mad”, “dad should stop all the insults”, and similar others was a main trigger of treatment recidivism that underlie the complaints of suicidal ideation and threats, non-suicidal self-injuries/self-cutting, anger, aggression, fighting, acting out, truancy, and depression that led to their frequent readmission. They believe the above listed signs and symptoms manifested their feelings of isolation, alienation, loneliness, desperation, not being loved and wanted, distrust, and worthlessness mostly due to the underlying trigger of problematic parental relations.

The participants were unequivocal that the additional stressors of problematic parental relations were a major trigger of treatment recidivism, but they also acknowledged the contribution of some obvious factors previously noted in the literature such as their psychiatric diagnosis, medication non-compliance, lack of aftercare services follow-up, neighborhood and family circumstances. They viewed these as “routine stressors” with which they could function. One 15 year old female participant said this about problematic parental relations trigger: *“Most of the time I hear from other teens that their parents brought them here because they were having problems with their parents rather than at school or at work”*. A 16 year old male talking about his mother added: *“I try to be calm but then she does everything in her power to get me mad”*. A 15 year old female participant said: *“Just that I feel like my parent, my family doesn't love*

me for me, and I feel like they don't accept me. Since I admitted that I was gay and my mom didn't take it so well".

Bullying in schools.

Bullying in schools has been variously defined, but essentially is unwanted aggressive physical or verbal behavior due to some power imbalance that is likely repeated over time with the intention of excluding the bullied from the group (Bullying Definition, n.d.). "Bullying" in schools derived from the repetitive patterns of difficult interpersonal relations with school mates described variously as "bullying", "how the students interact with each other", "they say all sorts of things to get you", and "guys sometimes fake illness to avoid going to school because of other kids", which appear to align with the above definition of bullying. They believed that bullying was a major trigger of treatment recidivism.

On bullying in schools as a main trigger of treatment recidivism, a 16 year old male responded: *"I think school plays a major part, because of bullying and peer pressure"*. Another 15 year old female replied: *"Most of the time the kids are depressed because they're students in a school where they get bullied"*. One 14 year old male participant added: *"We may start faking illness just not to go to school and experience bullying"*. Another 15 year old male simply replied to main triggers: *"It's problems from school and from home, but mainly home"*. A 17 year old female participant blamed bullying thus: *"Sometimes, it could be because of bullying. That's just bullying or people just saying stuff just to get to you, some stuff like that"*.

Suggestions to Reduce Treatment Recidivism

The participants suggested that addressing the additional stressor triggers of problematic parental relations and bullying in schools could reduce treatment recidivism. They also envisaged that the routine stressors such as ensuring medication compliance, follow-up with aftercare treatment and counselling services, and neighborhood issues should be maintained to complement the effort. The suggestions came in different but related forms. One 15 year old female participant said while talking about parental interaction: *“Um, talk it out, like, instead of always forcing me to do things to meet me halfway, at least, you know? Instead of never asking my opinion, ask it. To hear me out on some things”*. Another 15 year old male participant advised: *“The interaction should be very healthy interactions. It needs to be very healthy interactions, very positive interactions. Such that a parent at the very least, pretends that he or she cares about how the child is doing, such as asking them how their day was or making sure they're well fed, asking if they're feeling okay, that kind of stuff”*. Another 15 year old female participant has this to say on parents: *“The parents can try to become closer to their kids. My parents—we're close, but we're just not, like—I don't know how to explain it”*. Another 15 year old female was even more conciliatory: *“Because sometimes parents don't understand their kids half of the time. They're still learning how to raise a kid themselves”*.

On how to address bullying in schools to make the recidivist adolescents feel safe, less stressed in school, and able to function at the routine level despite their mental illnesses; a 16 year old female participant indicted school administrators saying: *“Most schools tend to just not care”*. She advised school administrators: *“To actually watch,*

just like watch more and listen more. Look for signs, you know? Just help kids speak out. Let the kids know that they don't have to be scared". Another 15 year old female participant said: *"The way I see it is for them to set up a club for those who are bullied, those who want to seek refuge. Like, if you're being chased by somebody inside the schools go to the library and seek refuge in there".* Yet another 14 year old male participant advised: *"When someone says that there is bullying going on, they should accept it. They should not consider it as a tattletale".* He further added: *"I want more staff in the hallways.....so I think we should get more security to supervise the schools".* Similar suggestions ran through the transcripts in different forms with a 17 year old female participant advocating for school counselling: *"School counseling, I think it helps because I go to school counseling and I know. I see a therapist three times a week at school, whenever I need it. I think that helps".*

Perception of the Interaction with the Medical Culture

The participants described the perception of their interaction with the medical culture as mostly positive and satisfactory. They however made suggestions on different areas they want to see some adjustments to make it even better. A 17 year old female participant said: *"I see it's worked, from what I've seen, I think everything is working pretty good. I see that the kids like it here. I mean, everybody's getting the help they need and the medical help is good here. Everything I like it. They're helping me and I've been good so far".* While a 15 year old female believes: *"It's very organized, but I see that admissions process—well, but it's usually very long and kind of painful",* another 15 year old male stated: *"I feel like the things the hospital is doing are things needed within the hospital's environment, such as keeping a structured, organized schedule throughout the*

day making it a safe environment all that is perfectly fine". Yet another 15 year old female participant said: "Well, it's very organized, and as Ricky Martin said, life is crazy. So having a schedule, a structured place, like this, can be very easy I guess on yourself. And then when you go back to the world, it's like so crazy, you want to go back in, into your little turtle hut".

Discussion

The adolescents' acknowledgement of the routine stressors/factors associated with readmission underscore the significance of their perspective that problematic parental relations and bullying especially in schools were the main triggers of treatment recidivism. Even though they acknowledged the routine stressors are part of their lives, they were only mentioned when the participants were asked to think of any other factors that could lead to rehospitalization. They viewed the "routine stressors", more like the "hygiene factors" in Herzberg's motivational theory (Herzberg, 1959; Herzberg, Mausner & Snyderman, 1968).

The findings that problematic parental relations and school bullying were the main triggers of treatment recidivism appear to have support in both the ecological transactions model (Bronfenbrenner, 1979; Gonzales, 2009; O'Connell, Boat & Warner, 2009) and systems theories (Bertalanffy, 1968; Neuman & Young, 1972) which postulate that humans live in an ecological system, interact with and are influenced by their environment which they also influence. The findings also appear to have support in the stress theories (Lazarus & Folkman, 1984) that emphasized the influence of stressors on physiological, emotional, mental and physical behaviors of humans.

Thus, the mere grouping of problematic parental relations with the broad family characteristics or bullying in schools with the broad environmental factors may conceal the specific nature of these triggers and diminish the level of clarity revealed by this finding. The specific clarity of isolating the main triggers could help in early identification of those at risk and aid the search for focused interventions that could reduce treatment recidivism. Based on anecdotal evidence from the first author's interaction with families while working in the adolescent units of different psychiatric hospitals, parents tended to "medicalize" their teen's situations and got frustrated that the hospitals "failed to provide the quick and permanent fix" for their troubled teens. However, parents "medicalization" of all their teens' problems may be overly simplistic. It is not certain which of these two main triggers has more influence on treatment recidivism. Anecdotal evidence from several psychiatric hospitals points to the increased admission of these adolescents to the hospitals when schools are in session than during the holidays, which may suggest that bullying has a higher level of influence. However, the exact nature and level of influence for these triggers is uncertain because of the complex relationship that could exist between them and could only be ascertained through mixed method studies on the subject in the future.

The findings highlights the need for possible adjustment to the "content" of the present family meetings and family therapy in the hospitals to go beyond mainly "sharing of information with patients and families on available resources and encouraging compliance with aftercare follow up" to accommodate more of "adolescent parental relations and parenting skills" especially for parents of troubled teens. It should be noted that the previous opportunities of the informal socialization of parenting skills have been

eroded by the circumstances of our changing society (Marcosi, 2015; Bumpass, 1998).

Therefore, stakeholders may need to investigate new avenues for teaching these skills to address the present inadequacy. As one participant put it while talking on parents,

“.....but it’s like they don’t understand either. Because sometimes parents don’t understand their kids half of the time. They’re still learning how to raise a kid themselves. They’ve never raised a kid before. They’re still learning”.

The findings of this study also further spotlight the recognition that bullying has become a major problem in schools, different from the routine pressures of school work. Judged by the grade level at school, responses of participants and parents, it appears that a sizeable number of these recidivist adolescent participants were getting along enough with their school work. They were capable of being in school and functioning reasonably notwithstanding the routine stressors of adolescence and mental illness, except for the additional stressors of bullying and/or problematic parental relations. Recent studies have not only supported the traumatic and harmful effects of bullying, but even associated bullying with higher probability of developing a mental illness later in life (Sourander et al, 2009). Bullying was not mentioned as peculiar to these adolescents because of their mental illnesses as they claimed that most of their school peers were not aware of their psychiatric diagnosis, but that bullying was rampant across board. The immediate impact of bullying was probably felt more by these adolescents with mental illness because they were already “stressed” relative to other students.

Again stakeholders would need to redouble efforts on the menace of bullying in schools. While bullying may occur outside the schools, most occurs in schools. Bullying

in schools has been recognized as a serious societal problem, but current efforts to address it are not adequate as the participants revealed. The participants, though from different schools, very easily attested to its existence in their various schools. Their suggestions that more opportunities be created for them to speak out without being afraid and for schools to have trained personnel that will proactively be on the lookout for signs of bullying should be considered. Schools should evaluate implementing visible and deterrent interventions on those caught engaging in bullying to protect and assure other students. Schools should not only be safe, but should be seen as such by the students, so that their anxiety is limited to school work.

Their mixed perception of treatment recidivism should not come as a surprise, because adolescents should have more important “adolescent activities” to do outside the hospitals such as learning, growing and interacting than being in the hospital. But the overwhelming anxiety created by the identified additional stressors makes their illness relapse and render them unable to effectively participate in those adolescent activities and so they settle for the inevitable option of going back to the hospital. Their positive perception of the medical culture should be expected, because they see the hospitals as the last resort. The order, structure, caring, listening ear, respect, and non-judgmental interactions in the hospitals provide what they desired but could not get in the outside world of the home and school.

The supplemental finding that most recidivists had combinations of psychiatric diagnoses than combined psychiatric and substance use diagnoses was also revealing. However, this finding has to be considered against the background that a lot of these

adolescents use substances at various levels that may or may not meet diagnostic criteria (CDC, 2014) at their time of hospitalization. Another supplemental finding was that a majority of the participants were from low socioeconomic families; low socioeconomic status determined on the basis of participants' receipt of free meal in school. Though this finding has support in previous studies that found association between negative health outcomes and low family socioeconomic status, it could be associated with the fact that the study hospital serves a good number of the indigent families. However, it could also be a mirror of the disparity that still exists in health care which needs to be addressed to improve health.

Limitations of the Study

The major limitations of this study include that it was conducted in one inpatient psychiatric hospital that served mostly the indigent population in one region of the United States and focused only on the perspectives of a relatively small number of purposively selected recidivist adolescents with mental illness. Furthermore, non-English speaking participants were excluded and the study included a broad rather than narrow classification of mental illnesses.

Conclusions

Though the findings represent only the perspectives of the recidivist adolescents with mental illness, they are both insightful and well-articulated. The findings could further the efforts towards focused assessments of adolescents with mental illness and help with early identification of those at risk which would support well targeted interventions to address treatment recidivism in that sub-culture.

There is the need to follow this study with large multicenter studies that could span regions and/or countries. Such studies could be inclusive of other perspectives such as those of parents and/or healthcare providers, employ methodological diversity, and benefit from multidisciplinary teams considering the nature of the issues raised in the findings of this study.

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Table 1

Participant demographics and other characteristics

Participant	Age	Gender	Race	# of Re- Admits	DSM- IV Axis I Dx	Status	Living Status	Family SES	Family - Structure	Family Psych Hx
1	15	F	W	≥ 2	B/D, PTSD SUD	NS/NW	CPS	L	CPS	Psych + SUD
2	16	M	B	≥ 2	B/D	S = 10 th	Family	L	Single parent	N/A
3	15	F	W	≥ 2	MDD	S = 10 th	Family	L	Dual parent	N/A
4	16	M	H	≥ 2	B/D, ADHD	S = 8 th	Family	L	Dual parent	N/A
5	15	F	W	≥ 2	MDD	S = 10 th	Family	M	Dual parent	Psych Dx
6	13	F	B	≥ 2	B/D, ODD	S = 7 th	Family	L	Single parent	N/A
7	13	M	B	≥ 2	B/D	S = 7 th	Family	M	Dual parent	N/A
8	17	M	H	≥ 2	M/D, ADHD	S = 9 th	Family	L	Single parent	Psych Dx
9	17	F	H	≥ 2	B/D	S = 11 th	Family	L	Dual parent	N/A
10	15	F	B	≥ 2	B/D, PTSD	S = 9 th	Family	L	Single parent	Psych Dx
11	16	F	W	≥ 2	D/D	S = 10 th	Family	M	Dual parent	Psych + SUD
12	16	F	B	≥ 2	M/D, ADHD	S = 9 th	Family	L	Dual parent	Psych + SUD
13	15	M	H	≥ 2	M/D, ADHD	S = 9 th	Family	L	Single parent	N/A
14	15	F	B	≥ 2	B/D, ADHD	S = 8 th	Family	L	Dual parent	Psych Dx
15	16	M	W	≥ 2	M/D, C/D, SUD	S = 10 th	Family	M	Single parent	Psych + SUD
16	14	M	W	≥ 2	M/D, I/D	S = 10 th	Family	H	Dual parent	N/A

Note. B=Black; H=Hispanic; W=White; N/A= Denied/not seen in record; N/S=Not schooling; N/W=Not working; S=Schooling; B/D=Bipolar D/O; C/D=Conduct D/O; D/D=Depressive D/O; I/D=Impulsive D/O; M/D=Mood D/O; MDD=Major Depressive D/O; ODD=Oppositional Defiant D/O; SUD=Substance Use Disorder.

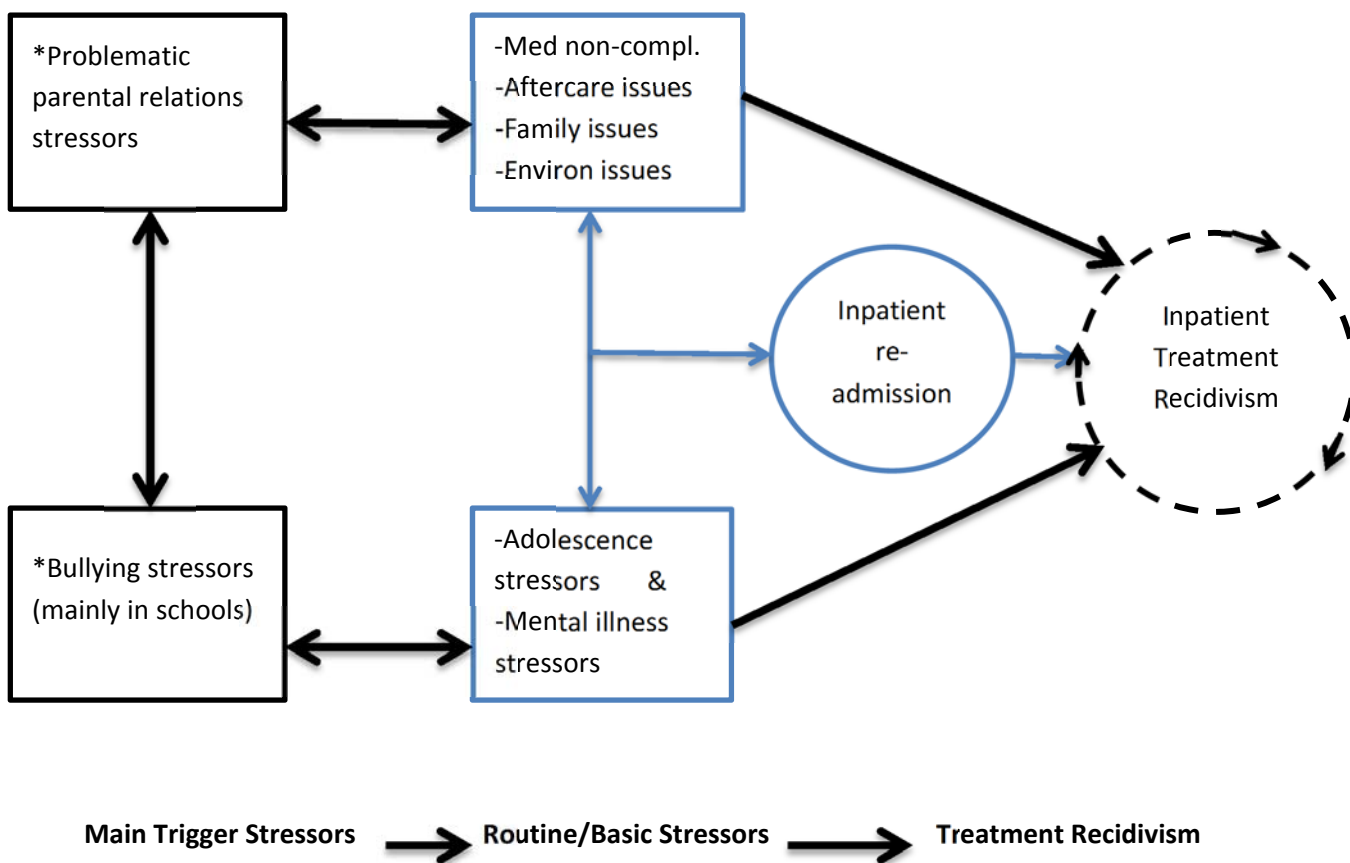


Figure 1. Model of Triggers of Readmission and Treatment Recidivism

Manuscript Appendix A

1. Treatment recidivism and its meaning to the recidivist adolescents,
2. What factors the recidivist adolescents consider as contributors to recidivism in relation to the under listed,
 - 2a. Contributions of patients if any,
 - 2b. Contribution and nature of their problem condition,
 - 2c. Contributions of their families and immediate environment if any,
 - 2d. Contributions of hospitals and treatment team if any,
 - 2e. Contributions school and/ or work and that environment if any,
 - 2f. Participants' other thoughts not included in the above listed,
3. Recidivist adolescents' suggestions on the way forward if they consider it necessary with respect to the under listed,
 - 3a. Contributions of patients if any,
 - 3b. Contribution and nature of their problem condition,
 - 3c. Contributions of their families and immediate environment if any,
 - 3d. Contributions of hospitals and treatment team if any,
 - 3e. Contributions school and/ or work and that environment if any,
 - 3f. Participants' other thoughts not included in the above listed.
4. Participants' perspectives and attitudes to the medical culture.

Topic Guide for the Interviews

Manuscript Appendix B

1. Hi John, please tell me a little about yourself and your likes and dislikes (John is an example, to show how to address patient by name).
2. What was the issue that brought you to the hospital this time?
3. How many times have you been admitted to the hospital in the last 12 months?
4. Have you been previously admitted outside the last 12 months?
5. Think about your very first admission and what were the issues at that time?
6. In your readmissions in the last 12 months, could you recall what happened?
7. Tell me your thoughts about being admitted to the hospitals again and again.
8. How do you see this? (As a problem or solution and what makes you think about it that way?)
9. How does your family see this? How do they talk you about it?
10. How did your school and/or work, teachers and classmates see this? How did the hospitals and the treatment team, specifically- doctors, nurses, social workers, therapists, chaplain and other patients see this? How did they talk to you and others about it?
11. If you see it as a problem, what do you think can be done to reduce it?
12. If you do not see this as a problem, what other suggestions do you have about it?
13. Would you talk about other things related to this that we have not covered, but you remember and consider important?
14. What are your perspectives and attitude to the medical culture?

List of Typical Questions used in the Interview

Appendix A

Committee for the Protection of Human Subject Approvals



Committee for the Protection of Human Subjects

6410 Fannin Street, Suite 1100
Houston, Texas 77030

Dr. Chukwudi Ekwemakor
UT-H - SN - Department of Family Health

NOTICE OF APPROVAL TO BEGIN RESEARCH

February 09, 2016

HSC-SN-15-0894 - Treatment Recidivism in Adolescents with Mental Illness: An Ethnographic Study

Number of Subjects Approved: Target: 20 /Screen: 20

PROVISIONS: This approval relates to the research to be conducted under the above referenced title and/or to any associated materials considered at this meeting, e.g. study documents, informed consent, etc.

NOTE: If this study meets the federal registration requirements and this is an investigator-initiated study, or if the PI is the study sponsor or holds the IND/IDE applicable to this study, and no one else has registered this trial on the national registry, **you are required to register at <https://register.clinicaltrials.gov/> before enrollment or no later than 21 days after the first patient is enrolled.** For website access and further information visit <https://www.uth.edu/ctrc/regulatory/clinicaltrials.gov-registration.htm> or contact clinicaltrials@uth.tmc.edu or call 713-500-3622.

APPROVED: At a Convened Meeting on 11/13/2015

EXPIRATION DATE: 10/31/2016

CHAIRPERSON: Rita Swinford, MD

Subject to any provisions noted above, you may now begin this research.

CHANGES: The principal investigator (PI) must receive approval from the CPHS before initiating any changes, including those required by the sponsor, which would affect human subjects, e.g. changes in methods or procedures, numbers or kinds of human subjects, or revisions to the informed consent document or procedures. The addition of co-investigators must also receive approval from the CPHS. **ALL PROTOCOL REVISIONS MUST BE SUBMITTED TO THE SPONSOR OF THE RESEARCH.**

INFORMED CONSENT DETERMINATION:

Signed Informed Consent Required

INFORMED CONSENT: Informed consent must be obtained by the PI or designee(s), using the format and procedures approved by the CPHS. The PI is responsible to instruct the designee in the methods approved by the CPHS for the consent process. The individual obtaining informed consent must also sign the consent document. Please note that only copies of the stamped approved informed consent form can be used when obtaining consent.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):**HIPAA Authorization required:**

HIPAA Authorization within consent form

Waiver for Screening and Recruitment granted:

Information to be accessed: date of birth, initials, and treatment /service dates

Information to be retained: date of birth, initials, and treatment /service dates

UNANTICIPATED RISK OR HARM, OR ADVERSE DRUG REACTIONS: The PI will immediately inform the CPHS of any unanticipated problems involving risks to subjects or others, of any serious harm to subjects, and of any adverse drug reactions.

RECORDS: The PI will maintain adequate records, including signed consent documents if required, in a manner that ensures subject confidentiality.



Committee for the Protection of Human Subjects

6410 Fannin Street, Suite 1100
Houston, Texas 77030

TO: Dr. Chukwudi Ekwemalor
UT-H - SN - Department of Family Health

FROM: Susan Vanessa Fuller
IRB Coordinator
CPHS Office

DATE: November 20, 2015

RE: **HSC-SN-15-0894** - "Treatment Recidivism in Adolescents with Mental Illness:
An Ethnographic Study"

Dear Dr. Ekwemalor,

The above referenced protocol was reviewed by the IRB #3 on 11/13/2015 and received contingent approval pending response to the following requests for clarifications or revisions.

Stipulations:

1. Please clarify if the Principal Investigator has an affiliation with HCPC.
2. Please provide CPHS with a Letter of Support from HCPC.
3. Please clarify why this study is accepting only English speaking subjects.
4. CPHS does not approve going into the home for follow-up interviews. The PI should only use follow-up interviews by phone in cases where the subject is discharged prior to completion. Please confirm that the interviews will be limited to HCPC.
5. Revisions to the informed consent forms for this study are required. The requested revisions are marked using Microsoft Mark-up and can be observed as (Version 1.1) Modified by the IRB.

Please respond to the above mentioned issues at your earliest convenience. Thank you for your cooperation.

Appendix B

Study Hospital Approvals



UT-Harris County Psychiatric Center

January 13, 2016

Chukwudi C. Ekwemalor
UTHealth School of Nursing
6901 Bertner Ave.
Houston, Texas 77030

**Re: Support for "Treatment Recidivism in Adolescents with Mental Illness:
An Ethnographic Study"**

Dear Chudi,

I am writing this letter to indicate support for your UTHealth School of Nursing doctoral dissertation project, "Treatment Recidivism in Adolescents with Mental Illness: An Ethnographic Study", which will primarily be conducted at the UTHealth Harris County Psychiatric Center and include patient interviews. I have reviewed the proposed protocol. As we have discussed, this protocol would also need to be reviewed and approved by the hospital Research Committee prior to starting and in the case of any changes made during the study period. This project aligns with the research and patient care missions of this hospital and the results have the possibility of improving patient care. I wish you success and look forward to the results of this investigation.

Sincerely,

R. Andrew Harper, MD
Medical Director, UTHealth-Harris County Psychiatric Center
Professor and Vice Chair for Education
Department of Psychiatry and Behavioral Sciences
UTHealth McGovern Medical School

713.741.3830 Phone 713.741.6909 Fax
2800 S. MacGregor Way
Houston, Texas 77021
www.hcpc.uth.tmc.edu



Office of Academic and Research Affairs
Human Research Protection Programs

Departmental Research Review Form For Committee for the Protection of Human Subjects	
<p>Introduction: The objective of initial departmental review is to assess scientific validity and feasibility of successful completion of the study. Ongoing departmental oversight will help to ensure that the research is progressing well and troubleshoot when there are unanticipated problems. The department review mechanism will achieve its objectives by:</p> <ul style="list-style-type: none"> • Facilitating conduct of research protocols which meet the department research goals. • Advising on the scientific validity of proposed protocols. • Assessing the feasibility of proposed protocol: <ul style="list-style-type: none"> • Whether the protocol would answer the research question, • Whether investigators are qualified by experience, education and training to conduct the research, • Whether the investigator has access to adequate resources including facilities and research staff, • Whether there are recruitment plan will be able to meet target accrual. • Establishing prioritization for recruitment when there are multiple open protocols with similar eligibility criteria. • Assist researchers to conduct research according to the good clinical practice guidelines. • Oversee the progress of various projects in the department's research program. 	
<p>Study Title:</p> <p>Treatment Recidivism in Adolescents with Mental Illness: An Ethnographic Study</p> <p>Department / Location: Psychiatry / HCPC</p>	
<p>PI: Ekwenmaior (School of Nursing)</p>	
<p>1. Background: Has an adequate review of relevant literature and prior studies been performed? Is it accurately reflected in the submitted materials?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	
<p>2. Hypothesis: Does the study address a meaningful scientific question? Is it clearly stated?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	
<p>3. Methodology: Is the methodology appropriate to address the hypothesis? Are subject and control/ comparator populations constituted appropriately to address the stated hypothesis? Are the subject inclusion and exclusion criteria appropriate to optimize benefit and risk? Is the study powered sufficiently to provide a meaningful outcome? Is the statistical analysis plan appropriate?</p> <p>This is an ethnographic study that will collect open-format interview data and engage in qualitative data analyses. I am unfamiliar with the analytic techniques, but the question format provided in the protocol addresses the study aims. The focus is on recidivism to an inpatient psychiatric setting (here, HCPC) in adolescents, focusing on those adolescents own perceptions and self-reports of factors involved in their readmissions. Control groups, sample size, and power are NA. The proposed sample is 10-20 adolescents.</p>	
<p>4. Feasibility: Is the research feasible as designed at this site? Is the PI likely to meet enrollment goals? Are stated recruitment methods appropriate for this population?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	
<p>5. Comparison to routine clinical care: What is the routine clinical care for the condition being studied? Are any subjects denied access to routine clinical care at any time in the course of the study? How does the risk of the study intervention compare to that of the routine care?</p> <p>This is not an intervention study; patients will be under acute care at HCPC. Care will not be compromised or altered in any way.</p>	

6. Risk to participants: Are study risks accurately described? Could modifications to the protocol improve the benefit to participants or reduce risks? Is the data safety monitoring plan appropriate for the study?

Risks are adequately described and the study is deemed to be minimal risk, except that this is a population of minors. Parental consent and patient assent documents are provided, and protections against confidentiality are described.

7. Resources: Do the investigators have the qualifications (education, experience and expertise) and resources to carry out the protocol?

☒ Yes ☐ No ☐ N/A

8. Comments : Please use this space to elaborate on any concerns, issues or problems with your review of this study.

This is a PhD dissertation from the SON. The dissertation committee is well constructed and includes Andy Harper, MD (medical director at HCPC). Dr. Harper is familiar with the protocol and the logistics and (minimal) risks within the HCPC setting.

Recommendation:

- ☒ Continue with CPHS submission
- ☐ Minor revisions recommended.
- ☐ Major issues identified for revision.
- ☐ Scientific pre-review not necessary.

If you have a digital signature, please apply below, then click, "Return to PI" to send the form back to the Principal Investigator via email. If you do not have a digital ID, please print the form, sign and return to the Principal Investigator.

Scott Lane

Digitally signed by Scott Lane
DN: c=US, o=Lane, ou=UTMSD-Houston,
ou=Psychiatry & Behavioral Sciences,
email=Scott.Lane@uth.tmc.edu, cn=US
Date: 2016.01.13 11:29:35 -0800

Signature

Printed Name

Date

[Return to PI](#)

Appendix C

Research Study Protocol – Parental Consent and Adolescent Assent




CPHS Study Reference #: HSC-NS-15-0894. Approved 02/09/2016

Research Study Protocol

For

Treatment Recidivism in Adolescents with Mental Illness: An Ethnographic Study

February, 2016

 IRB NUMBER: HSC-SN-15-0894
IRB APPROVAL DATE: 02/09/2016

Summary of this Research Study

What is this study about?

To better understand the frequent unplanned or avoidable readmission referred to as treatment recidivism from the perspectives of the adolescents with mental illness that experience it.

Treatment recidivism or frequent unplanned readmission is very common in adolescents with mental illness more than others and has continued to increase. Treatment recidivism has significant social and economic consequences to the adolescents, their families, their healthcare providers, and the nation.

The views and voices of these adolescents have not been sufficiently sought with respect to the issue of treatment recidivism and we need to hear and add their voices in the search for ways to reduce treatment recidivism.

Who will participate in the study?

Adolescents who are on admission at UTHealth-HCPC at the time of recruitment who meet the underlisted eligibility criteria:

1. Any male or female adolescents aged 13 - 17years,
2. Diagnosed with at least one mental illness,
3. With a history of at least one previous inpatient admission and discharge from a psychiatric hospital before this current admission,
4. Who are able to read and speak English at 6th grade level at least.
5. Who do not have an intellectual disability and communication disorders,
6. Who do not have any serious medical condition for which they had been hospitalized at least twice in the last 6 months before this admission.

Where will the study take place?

At UTHealth-HCPC, in the adolescent unit while those selected are still on admission.



IRB NUMBER: HSC-SN-15-0894
IRB APPROVAL DATE: 02/09/2016

What will be done in the study?

Those who agree to participate and are selected to be in the study will be;

1. Interviewed individually and later in group and the interviews will be audio recorded so as not to miss anything important that they may say,
2. The interviews will be for short periods , but may be for two or more times,
3. Their parents may or may not also be interviewed individually if necessary to confirm certain information of which the adolescents are not very sure,
4. Their medical records chart will be reviewed to get information confirm information on their diagnosis, number of previous admissions, race, age and other information required for this study, but not more,
5. The adolescents may be un-obstructively observed to further understand what they say in the interviews.

Who will do the study?

Chukwudi Ekwemalor a psychiatric and mental health nurse who is a doctoral student at the UTHealth School of Nursing do the interviews and other things required in the study.

Contacts for concerns with this study:

1. Chukwudi Ekwemalor on 713-382-4659 or chukwudi.c.ekemalor@uth.tmc.edu
2. UTHealth CPHS on 713-500-7943
3. UTHealth-HCPC Patient Advocate on 713-7417881
4. UTHealth Research Committee on 713-741-5050
5. The Joint Commission on 1-800-999-1010

Thank You

For accepting to participate in this important study on frequent unplanned readmissions.



IRB NUMBER: HSC-SN-15-0894
IRB APPROVAL DATE: 02/09/2016



THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON
 PARENTAL INFORMED CONSENT FORM TO TAKE PART IN RESEARCH
 TREATMENT RECIDIVISM IN ADOLESCENTS WITH MENTAL ILLNESS: AN ETHNOGRAPHIC STUDY
 HSC-NS-15-0894
 Parental Permission

INVITATION TO TAKE PART

You are invited with your adolescent child to take part in a research project called, "Treatment Recidivism in Adolescents with Mental Illness: An Ethnographic Study", conducted by Chukwudi C. Ekwemakor, PhD(c), MBA, MSN, RN-BC (Psych Nursing), of the University of Texas Health Science Center at Houston and Harris County Psychiatric Center (UTHealth-HCPC). For this research project, he will be called the Principal Investigator or PI.

You and your child's decision to take part in the study is voluntary. You and your child may refuse to take part or choose to stop taking part, at any time. A decision not to take part or to stop being a part of the research project will not change the services available to your child from the UTHealth-HCPC.

You and your child may refuse to answer any questions asked or written on any forms. This research project has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston as HSC-NS-15-0894.

PURPOSE

The purpose of this research study is to better understand the frequent inpatient readmission of adolescents with mental illness called treatment recidivism from the position of the adolescents frequently readmitted. This study is being conducted to see how we could use their suggestions in reducing the frequent readmissions in the future.

You and your adolescent are being invited to join this research study because he/she has a history of two or more psychiatric inpatient readmissions in a 12 months period. This study is being conducted to learn more about frequent readmission from adolescents such as your child as we search for ways to reduce frequent psychiatric inpatient readmission among adolescents with mental illness.

This is a local study being conducted in one location here at the UTHealth-HCPC. The study will enroll about 10 to 20 adolescents. This study is not sponsored by any organization.

PROCEDURES

- What to expect as a subject:

If you and your adolescent agree to take part in this study, the following will happen:

- You may be interviewed if we consider it necessary to confirm or validate information given by your adolescent that he/she is not very sure of, otherwise you may not be interviewed.
- Your adolescent will continue to receive normal care as determined by his treatment team. Care received by your adolescent will not be affected by participation or non-participation in the study.
- Your adolescent will be interviewed and his/her interviews will be audio-taped. This is to make sure that his/her information is collected correctly. Once the interviews are transcribed and reviewed for accuracy, the tape will be erased to destroy the information. This will be within a period of about six months of the interviews. Your adolescent will not be video-taped.
- Your adolescent will be observed sometimes as he/she interacts with others in the unit.
- Your adolescent's medical records will be reviewed to get certain other information relevant to the study such as age, gender, race/ethnicity, psychiatric diagnosis and medical history, previous admission history, school or work status, living arrangements, family structure, family socioeconomic status, and family history.
- No drugs or special treatments will be administered to your adolescent child as a result of participation in this study, other than those prescribed by your adolescent's psychiatrist for his/her treatment in the hospital.

TIME COMMITMENT

Total duration: You and your child will be in this research study for about two to three weeks from recruitment. This period will be while he/she is still on admission at UTHealth-HCPC. But, if your child is discharged early before conclusion of the interviews, he/she may be interviewed over the phone.

- Your adolescent will be interviewed for a few days within the two to three weeks period and the interviews will be audio-taped. The interviews will be at the convenience of your adolescent in one to two segments of about 10-20 minutes on each day.
- If your adolescent is discharged before concluding the interviews, he/she will be dropped from the study and whatever information collected will be destroyed and not be reported in the study.
- You may be interviewed once or twice if we considered it necessary to verify some information from your adolescent where we have some doubts. Your interview will also last about 10-20 minutes.
- Your adolescent will not remain in the study beyond the interview period explained above.

BENEFITS

The study may or may not provide immediate benefits for your adolescent or your adolescent at the time of this study. However, the result of this study could benefit future decisions as to how treatments will be made so as to reduce frequent readmission in adolescents with mental illness.

RISKS AND/OR DISCOMFORTS

Very minimal risks, if any are anticipated for your adolescent participating in this study.

You and your adolescent may lose time as a result of participating in the study. We shall do all the interviews at your convenience and that of your child.

Your adolescent may become emotional and too agitated during the interviews while remembering some aspects of his/her past. If your adolescent becomes agitated, the interview will be stopped immediately, and the unit treatment team will be notified for appropriate intervention based on his/her plan of care. The interview will be concluded at a later day and time convenient to your adolescent when he/she is comfortable and stable.

There is a risk that your child's private information may be mistakenly released to those you do not want know about them. This study team will make every reasonable effort to protect your adolescent's information from getting to unauthorized persons. Your adolescent will be de-identified and a special number called a code will be used to represent him/her instead of the name. The study laptop will be password protected. The laptop, digital audio recorders and other study material will not be left unattended at any time and will be stored in secure locked file cabinet to preserve the confidentiality of your child's information.

ALTERNATIVES

The only alternative is not to take part in this study.

STUDY WITHDRAWAL

Your decision for you and your adolescent to take part in this study is voluntary. You and your adolescent may decide to stop taking part in the study at any time. A decision not to take part or to stop being a part of the research project will not change the services available to your adolescent child from UTHealth-HCPC.

Also, there may be instances where the PI may withdraw your adolescent from the research study. The PI will explain this to you and your adolescent and the procedures to allow him/her to stop taking part in the research study in the safest manner. If your adolescent withdraws or he/she is withdrawn from the study, whatever information obtained from you or your child will be destroyed and will not be used in the study.

COSTS, REIMBURSEMENT AND COMPENSATION

If you and your adolescents decide to take part in this study, there will be no cost to you or your adolescent for participating in the study. You and your adolescent will not be paid to take part in the study.

However, your adolescent will receive a \$25 Walmart gift-card in appreciation for taking the time to participate and complete the study. The gift card will be given when he/she is being discharged.

If you receive a bill that you believe is related to your taking part in this research study, please contact the PI, Chukwudi Ekwemalor at 713-382-4659 with any questions.

CONFIDENTIALITY

Please understand that representatives of the University of Texas Health Science Center at Houston may review your research and or medical records for the purpose of verifying research data, and will see personal identifiers. However identifying information will not appear on records retained by the PI, with the exception of date of birth, initials, and treatment /service dates.

Your adolescent will not be personally identified in any reports or publications that may result from this study. Any personal information about your adolescent or your family that is gathered during this study will remain confidential to every extent of the law. A special number (code) will be used to identify your adolescent in the study and only the investigator will know his/her name. Your adolescent information will be put in a password protected laptop. The laptop, digital audio recorders and other study material containing you child's information will not be left unattended at any time and will be stored in secure locked file cabinet to preserve the confidentiality of your child's information.

There is a separate section in this consent form that you will be asked to sign which details the use of and disclosure of your adolescent's protected health information.

QUESTIONS

If you and your adolescent have questions at any time about this research study, please feel free to contact the PI, Chukwudi C. Ekwemalor at 713-382-4659, as he will be glad to answer your questions.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH

Patient Name _____ Date of birth _____

Protocol Number and Title: HSC-SN-15-0894; TREATMENT RECIDIVISM IN ADOLESCENTS WITH MENTAL ILLNESS: AN ETHNOGRAPHIC STUDY.

Principal Investigator: Chukwudi C. Ekwemalor, PhD(c), MBA, MSN, RN-BC (Psych Nursing)

If you and your child sign this document, you and your child give permission to the University of Texas Health Science Center at Houston to use or disclose (release) your health information that identifies you and your child for the research study named above.

The health information that we may use includes your child's medical record, psychiatric diagnosis and medical history, previous admission history, school or work status, family structure, family socioeconomic status, family history, age, gender and race. The information disclosed/released is de-identified with the exception of date of birth, initials, and treatment /service dates.

The health information listed above may be used by and/or disclosed (released) to researchers and their staff. The researchers may disclose information to employees at the University of Texas Health Science Center at Houston for the purpose of verifying research records.

The University of Texas Health Science Center at Houston is required by law to protect your child's information. By signing this document, you and your child authorize The University of Texas Health Science Center at Houston to use and/or disclose (release) your child's health information for this research. Those persons who receive your child's health information may not be required by Federal privacy laws (such as Privacy Rule) to protect it and may share your child's information with others without your permission, if permitted by laws governing them.

If all information that does or can identify your child is removed from your child's health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes. No publication or public presentation about the research described above will reveal your child's identity without another authorization from you and your child.

Please note that health information used and disclosed may include information relating to HIV infection; treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. In case of an adverse event related to or resulting from taking part in this study, you and your child give permission to the researchers involved in this research to access test, treatment, and outcome information related to the adverse event from the treating facility.

Please note that you and your child do not have to sign this Authorization, but if you and your child do not, your child may not participate in this research study. The University of Texas Health Science Center at Houston may not withhold treatment or refuse treating you and your child if you and your child do not sign this Authorization.

You and your child may change your mind and revoke (take back) this Authorization at any time. Even if you and your child revoke this Authorization, researchers may still use or disclose health information they already have obtained about your child as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you and your child must write to:

Chukwudi C. Ekwemalor,
The University of Texas Health Science Center at Houston, School of Nursing,
6901 Bertner Avenue, Houston Texas 77030
Phone 713-382-4659.

This Authorization will expire six (6) years after the end of the study.

SIGNATURES

Sign below only if you understand the information given to you about the research and choose to take part. Make sure that any questions have been answered and that you understand the study. If you have any questions or concerns about your rights as a research subject, call the Committee for the Protection of Human Subjects at (713) 500-7943. You may also call the Committee if you wish to discuss problems, concerns, and questions; obtain information about the research; and offer input about current or past participation in a research study. If you decide to take part in this research study, a copy of this signed consent form will be given to you.

Printed Name of Child

Printed Name of Parent or Legally Authorized Representative

Signature of Parent or Legally Authorized Representative

Date

Printed Name of Person Obtaining Informed Consent

Signature of Person Obtaining Informed Consent

Date

CPHS STATEMENT: This study (HSC-NS-15-0894) has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston. For any questions about research subject's rights, or to report a research-related injury, call the CPHS at (713) 500-7943.



The University of Texas
Health Science Center at Houston

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER - HOUSTON
ADOLESCENT ASSENT FORM

Age 13-17 Years
HSC-NS-15-0894

Protocol Title: Treatment Recidivism in Adolescents with Mental Illness: An Ethnographic Study

Principal Investigator Name: Chukwudi C. Ekwemakor, PhD(c), MBA, MSN, RN-BC

Protocol No: HSC-NS-15-0894

INVITATION TO TAKE PART IN A RESEARCH STUDY

Mr. Chukwudi C. Ekwemakor is inviting you to take part in this research study. You need to know about the study so you can decide if you would like to join the study or not. If you decide to be part of this study you will be asked to sign this form. You may discuss all that is in this paper with your family if you want to before making your decision.

Your parent(s) gave the permission for us to talk to you about being in the study. About 10-20 adolescents just like you will participate in this study. This study will be done at University of Texas Health Science Center at Houston Harris County Psychiatric Center (UTHealth-HCPC). If you want to be in this study you will be asked to sign this form.

WHY IS THIS STUDY BEING DONE?

We are inviting you to take part in a research study because we are trying to learn more about the frequent readmission of adolescents with mental illness to the hospitals. We want to better understand what these adolescents who have been readmitted two or more times in a 12 month period think about their frequent readmissions. We want to hear their suggestions of what we can do to reduce their frequent readmissions. We believe the voices of adolescents like you have not been sufficiently heard.

WHAT WILL HAPPEN IF YOU JOIN THE STUDY?

If you agree to be in this study, the following things will happen:

- You will be interviewed and your interview will be audio-taped so that nothing is missed of the important things you will say.
- The interview will be at your convenience and will be in segments of 10-20 minutes and not more than two segments in a day. The interviews will last a few days in period of about two to three weeks when you are still in the hospital.
- It will be done in a private and safe location within the hospital unit.
- However, if you are discharged from the hospital before the interview, you will be dropped from the study, but we shall make every effort to interview you while in the hospital.
- You will be observed sometimes as you interact with other adolescents in the hospital during the study.

- Your medical record will be reviewed to get some other information needed for the study, such as your age, gender, race, psychiatric diagnosis, and medical history, number of previous admissions, living arrangement, whether you are in school or working, family structure, family socioeconomic status, and family history.
- If you do not want to do these things, you can say that you do not want to be in the study. Even if you say you want to be in the study now, you can stop later if you change your mind. If you change your mind, tell the Principal Investigator.

HOW LONG WILL THIS TAKE?

You will be in the study for about two to three weeks during the period that you are on admission at the UTHealth-HCPC. Your actual interview and follow-up will be for a few days within that period. The interviews will be in one to two segments of 10-20 minutes on each day.

WHAT ARE THE BENEFITS TO TAKING PART IN THIS STUDY?

Taking part in this study may or may not provide immediate benefits for you at the time of this study. However, the result of this study could benefit future decisions as to how treatments will be made so as to reduce frequent readmission in adolescents with mental illness.

WHAT ARE SOME OF THE RISKS AND DISCOMFORTS? WHAT COULD HAPPEN THAT NO ONE WOULD LIKE?

You may lose some time used to participate in the study.

You could get emotional and agitated while remembering some difficult aspects of your past during the interview. Your private information could be mistakenly released to those you do not want to know about them.

But know that the interviews of this study will always be done at your convenience.

If you get too emotional and agitated, the interview will be stopped immediately and your treatment team will be notified to help you. The interview will be continued at another day and time when you feel more comfortable. The study team will make every reasonable effort to protect your information from getting to unauthorized persons. You will be de-identified and a code will be used to represent you instead of your name. The laptop containing your information will be password protected. The laptop, audio recorder and other study materials with your information will not be left unattended at any time. The will be stored in secure locked file cabinet.

CAN YOU STOP BEING IN THE STUDY?

Although your parent(s) or legal guardian gave us the permission to contact you to take part in this study, you are to choose if you want to be in this study or not. You do not have to be in the study, if you do not want to. No one will be mad at you if you do not want to do this. Your doctor will still take care of you like before. If you do not want to be in this study, just tell someone. You do not have to tell them a reason. If you decide to be in the study, you can still decide to stop at any time.

Also, there may be instances where the PI may withdraw you from the research study. The PI will explain this to you and the procedures to allow you to stop taking part in the research study in the safest manner. If you withdraw or you are withdrawn from the study, whatever information collected from you will be destroyed and will not be used in the study.

IS THERE A COST TO BE IN THE STUDY?

There will be no cost to you or your parents for participating in the study.

But you will receive a \$25 Walmart gift-card in appreciation for taking the time to participate and complete the study.

The gift card will be given when you are discharged. You are not being paid to take part in the study.

WHO WILL KNOW YOU ARE IN THE STUDY?

When researchers are working on a research project like this, everything you say and everything they write down is private. Researchers don't talk or show the information to anyone who is not working on the study unless you are in danger and needs help right away. When anything is written down about you a special number called a code is written instead of your name. The list of codes for the names is kept in a secure locked file.

WHAT IF YOU HAVE ANY QUESTIONS?

You can ask questions any time. You can ask now or you can ask later. You can talk to Mr. Chukwudi C. Ekwemalor or you can talk to someone else in your treatment team. If you would like to contact Mr. Chukwudi C. Ekwemalor, his phone number is 713-382-4659.

SIGNATURES:

Sign this paper if you decide you want to participate in the study. It is not a promise or contract. It just means that you have read this and that you understand what we are asking. It also means that you would like to try it. Remember that you can always change your mind by just saying so to your parents or anyone working in this study. You understand everything that has been explained to you. You will get a copy of this assent form after the signatures.

 Printed Name of Subject

 Signature of Subject

 Date

 Printed Name of Individual Obtaining Consent

 Signature of Individual Obtaining Consent

 Date
CPHS STATEMENT:

This study (HSC-NS-15-0894) has been reviewed by the Committee for the Protection of Human Subjects (CPHS) of the University of Texas Health Science Center at Houston. For any questions about research subject's rights, or to report a research-related injury, call the CPHS at 713-500-7943.

CURRICULUM VITAE

Chukwudi C. Ekwemalor, PhD, MBA, MSN. RN-BC (Psych)

6901 Bertner Avenue, Houston, TX 77030

Private email: chudiekwem@hotmail.com

Phone: 713-382-4659 UTHHealth email: Chukwudi.C.Ekwemalor@uth.tmc.edu

EDUCATION

<u>Degree/Certificate</u>	<u>Institution</u>	<u>Date</u>
PhD in Nursing	University of Texas School of Nursing Medical Center, Houston, Texas	August, 2016
MSN Nursing Education	University of Texas School of Nursing Medical Center, Houston, Texas	December 2012
BSN- Nursing	Prairie View A&M University School of Nursing, Medical Center, Houston, Texas	December 2009
LVN- Certificate of Completion	Houston Community College Coleman Campus, Medical Center, Houston, Texas	December 2004
MBA- Financial Management	Lagos State University Lagos, Nigeria	December 1998
Diploma in Management	Nigerian Institute of Management, Lagos, Nigeria	December 2001
		July 1983

Diploma in Quantity
Surveying

The Polytechnic Owerri,
Nigeria

LICENSURE

<u>License</u>	<u>Organization</u>	<u>Expiration Date</u>
RN Registered Nurse	Texas Board of Nursing	June 2017
LVN Licensed Vocational Nurse	Board of Nurse Examiners for the State of Texas	June 2010

PROFESSIONAL MEMBERSHIP/HONORS

Sigma Theta Tau International (STTI) Zeta Pi Chapter Annual Student Excellence Award - PhD program	2015
Houston Livestock Show & Rodeo Scholar Accelerated PhD Nursing UTHHealth SON	Sept; 2013
American Psychiatric Nurses Association	Since 2012
ANCC Board Certified Psych & Mental Health	Dec; 2012
Special Award: UTHHealth School of Nursing: School of Nursing Spirit Award	Dec., 2012
Sigma Theta Tau International (STTI) Zeta Pi Chapter	Since 2012
ANA & Texas Nurses Association (TNA)	Since 2010
National Association of Practical Nurse Education and Services (NAPNES)	2008

WORK EXPERIENCE

<u>Facility</u>	<u>Position</u>	<u>Date</u>
		January 2013 to date

University of Texas HSC at Houston, School of Nursing	Graduate Assistant/Clinical Instructor, Psych Nursing	June, 2013 - Sept., 2013
University of Texas Harris County Psychiatric Center (UT-HCPC)	Staff Nurse/Relief Supervisor	September 2010- Sept., 2013
University of Texas Harris County Psychiatric Center (UT-HCPC)	Staff Nurse	
West Oaks (Psychiatric) Hospital, Houston Texas	Staff Nurse	March 2010- September 2010
Harris County Sheriff's Dept. Mental Health Unit (Agency Staffing)	Staff Nurse (Part time)	2008- June 2009
WinterHaven HealthCare Center, Houston Texas	LVN Unit Charge Nurse	2007- 2008
Sam Houston Gardens HealthCare Center, Houston Texas	LVN Unit Charge Nurse	2005- 2007
Bayou Manor Healthcare Center, Houston Texas	LVN Unit Charge Nurse (Part time)	2006-2007

OTHER ASSIGNMENTS/VOLUNTEER WORK

UTHealth SON Student Tuition & Fees Review Committee, Student Rep - PhD program	Fall Semester, 2015
UTHealth SON Selection of the Executive Director, Student Affairs & Admissions, Student representative - PhD program	Summer Semester, 2015
Fort Bend ISD School Health Advisory Council	2014 to Date
Member, Nursing Services Advisory Council UT-HCPC	2012 to 2013

Member, Nursing Services Advisory
Council West Oaks Hospital

2010

ACADEMIC WRITINGS AND PRESENTATIONS

PhD Dissertation: Treatment Recidivism in Adolescents with Mental Illness: A Focused Applied Medical Ethnography. To be submitted for publication in the Summer Semester, 2016.

Unpublished article: Risk Factors and Predictors of Treatment Recidivism in Adolescents with Mental Illness: A Literature Review. Submitted to Journal of the American Psychiatric Nurses Association (JAPNA) on 04/16/2015, but later withdrawn.

Risk Factors Associated with Malpractice Catastrophic Payouts among Advanced Practice Nurses in the United States. Co-presented with Santibáñez, L. P. and Cockerham, M. in the 2014 Research Day poster session presentation at The University of Texas Health Science Houston School of Nursing.

Unpublished MSN Thesis: Effects of Resistance Exercise Training on Glycemic Control in Adults with Type 2 Diabetes: A Literature Review. Fall Semester, 2012.

REFERENCES

To be provided when required.