Mental/Behavioral Health Virtual Learning Collaborative

Spring 2021

Session #3

MAY 5, 2021

12:30-1:30 P.M.

Learning Collaborative Faculty/Advisors

- **Steven Kairys, MD, MPH, FAAP**

NJAAP Medical Director & Co-Principal Investigator, NJ Pediatric Psychiatry Collaborative

- **Anthony L. Rostain, MD, MA**

Chair, Department of Psychiatry and Behavioral Health, Cooper University Health Care

- **Ruth S. Gubernick, PhD., MPH, PCMH CCE**

Quality Improvement Coach

- **Puthenmadam Radhakrishnan MD, MPH, FAAP**

Bellevue Pediatrics, Ewing, NJ

- **Melissa Wallach, MD, FAAP**

Hackensack Meridian Health Medical Group - Neptune Pediatrics & Asbury Park Pediatrics

Learning Collaborative Participants

Advocare West Deptford Pediatrics Dr. Angela Knestaut	Happynest MD. LLC Dr. Beth Gelman
Advocare West Morris Pediatrics Dr. Michele Davide	Howard Neil Kornfeld Dr. Howard Kornfield
Bergen West Pediatric Center Dr. Kathleen Cerkvenik	Integrated Pediatrics Dr. Sunita Gulati
Child Health Associates PA Dr. Mana Somasundaram	Jersey Shore University Medical Center Dr. Chee Tan
Children's Health Center Dr. Nancy Denicola	Luz Romero, MD, LLC Dr. Luz Romero
Complete Care Pediatrics Dr. Grace Yia	Mahi Pediatrics Uma Kanikicharla
Dr Neil Gittleman, MD Dr. Inna Lekht	Med 4 Kids Dr. Roji Andrews
Elite Pediatrics Dr. Sarah Elfanagely	Morris Pediatric Care, LLC Dr. Aradhana Rajkumar
Excel Pediatrics Dr. Anjana Dravid	My Whole Child Pediatrics Dr. Naveen Mehrotra
Florham Park Pediatrics Dr. Ellen Ganek	NeurAbilities Healthcare Dr. Amir Miodovnik

Learning Collaborative Participants

New Jersey Department of Health Lisa Jenkins	Tribeca Pediatrics Dr. Riddhi Thaker
Nurture Pediatrics Dr. Leena Benoy	Trinity Pediatrics PCPA Dr. Kia Grundy
Pediatricare Associates Dr. Sapna Shah	Valley Hospital Dr. Marivic Santiago
Plaza Family Care Dr. Ankita Trivedi	Dr. Radhakrishna and Associates Dr. Vijaya Radhakrishna
PM Pediatrics Dr. Khushbu Shah	Westfield Pediatrics Dr. Nicole Fersa
Premier Medicine and Wellness Ann Willitts & Dr. Jodi Peska Mosseri	Williamstown Pediatric Practice Dr. Mary Mathew
Princeton Nassau Pediatrics Dr. Payal Hemrajani & Dr. Wendy Rivers	Monmouth Medical Center Dr. Kristen Pyne
Rutgers RWJMS Dr. Natalia Karpova	West Deptford Pediatrics Dr. Heather Ruddock
Southern Jersey Family Medical Center Dr. Lillian Mekhail	

Session Agenda

- Welcome, Roll-Call, and Introductions – 5 minutes
- Brief Lecture/Didactic – 15 minutes
- Q.I. tools and strategies – 10 minutes
- Case Presentation #1 – 10 minutes
- Clarifying Questions and Discussion – 15 minutes
- Summary and Close – 5 minutes

Session #3: "Referral & Care Coordination: Working in Collaboration with Your NJPPC Hub"

Learning Objectives:

Participants will be able to . . .

- Describe how to collaborate with the PPC's child and adolescent psychiatrists to care manage and treat pediatric patients identified with mental/behavioral health concerns
- Discuss a case presentation of a patient identified with mental/behavioral health concerns
- Identify quality improvement strategies for testing and implementing mental/behavioral health patient services in their practice

Referral & Care Coordination: Working in Collaboration with Your NJPPC Hub

BETH YOUNG, LCSW

CLINICAL PROGRAM COORDINATOR

ATLANTIC HEALTH HUBS

JOSE L. POSOS, M.ED., LPC

CLINICAL PROGRAM MANAGER

HMH HUBS AT HUMC & PMC

How the process can look like in a practice:

Pediatric Well Visit or Sick Visit

- Pediatrician conducts initial mental/behavioral health screening

Discussion

- Mental health, behavioral health, substance use concern identified and discussed with patient and/or parent

Refer to Hub and Consent

- Based on results, discussion with parent and/or clinical impression, pediatrician obtains consent for Hub consult and sends needed paperwork to Hub staff

Factors to Consider in PPC Hub Referrals

- Screening tool results are positive
- Parent or pediatrician has concerns regarding their child/adolescent's social-emotional, behavioral, or developmental health (regardless of screening outcome)
- Pediatrician:
  - has questions regarding mental/behavioral health symptoms or diagnosis
  - needs assistance with medication initiation and/or management

What happens at the Hub:

- Consult form received from pediatric provider.
- Consult form reviewed for risk and prioritized accordingly.
- Clinician reaches out to parent/guardian* to conduct psychosocial assessment and determine appropriate treatment plan. (*patient directly if 18+)
- Community resources identified and provided to the patient/parent/guardian via email to review and schedule appointment. The clinician will check-in one week after the resources have been sent to answer any questions or discuss the recommendations further.
- The completed assessment and recommendations from the clinician will be sent to the referring pediatric provider for continuity of care.

Child & Adolescent (CAP) Evaluation:

- For children needing psychiatric intervention (i.e. medication recommendations, diagnostic clarification, etc.), a one-time CAP evaluation can be conducted.
- The goal of the evaluation is to provide further guidance to the pediatrician on the management of the mental health concern of the patient.
- All evals are currently conducted virtually by the Hub CAP and are covered under the program's grant (no charge to insurance or to patients).
- Following the evaluation, the Hub CAP will communicate directly to the referring pediatric provider to relay treatment recommendations.

Hub Psychiatric Evaluation process

Case presented to Hub CAP by clinical navigator and determined to be appropriate for evaluation.

Family is contacted to schedule appointment and all details are emailed to family.

Hub CAP conducts evaluation directly with patient and family, discussing findings and recommendations. If additional link to community resources is needed, Hub staff will work directly with family to provide such resources.

Hub CAP contacts referring pediatric clinician directly via phone to advise of impression and recommendations. If medication is warranted, CAP will discuss specific medication, dosage, and follow-up procedure, with the intent for the referring pediatric clinician to prescribe.

Complete psychiatric documentation is faxed to the referring provider.

QI Tools & Strategies

Ruth S. Gubernick, PhD., MPH, PCMH CCE

Quality Improvement Coach

How can my practice team assure that referrals are made to the Hub and care coordination is working to *improve the mental health and well-being of my patients and their families*?

Workflow:
How does the current process look in our practice?

Pediatric Well Visit or Sick Visit (office determines protocol if screening is not covered by patient insurance)

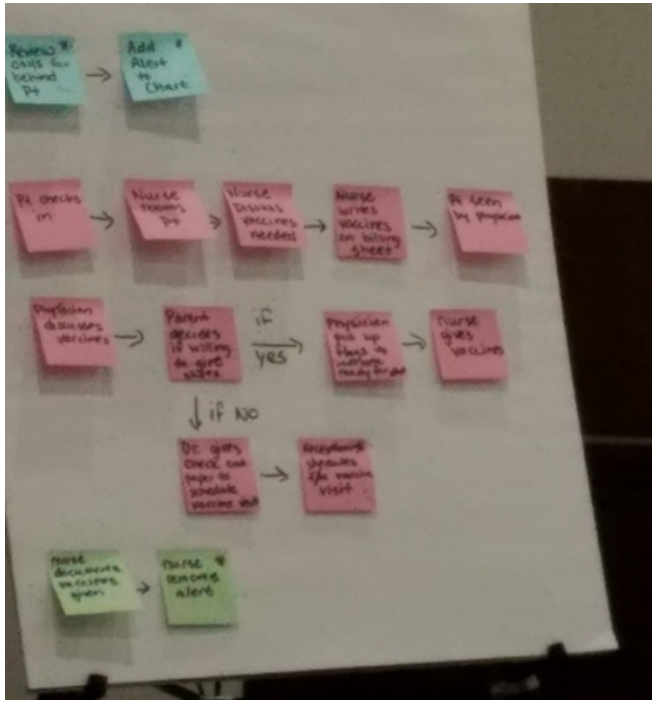
Initial Mental/Behavioral Health Screening
- Front desk hands out the screening tool (option for adolescent to receive in exam room)
- Nurse/MA scores it before doctor sees patient

Optional: Based on results, possible secondary screening (this can be done by PPC Hub staff as well, based on provider preference)

Based on results, discussion with parent and possible decision to consult with or refer to PPC Hub

PPC Hub reviews referral, performs intake with family, and makes recommendations for further referrals, or other services

Where is an opportunity for improvement?



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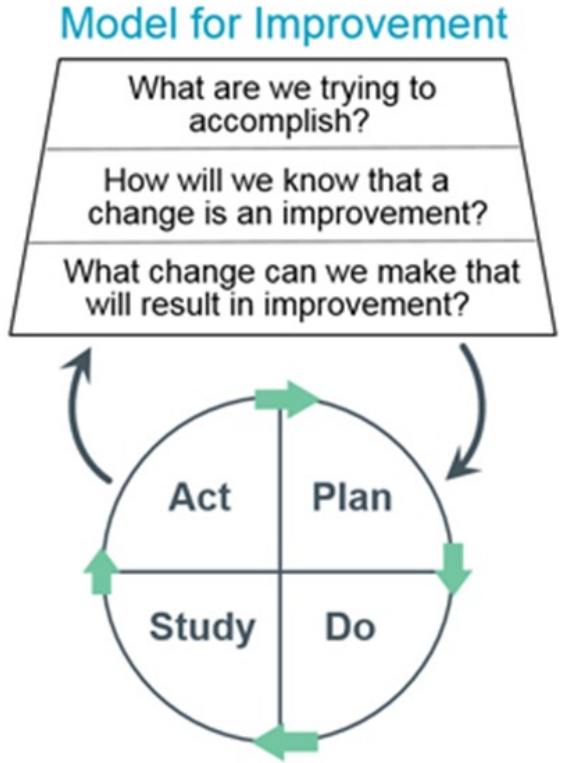
Complete psychiatric documentation is faxed to the referring provider.

Apply Quality Improvement (QI) Methodology!

- Form a QI team
- Meet
- Assign responsibility for key tasks
- Identify at least 1 best practice strategy or idea you want to test during your patient visit
- Plan and conduct small test(s) of change



Institute for Healthcare Improvement.
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx.

Use Rapid-Cycle Small Tests of Change!

PDSA Worksheet for Testing Change

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done

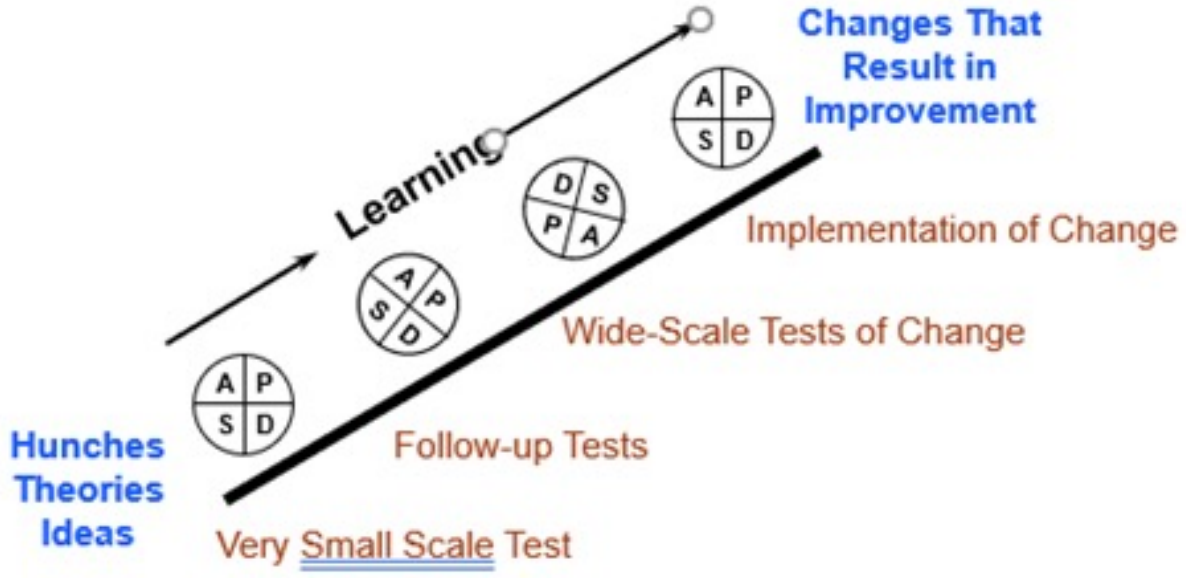
Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do **Describe what actually happened when you ran the test**

Study **Describe the measured results and how they compared to the predictions**

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

Institute for Healthcare Improvement



Case Presentation

MARY MATHEW, MD, FAAP

LEENA RAJU, NP

WILLIAMSTOWN PEDIATRIC PRACTICE

925 SOUTH BLACK HORSE PIKE

WILLIAMSTOWN, NJ

Patient Case Presentation

- **Age**: 11years old Girl **Gender:** Female
- **Reason for Presenting Case:** This case was a Challenge to manage and the need for guidance from psychiatrist
- **How long has the child been in your care**? Since she was 9 days old.
- **Child's current diagnosis(es) and age of onset (if there is one): Generalized Anxiety Disorder, Unspecified depressive disorder, ADHD- Inattentive type.**
- **Current Medication**: Wellbutrin SR 100mg BID since 12/18/20, and increased to Wellbutrin SR 150mg in am and 100 mg in pm in March
- **What were the scores of the Sreens, PSC-35, Y-PSC-37?** **PSC-35** score: 9 **PSC-Y-37** score: 39
- **Concerns identified? Child screened positive in PSC Y including suicidal ideation.**
- **Was patient in crisis(at-risk to self or others) at time of visit?** No, further evaluation revealed it was safe for child to go home.
- **Risk factors:** Social isolation due to remote learning. School teacher and child were not getting along. Parental divorce 4 years ago. Mom's recent diagnosis of breast cancer.
- **Protective factors:** Good support at home. Being able to talk to 21y/o brother, 18yo sister and mother.

PSC-35; Score = 9

Child's Name [redacted] Record Number _____
Today's Date 10.8.20 Filled out by Mom
Date of Birth 9.18.09

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1		X	
2.	Spends more time alone	2		X	
3.	Tires easily, has little energy	3	X		
4.	Fidgety, unable to sit still	4	X		
5.	Has trouble with a teacher	5	X		
6.	Less interested in school	6	X		
7.	Acts as if driven by a motor	7	X		
8.	Daydreams too much	8	X		
9.	Distracted easily	9	X		
10.	Is afraid of new situations	10		X	
11.	Feels sad, unhappy	11		X	
12.	Is irritable, angry	12			X
13.	Feels hopeless	13		X	
14.	Has trouble concentrating	14	X		
15.	Less interest in friends	15	X		
16.	Fights with others	16		X	
17.	Absent from school	17	X		
18.	School grades dropping	18		X	
19.	Is down on him or herself	19			
20.	Visits doctor with doctor finding nothing wrong	20	X		
21.	Has trouble sleeping	21	X		
22.	Worries a lot	22	X		
23.	Wants to be with you more than before	23	X		
24.	Feels he or she is bad	24	X		
25.	Takes unnecessary risks	25	X		
26.	Gets hurt frequently	26	X		
27.	Seems to be having less fun	27	X		
28.	Acts younger than children his or her age	28	X		
29.	Does not listen to rules	29	X		
30.	Does not show feelings	30	X		
31.	Does not understand other people's feelings	31	X		
32.	Teases others	32	X		
33.	Blames others for his or her troubles	33	X		
34.	Takes things that do not belong to him or her	34	X		
35.	Refuses to share	35	X		

Total score 7+2=9

Does your child have any emotional or behavioral problems for which she/he needs help? XN ( ) Y
Are there any services that you would like your child to receive for these problems? XN ( ) Y

If yes, what services? _____

WM pass. 10/8/20

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PSC-Y-37; Score = 39

A Survey From Your Healthcare Provider — PSC-Y

Name [redacted] Date 10.8.20 ID 9.18.09

Please mark under the heading that best fits you or circle Yes or No

		Never 0	Sometimes 1	Often 2
-	1. Complains of aches or pains	X		
-	2. Spend more time alone		X	
-	3. Tire easily, little energy	X		
@	4. Fidgety, unable to sit still			X
-	5. Have trouble with teacher			X
-	6. Less interested in school		X	
@	7. Act as if driven by motor			X
@	8. Daydream too much			X
@	9. Distract easily			X
-	10. Are afraid of new situations		X	
A	11. Feel sad, unhappy		X	
-	12. Are irritable, angry			X
A	13. Feel hopeless			X
@	14. Have trouble concentrating		X	
-	15. Less interested in friends			X
✱	16. Fight with other children		X	
-	17. Absent from school	X		
-	18. School grades dropping		X	
A	19. Down on yourself			X
-	20. Visit doctor with doctor finding nothing wrong			
-	21. Have trouble sleeping		X	
A	22. Worry a lot		X	
-	23. Want to be with parent more than before		X	
-	24. Feel that you are bad			X
-	25. Take unnecessary risks		X	
-	26. Get hurt frequently		X	
A	27. Seem to be having less fun	X		
-	28. Act younger than children your age			X
✱	29. Do not listen to rules	X		
-	30. Do not show feelings	X		
✱	31. Do not understand other people's feelings	X		
✱	32. Tease others	X		
✱	33. Blame others for your troubles		X	
✱	34. Take things that do not belong to you	X		
✱	35. Refuse to share			
✱	36. During the past three months, have you thought of killing yourself?		Yes	No
✱	37. Have you ever tried to kill yourself?		Yes	No

@ = A ≥ 7 A = I ≥ 5 ✱ = E ≥ 7 | Note— the sub scores do not impact the overall score; they are for interpretation purposes only.

TS 13+26=39

Q 36 or Q 37-Y ✱ | Screen ≥ 30

FOR OFFICE USE ONLY
Plan for Follow-up: ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor ☐ Referred to specialist

- Refer to CDD peds
- Flu in month here. Safety screen in place WM 10-8-20

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)

PHQ-9 Score: 5

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: [redacted] DATE: 12/31/20

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "√" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	(1)	2	3
2. Feeling down, depressed, or hopeless	0	1	(2)	3
3. Trouble falling or staying asleep, or sleeping too much	(0)	1	2	3
4. Feeling tired or having little energy	0	(1)	2	3
5. Poor appetite or overeating	(0)	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	(1)	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	(0)	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	(0)	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	(0)	1	2	3
add columns	2	+ 2	+ 1	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:	5			

12/31/20

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all
	(Somewhat difficult ✓)
	Very difficult
	Extremely difficult

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A36639 10-04-2005

Q: What else do you want to know about this case?

Please post your answers in the chat box . . .

Past History

- Seen in the office since 9 days old. One of twins. Mother has 5 children.
- Well visit 10/2016 - 7-year-old. Parental divorce. Child is showing symptoms of anxiety and frequent abdominal pain and shortness of breath.
- Well visit 10/2017 - 8 yr. old well visit. Family is adjusting well to parental separation.
- Well visit 10/2018 - 9yr old. No concerns.

What Worked/Successes

1. Being able to refer to Copper PPC. Seen by Dr. Gogineni on 12/17/21. Dr. G called me after the visit with his impression and recommendation and reasoning to start Wellbutrin and therapy.
2. Having Curbside consult with Dr. Pradhan on 3/22/21 for issues that came up in March, when child was not doing well.
3. Follow up visit in the office on 4/26/21- child is doing much better at home and school.

What Didn't Work/Barriers:

1. After doing better initially, child's condition worsened. Mom thinks the medication is not working. Child was not taking the medication regularly.
2. Insurance letter on 4/1/21- Wellbutrin is not recommended for children.

Referral Process – Leena Raju, NP

1. Referral form is completed and faxed to SW. On the referral form we state whether psychiatry evaluation and medication consult is needed or just counseling resources
2. SW reaches out to office via phone to discuss history of the patient
3. Then SW reaches out to parents and sets up evaluation
4. Cooper PPC offers curbside consults with Psychiatrist for any issues that come up
5. The consult report is sent to the office via secure Cooper email or fax

Psychopharmacology of Suicide Prevention

- Psychotropic medication may have a significant role in suicide prevention.
- This is most striking for lithium and clozapine. Consistent medication concordance appears to have a protective effect with regard to all mood stabilizers.
- The augmentation of mood stabilization with antidepressants or antipsychotic in bipolar disorder should be accompanied by an increased awareness of suicide risk in this group.
- The use of antidepressants in unipolar depression (especially in the under 18s) remains contentious but the balance of evidence appears to favor active treatment with careful monitoring in younger age groups.
- Caution should be observed when prescribing hypnotic medication
- At present the evidence for the use of medication in personality disorder is inconclusive

Q: Have any of you ever started an adolescent on Wellbutrin?

Please post your answers in the chat box . . .

What is Bupropion and What It is Prescribed for

Bupropion is an antidepressant medication.

Its unique mechanism of action among antidepressants is thought to be due to reuptake of dopamine and norepinephrine

It is used in the treatment of Major depressive disorder (MDD), Bipolar Depression, Dysthymic Disorder, Social Phobia, Seasonal affective disorder (SAD), and to help people quit smoking (Smoking Cessation), ADHD, Neuropathic Pain, Bulimia

Symptoms of depression include:

- Depressed mood - feeling sad, empty, or tearful
- Feeling worthless, guilty, hopeless, and helpless
- Loss of interest or pleasure in your usual activities
- Sleep and eat more or less than usual (for most people it is less)
- Low energy, trouble concentrating, or thoughts of death (suicidal thinking)
- Psychomotor agitation
- Psychomotor retardation (feeling like you are moving and thinking in slow motion)
- Suicidal thoughts or behaviors

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ORIGINAL ARTICLE

WILEY

Suicide assessment and treatment in pediatric primary care settings

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Funding information

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Abstract

Topic: This article will briefly review screening for depression and suicidal ideation in primary care and school-based clinics, with a focus on in-depth screening for imminent suicide risk, developing a safety plan, and incorporating handoffs to urgent and emergency mental health care personnel. The article will cover current definitions of levels of suicidal risk and clinic-based protocols for a team approach to adolescents in crisis.

Purpose: To provide primary care and behavioral health nurses with evidence-based suicide risk screening and assessment tools and best practices for using them in patient-centered encounters with adolescents with suicidal thinking or behavior.

Sources Used: Journal articles, books, and reports.

Conclusion: Past studies have shown that many individuals who died by suicide had seen a primary care provider in 30 days before their deaths. Nurses in primary care settings should develop clinic-based protocols for screening all adolescents for suicide risk, developing safety plans, and providing suicidal youth and families with monitoring, appropriate referrals, follow-up, and support.

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NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

If yes, how? _____

_____

_____

When? _____

_____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

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RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193

Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN S
Substance Abuse and Mental Health Services Adr
www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live
- * *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
- * *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

Hackensack Meridian
Children's Health at
K. Hovnanian Children's Hospital

Mental Health Collaborative Program Announcements

Upcoming Learning Collaborative Sessions

Session #4 - June 2nd 12:30-1:30 p.m.

Case Presentations

- 3 cases chosen for Sessions #2 - #4
- For those who submitted case with challenge indicated or coaching requested . . .
- Looking into optional, additional session on Wednesday, June 16th at 12:30 pm
- No didactic or QI – just cases

Track 1 vs Track 2 REMINDERS:

Track 1 Participants:

- Attend sessions as schedule permits and complete post-session CME surveys for credits/points and program feedback

Track 2 Participants:

- Agree to attend all 4 Learning Collaborative sessions (March – June)
- Submit a Pre-LC program survey by March 2, and Post-LC Survey by June 11th
- Complete one case submission by March 17th
- Will receive program incentives – pediatric psychopharmacology book and mental/behavioral health coding guide

Resources

Personalized Medicine in Psychiatry
Volumes 19–20, March–April 2020, 100042

An updated classification of antidepressants: A proposal to simplify treatment

Sebastian A. Alvano [a, b], Luis M. Zieher [b]

https://www.sciencedirect.com/science/article/pii/S2468171718300280

NEW JERSEY
PEDIATRIC
PSYCHIATRY
COLLABORATIVE

For More Information or to Register:

Visit:

https://njaap.org/programs/mental-health/ppc

Contact:

NJAAP

Mental Health Collaborative

mhc@njaap.org

According to the CDC, one out of every five children will experience a mental health disorder in the United States. In honor of National Mental Health Awareness Month, NJAAP will be sharing tools, resources and activities to support mental health awareness in children and youth.

https://www.facebook.com/AAPNJ/

https://twitter.com/NewJerseyAAP

Questions?

Please contact anyone from our MHC team:

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Thank you!

Please provide us with feedback on today's session by completing the brief survey at:

https://www.surveymonkey.com/r/NQ73G28

This is also required for those seeking CME credits/MOC part 2 points for today's session.