DEPRESSION SCREENING

CHANGE PACKAGE

T1D Exchange

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BACKGROUND & SCOPE

A change package is a document that describes the improvement methodology for a clinical or operational process. The change package is intended to be a pragmatic guide of best practices, testable ideas, tools, and strategies that can be adapted to a new setting, thereby accelerating implementation. The depression screening change package presented represents shared learning from seven clinical sites participating in the T1D Exchange Quality Improvement Collaborative (T1DX-QI). This document aims to give a strong framework for successfully implementing the elements described to reliably perform depression screening in a variety of clinical practice environments.

This change package describes interventions for an effective process to screen for depression in a diabetes clinic. It was produced in collaboration with participating sites in the T1D Exchange Quality Improvement Collaborative (T1DX-QI). The QI Collaborative was formed to improve health outcomes for people with T1D and to support clinics and hospitals making sustainable change through shared learning. The change package content is grounded in quality improvement methods (http://www.ihi.org/) tested by participating centers. Of the ten clinics participating in the network, clinicians and parents from T1DX-QI centers partnered to share existing depression screening materials and developed, tested, and implemented the interventions described within this change package. The project aim is to demonstrate feasibility and reliability of depression screening in diabetes clinical practice across seven sites.

Depression is a contributing factor to suboptimal health outcomes and is common among adolescents and adults with chronic health conditions, such as diabetes. When present, depression in adolescents with type 1 diabetes is associated with less frequent blood glucose monitoring,[1] higher A1c values,[2–4] and increased rates of diabetes-related hospitalizations.[5, 6] Furthermore, depression does not typically resolve without treatment. Thus, depression during adolescence increases the likelihood for depression as an adult.[7, 8] Standards of care recommend integration of psychosocial screening into comprehensive medical care.[9,]

[10] Early detection of distress, or symptoms of depression makes referral for formal evaluation possible and has shown to be effective in primary care settings. Given the impact of depression on outcomes, "patients with diabetes should be screened annually using age-appropriate screening measures and patients with positive screens should receive further evaluation and treatment as necessary. When appropriate, referrals should be made to experienced mental health providers who will provide treatment in coordination with the patient's diabetes care".[11]

From a parent perspective, Amy Ohmer shares the following insights: "depression screening opens the door to the understanding that there is a mental, and social burden from chronic care that can often feel insurmountable to patients and their families. With knowledge of mental health, families can start therapies designed to help reduce barriers to care. By creating a pathway through the process of implementing depression screening around the country, patients and families can begin treatment, utilizing the medical tools and resources given by expert providers that will lead to better health outcomes; both mentally and physically. Depression screening aligns perfectly with the most important goal of having a happy and healthy child. There is nothing more important than that."

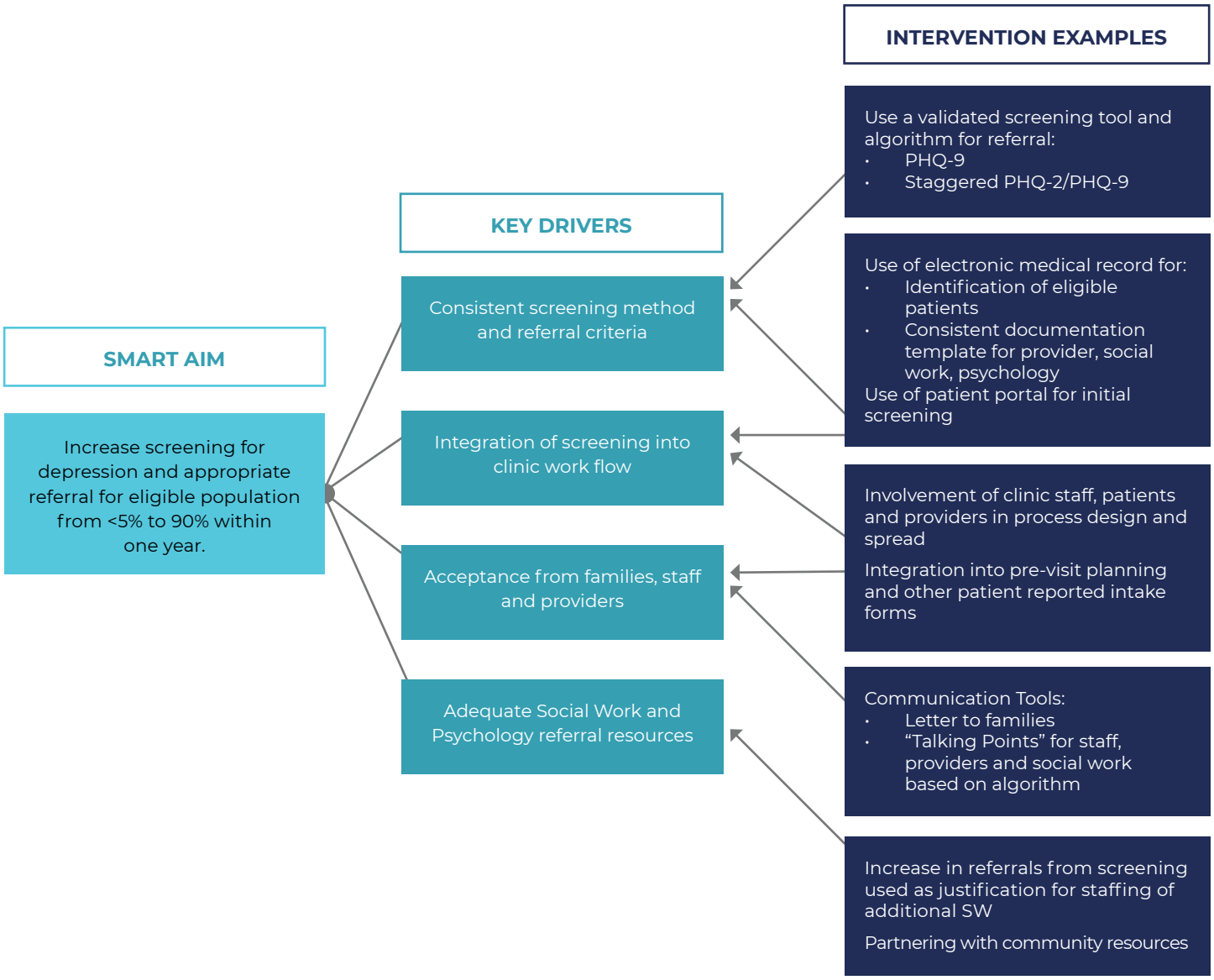
HOW TO USE THIS CHANGE PACKAGE

This document should be used by teams who are seeking ideas for changes to test for improvement efforts. It is best used in combination with other tools, including skills and experience with quality improvement methodology.

Items to consider with determining readiness to implement a change package:

- Strategic alignment with institutional goals
- Identification of a champion and motivated team
- Consensus around relevance of project aims and desire to implement change
- Development of a specific, measurable, achievable, realistic, time-bound aim
- Personnel with skills to map existing clinical processes, identify potential failures and opportunities
- Organizational willingness to try small tests of change (PDSA cycles); adapt what works and abandon what doesn't
- Personnel with analytic capabilities to measure and display data over time for learning
- Infrastructure to spread successful interventions to eligible clinic population and sustain over time

KEY DRIVER DIAGRAM



A key driver diagram is a theoretical model for improving a process. The left side of the figure includes a SMART (specific, measurable, achievable, realistic, time-bound) aim. The aim should be a precise statement of what the team hopes to achieve as determined by measurable changes that can be accomplished in a given time frame with available resources (people, time, support). The center column lists key drivers that are essential components for the aim to be accomplished.

For depression screening, these include:

1. consistent method for screening with objective referral criteria
2. seamless integration into clinic workflow
3. acceptance of psychosocial screening in diabetes clinic from families, staff, and providers and
4. adequate social work and psychology referral resources to respond to positive screens.

Lastly, the right hand column lists potential interventions, or testable ideas, that relate to each of the drivers.

PROJECT INTERVENTIONS & KEY LEARNINGS

Systematic depression screening in adolescents and adults with type 1 diabetes can be reliably implemented with clinically significant results. Teams customized implementation of elements reflected in key drivers to meet resources of the clinical care environment in which the teams operate.[12]

PROCESS CATEGORY: SCREENING TOOLS

CHANGE CONCEPT	TESTABLE IDEA	RESULTS/CHALLENGES	INTERVENTION
Standardize use of objective screening tools to create a formal process with less variation	Select a valid and reliable depression screening tool, e.g. PHQ-9, to administer to eligible patients in clinic	Clinic needs guidance on actions to take as a result of screening and how to best incorporate psychosocial screening into medical encounter	Clinical Decision Supports to guide action based on score thresholds

PROCESS CATEGORY: INTEGRATION INTO CLINIC WORKFLOW

CHANGE CONCEPT	TESTABLE IDEA	RESULTS/CHALLENGES	INTERVENTION
Strategies to include new process into existing clinic work flow include using automation when possible, doing tasks in parallel, and implementing cross-training to respond to screening	Teams trialed paper versions of tools or automated versions either in RedCap or integrated into EMR Paper vs. Electronic Teams trialed a staggered model of PHQ-2 followed by PHQ-9 or universal PHQ-9 Teams trialed use of My Chart for PHQ-2 screening before visit, administration at registration, administration by dedicated team member	Small tests of change with paper screening tools are useful to define process without intense resource investment Centers with high volume, benefitted from initial screening with brief two-item PHQ-2 In centers with high uptake of patient portals, staggered screening can be effective	Automation after optimal work flow is determined increases reliability

PROCESS CATEGORY: ENHANCE THE RELATIONSHIP BETWEEN CLINIC AND FAMILIES FOR ACCEPTANCE OF DEPRESSION SCREENING

CHANGE CONCEPT	TESTABLE IDEA	RESULTS/CHALLENGES	INTERVENTION
Use screening as an opportunity to open dialogue and listen to patients, families, staff, and providers	Teams developed training for staff and providers to increase familiarity discussing psychosocial topics in a medical setting Teams partnered with patients to write letters to families describing why depression screening is offered and expectations for confidentiality and safety	Talking points and clinical algorithm to guide decision making increased provider willingness to participate Qualitative feedback of unexpected positive screens reinforced purpose and importance of project Families endorsed acceptance of talking about mood during visits	Communication tools designed for staff and families

PROCESS CATEGORY: FOCUS ON RESOURCES REQUIRED FOR SERVICES

CHANGE CONCEPT	TESTABLE IDEA	RESULTS/CHALLENGES	INTERVENTION
Design systems in which eligible populations can reliably receive depression screening with timely, customized response to positive screens	Utilization of in-clinic social work and psychology personnel Training of additional staff to expand capacity of personnel with skills to respond to positive screens Outreach to community mental health resources	One center was able to justify additional social work FTE based on results of screening Adult centers in particular needed to build lists of community mental health referral options because SW and psychology resources within clinics were less common	Centers with access to SW, psychology defined referral processes and standard approach for evaluation Centers with limited resources can access ADA Directory of Mental Health Resources: https://professional.diabetes.org/mhp_listing

TOOL KIT DEPRESSION SCREENING TOOLS

There are many validated tools available for depression screening.[13] The teams participating in the T1DX-QI selected the **Patient Health Questionnaire, 9-item (PHQ-9)** (see appendix) as the most frequently utilized measure. There is also a brief two item measure, the **PHQ-2** that can be used for a staggered screening approach.

The Patient Health Questionnaire, 9-Item (PHQ-9) (PHQ-9 Copyright © Pfizer Inc.) is a multipurpose instrument for screening, diagnosing, monitoring, and measuring severity of depression symptoms in a self-report tool. Items assess frequency of symptoms over the past two weeks; the last item screens for the presence of suicide ideation. Scores range from 0–27. There are several options for thresholds to prompt referral action.[14,15] A majority of clinical sites within the T1DX–QI use ≥10 for social work and/or psychology referral, although sites with more robust integrated mental health resources may opt for a lower cutoff of > 5 to capture more mild symptoms of depression or distress.

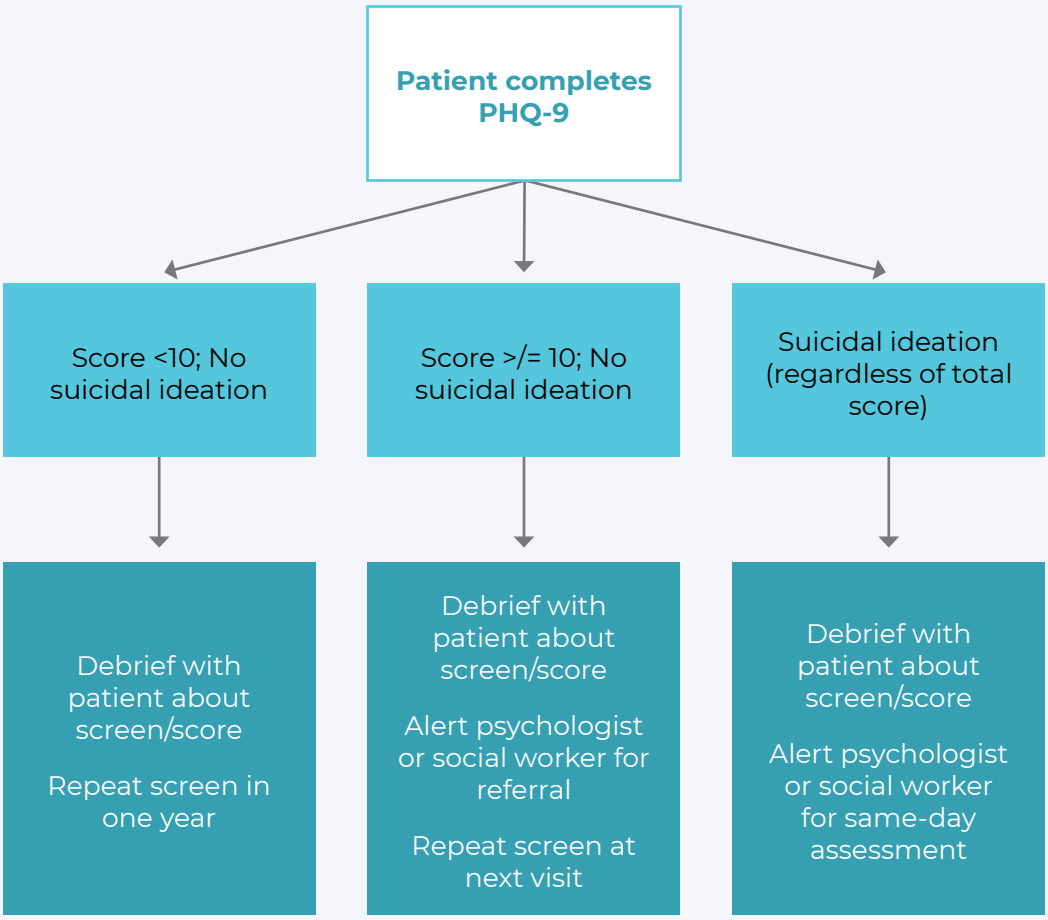
Annual screening is the minimum recommended frequency. Some T1DX–QI centers began screening at every visit until systems are in place to identify who has been screened and a different interval can be specified. More mature centers have evolved to an adaptive screening frequency based upon previous score, (e.g. if score was high, screen again at next visit, if moderate, screen in 6 months and if low, screen annually).[16]

INTERPRETING PHQ-9 SCORES

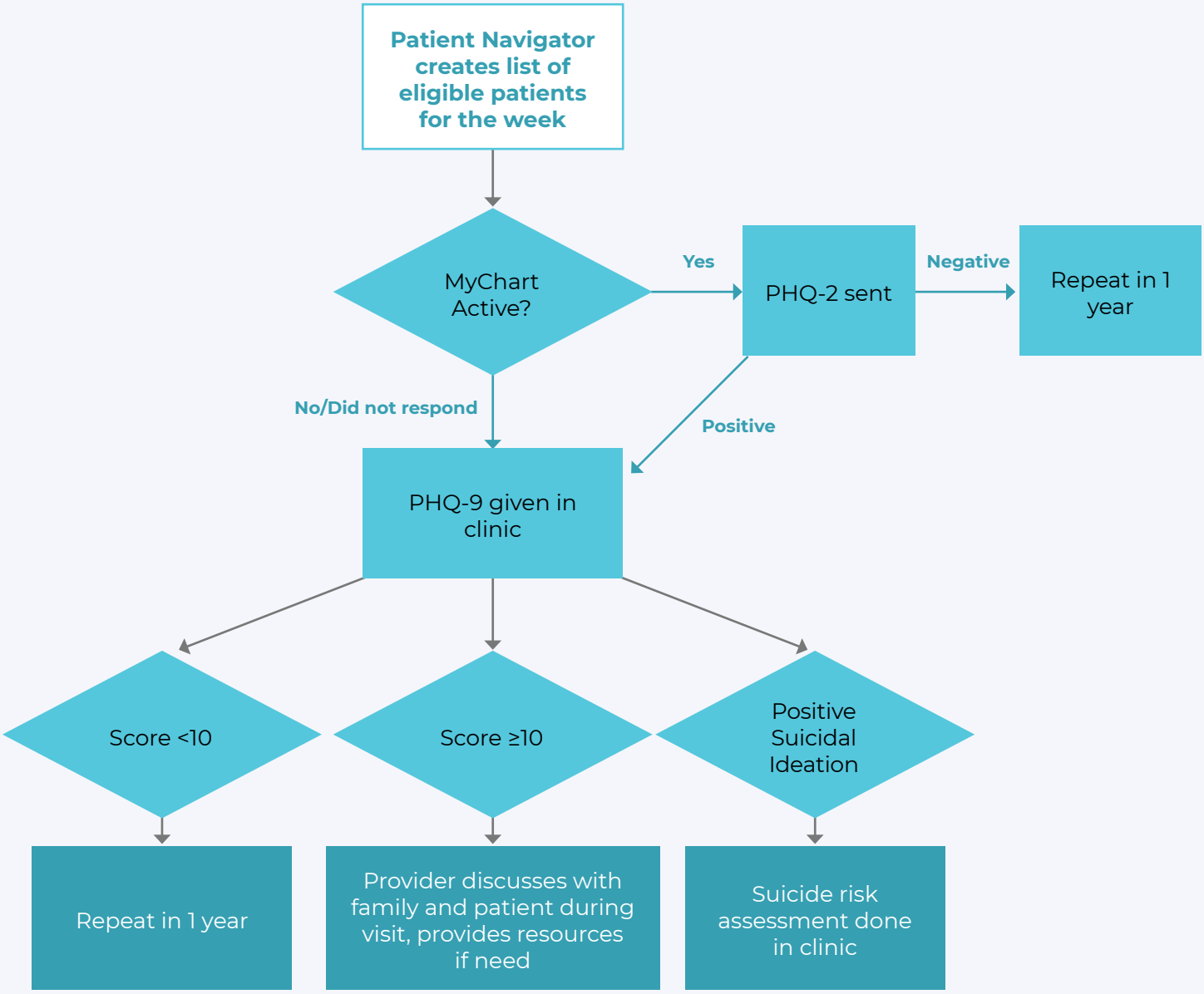
DIAGNOSIS	TOTAL SCORE	FOR SCORES	ACTION
Minimal depression	0–4	≤ 4	The score suggests the patient may not need depression treatment
Mild depression Moderate depression	5–9 10–14	5–14	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression Severe depression	15–19 20–27	>14	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

*The PHQ-9 is described in more detail at the Pfizer website: http://phqscreeners.com

Each clinical site developed a process to integrate depression screening into the clinical workflow and provided clinical decision supports to guide provider response to patient reported symptoms. Below are two examples. In the first pediatric center, screening is completed at the clinic. In the second pediatric and adult center, there is a staggered screening approach, with use of patient portal prior to clinic visit when applicable.



At University of Michigan, a paper form is given to patients by a certified diabetes educator during a visit to ensure that teen responses remain confidential. Providers record result in a flowsheet within the electronic medical record. The team began with select providers and clinic sessions and ramped up to universal screening of eligible teens over time. Currently, electronic tools such as a best practice alert to notify when a teen is eligible for mental health screening, clinical decision supports for referral actions based upon scores, and safety assessment for any endorsement of suicidal ideation, all combine to increase the reliability of the process.



The Barbara Davis Center for Diabetes (BDC) has the largest volume of patients of any of the participating centers. In order to accommodate widespread screening with limited resources, BDC adopted a staggered screening process offering the PHQ-2 via a patient portal (My Chart) in advance of an upcoming in-person visit. Patients who had a positive PHQ-2 screen, or those who did not use the patient portal are offered PHQ-9 screening in clinic. This approach allowed for better integration into the local clinical context.

Participating clinical sites shared resources to equip clinic staff on how to talk about mental health screening rationale and results in the context of a medical subspecialty clinic. These talking points were useful for training of clinic staff and engaging with families. Below is an example of talking points adapted from materials developed at Cincinnati Children's and University of Michigan. See appendix for additional communication tools and assessment examples.

Mental Health & Wellness Screening

Introductory Talking Points for Educators & Physicians Example

- We recognize that managing diabetes can be challenging, particularly during adolescence.
- Teens (ages 12 and above) with type 1 diabetes visiting Endocrinology clinics will now be given the opportunity to complete a brief survey during their clinic visit.
- This survey will ask questions about feeling stressed or down.
- We are asking you/your child to complete this survey because we know teens may feel this way, and when they do, taking care of diabetes can be harder.
- We are trying to find better ways to support teens with diabetes.
- Answers will be kept confidential, with the exceptions of an item that suggests harm to self.
- Your doctor will review your/your child's score during the visit. This information will be used as part of your/your child's diabetes treatment plan.
- Depending on the score, additional resources, such as meeting with a social worker or psychologist may be suggested.

Suggestions for Communicating Scores/Referrals to Patients and Families

PHQ-9 score is below 10

- Note that the questionnaire was completed and what it was for; thank them for completing it; ask if they have any questions or concerns
- Example: "You completed a questionnaire earlier about how you're feeling. Your answers tell us that you're overall feeling okay right now, but we recognize that this may change, so please let me or something else on the diabetes team know. Thank you for completing that questionnaire. Do you have any questions for me?"

No Suicide Ideation, but PHQ-9 score is 10 or above

- Note that the questionnaire was completed and what it was for; convey that it is common and normal to feel down or stressed; highlight what's next; ask if they have any questions or concerns
- Example: "You completed a questionnaire earlier about how you're feeling. Your answers tell us that you may be feeling down or stressed. This is something that happens to a lot of teens with diabetes. When we get those answers, we ask that you talk to a social worker or psychologist to see if there's anything we can help with. Do you have any questions for me?"

Suicidal Ideation, regardless of PHQ-9 score

- Endorsement of thoughts about harming one's self should be taken very seriously; convey to the patient that you are concerned and want the patient to have an immediate evaluation

- Example: "You completed a questionnaire earlier about how you're feeling. One of the questions asked whether you have thoughts that you would be better off dead or of hurting yourself in some way. Your answer tells us that you sometimes think about those things. There are other teens with diabetes who feel this way too. When this happens, we have you see our social worker or psychologist so they can help you right now and come up with a plan for how you can manage these thoughts. Do you have any questions for me?" See appendix for additional communication tools and assessment examples.

TOOL KIT SAFETY PROTOCOL FOR ASSESSING SUICIDAL IDEATION

At each site, a clinical decision support guides referrals for further evaluation if positive suicidal ideation is identified. Most frequently, a trained social worker, or in some contexts, an embedded psychologist, performs a standard assessment in clinic that includes ascertaining details about suicidal thoughts or behaviors, risk factors, protective factors, mental status evaluation, and plan. It is essential to address any positive endorsement of suicidal ideation with a safety assessment. Please see appendix for specific examples of standardized assessment templates.

Strategies for Differently Resourced Scenarios

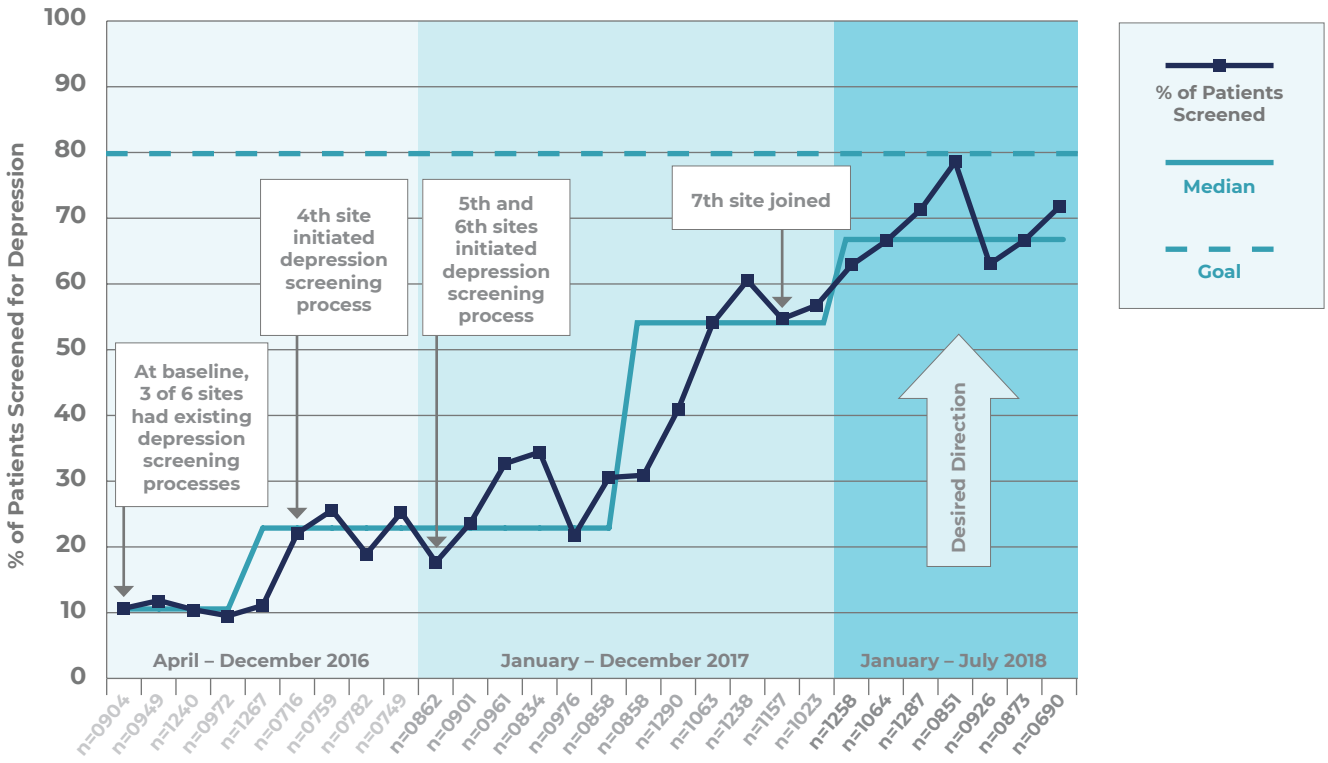
In a clinic with limited access to social work and psychology:

- Offer training to increase provider comfort with assessing safety
- Develop handout of available psychology services offered in the medical center and community
- Provide crisis and hotline numbers
- Follow up with families over the phone when feasible, and at subsequent visits
- If any question of safety, refer directly to emergency services

MEASUREMENT

Monthy Aggregate Percentage of Patients with Type 1 Diabetes Screened for Depression at Seven Learning Collaborative Sites

April 2016 – July 2018



Operational Definition: Percent of eligible patients (age range defined by each clinical site) screened for depression

SUMMARY

Through a series of monthly calls and two in-person learning sessions, seven clinical centers were able to share resources and follow QI methodology to successfully advance depression screening for youth and adults with diabetes. Participants expressed value in the opportunity to collaborate with others to improve current screening procedures, learn from existing resources, and address a clinically relevant topic. Working together, sites increased rates of screening from a baseline of 10% to nearly 70% over 18 months, representing approximately 700 additional individuals/month with T1D receiving psychosocial screening nationwide. The resources within this change package should equip additional sites with tools to accelerate adoption of a reliable depression screening process.

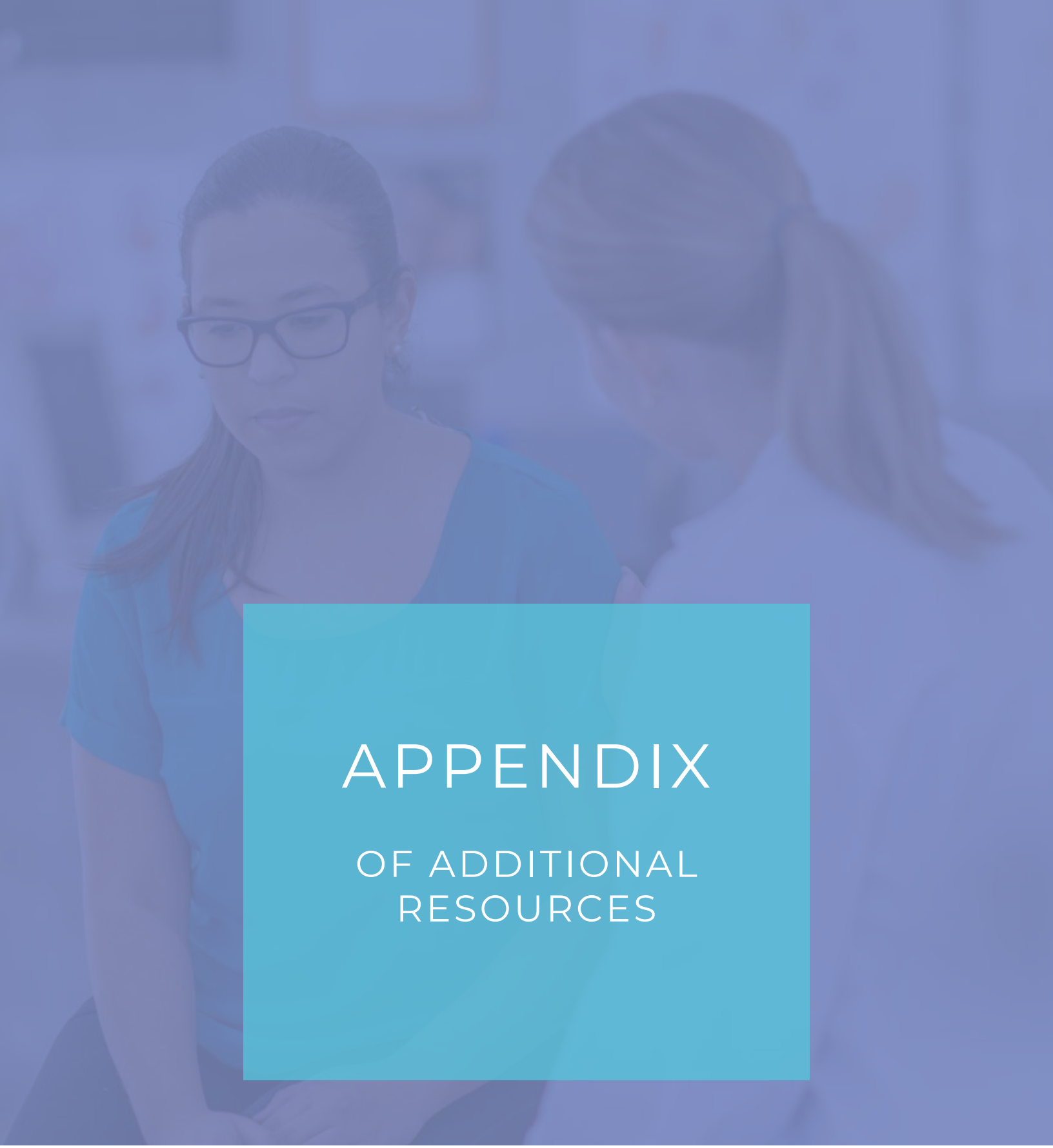
TEAM COMPOSITION AND KEY CONTACTS

CLINIC	MULTIDISCIPLINARY TEAM MEMBERS	VOLUME & MEDICAID	CONTACT NAMES
MICHIGAN ***Pediatric***	• 11 Attending Physicians • 2 Endocrinology Fellows • 6 Certified Diabetes Educators • 3 Social Workers • 1 Psychologist	100–150 newly diagnosed patients seen annually 1,400 established T1D patients receiving ongoing care 3 locations **Estimated 56% Medicaid**	**Site PI** Joyce Lee, MD *joyclee@med.umich.edu* **Site Coordinator** Ashley Garrity, MPH *ashleyna@med.umich.edu*
CINCINNATI CHILDREN'S ***Pediatric***	• 15 Attending Physicians • 10 Endocrinology Fellows • 9 Advanced Practice Providers • 12 Certified Diabetes Educators • 6 Social Workers • 1 Psychologist	200–250 newly diagnosed patients seen annually 2,000 established T1D patients receiving ongoing care 2 locations **Estimated 40% Medicaid**	**Site PI** Sarah Corathers, MD *sarah.corathers@cchmc.org* **Site Coordinator** Mary Jolly, RN *mary.jolly@cchmc.org*
NATIONWIDE CHILDREN'S ***Pediatric***	• 10 Attending Physicians • 4 Endocrinology Fellows • 4 Advance Practice Providers • 9 Certified Diabetes Educators • 5 Social Workers • 1 Psychologist	300–325 newly diagnosed patients annually 1,350 established T1D patients receiving ongoing care 2 locations **Estimated 53% Medicaid**	**Site PI** Manmohan Kamboj, MD *Manmohan.Kamboj@nationwidechildrens.org* **Site Coordinator** Don Buckingham, MBOE *Don.Buckingham@nationwidechildrens.org*

TEAM COMPOSITION AND KEY CONTACTS continued

CLINIC	MULTIDISCIPLINARY TEAM MEMBERS	VOLUME & MEDICAID	CONTACT NAMES
BARBARA DAVIS CENTER ***Pediatric***	• 9 Attending Physicians • 6 Endocrinology Fellows • 7 Advanced Practice Providers • 10 Certified Diabetes Educators • 3 Social Workers • 1 Psychologist	400 newly diagnosed patients annually 3,550 established T1D patients receiving ongoing care 5 locations, plus telehealth **Estimated 23% Medicaid**	**Site PI** Todd Alonso, MD *guy.alonso@ucdenver.edu* **Site Coordinator** Sarah Thomas *sarah.3.thomas@ucdenver.edu*
SUNY UPSTATE ***Pediatric and Adult***	• 11 Adult Attending Physicians • 3 Pediatric Attending Physicians • 1 Internal Medicine/ Pediatric Physician • 7 Endocrinology Fellows • 6 Adult Advanced Practice Providers • 5 Pediatric Advanced Practice Providers • 1 Social Worker	3,500 Established T1D adult patients 1,650 Established T1D pediatric patients **Estimated 20% Medicaid (adult) and 46% Medicaid (pediatric)**	**Site PI** Ruth Weinstock, MD, PhD *weinstor@upstate.edu* **Site Coordinators** Katie McDaniel Lambert *McDanieK@upstate.edu* Margie Greenfield *greenfma@upstate.edu*

CLINIC	MULTIDISCIPLINARY TEAM MEMBERS	VOLUME & MEDICAID	CONTACT NAMES
CHILDREN'S MERCY ***Pediatric***	• 23 Attending Physicians • 3 Endocrinology Fellows • 2 Advanced Practice Providers • 14 Certified Diabetes Educators • 2 Social Workers • 1 Psychologist	250–300 newly diagnosed patients seen annually 2,130 established T1D patients receiving ongoing care 11 Locations **Estimated 40% Medicaid**	**Site Co-PIs** Mark Clements MD, PhD *maclements@cmh.edu* Ryan McDonough, DO *rjmcdonough@cmh.edu* **Site Coordinator** Dara Watkins MA, CCRP *djwatkins@cmh.edu*
TEXAS CHILDREN'S HOSPITAL	• 27 Attending physicians • 11 Endocrinology Fellows • 2 Advanced Practice Providers • 8 CDE/RNs • 15 CDE/RDs • 9 Social workers • 4 Psychologists	250–300 newly diagnosed patients annually 2,000 established T1D patients receiving ongoing care 6 locations **Estimated 32% Medicaid**	**Site PI** Kelly Fegan-Bohm, MD, MPH *kelly.fegan-bohm@bcm.edu* **Site Coordinator** Curtis Yee, Practice Administrator *cxyee@texaschildrens.org*



APPENDIX

OF ADDITIONAL RESOURCES

APPENDIX 1: PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

(name) _____ (date) _____

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				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead, or of hurting yourself				

Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

add columns		+		+	
TOTAL					

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	

APPENDIX 1: PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9
For every ✓ Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression severity
1–4	Minimal depression
5–9	Mild depression
10–14	Moderate depression
15–19	Moderately severe depression
20–27	Severe depression

The following assessment is only used by social work clinicians. If there is lethality and an urgent outpatient referral is needed, the patient is referred to our behavioral health outpatient crisis team. Once stabilized, the behavioral health team will then direct the family to a psychologist for continuation of care.

1. CASE Approach

A. Presenting suicidal ideation and/or behavior:
B. Recent suicidal ideation/behaviors (within past 8 weeks)
    Frequency: ***
    Duration: ***
    Intensity: ***
C. History of suicidal ideation and suicide attempts: ***
D. Immediate and future ideation/plan: ***

2. Risk Factors: (Check all that apply)

- Significant mental health
- History of alcohol and/or substance abuse
- Previous suicide attempts
- Family history of suicide attempts
- History of neglect, emotional, physical or sexual abuse
- Sexual orientation/LGBTQ
- Suicidal ideation/intent/plan
- Psychosis
- Paranoia/suspiciousness
- Poor problem solving
- Lack of positive social supports
- Negative view of self/low self-esteem
- Poor family functioning
- Social rejection by peers/ bullying
- Agitation/uncooperative/ aggressive behaviors
- Multiple emotional stressors
- Impulsivity
- Insomnia
- Hopelessness/worthlessness
- Chronic illness
- Cruelty to animals
- Legal problems
- Domestic violence/IPV
- Low IQ
- Low parental involvement
- Parental substance abuse/ mental health
- Gang involvement
- Lack of commitment to school/poor grades/truancy
- History or current CPS involvement
- Gender Identity
- Unplanned pregnancy
- Loss of a relationship
- Stressful life event (death, divorce, job loss or financial loss)
- Exposure to others who have died from suicide
- Easy accessibility to lethal means (firearms, drugs, sharp objects or other)
- Cultural or religious belief that view suicide or homicide as a noble resolution
- Stigma associated with asking for help (this may also include family members)
- Has written a suicide note
- Eating Disorder

3. Protective Factors: (Check all that apply)

- ☐ Will to live
- ☐ Family support
- ☐ Practices coping skills
- ☐ Ability to ask for help
- ☐ Commitment to school/ education
- ☐ Life satisfaction
- ☐ Access to substance abuse treatment
- ☐ Restricted access to firearms/ weapons
- ☐ Social/Friend support
- ☐ Spiritual support
- ☐ Involvement in activities
- ☐ Supportive services at school
- ☐ Cultural beliefs/values
- ☐ Access to mental health services

4. Mental Status Examination

APPEARANCE Disheveled, Physical abrasions/ visible lacerations, unremarkable

ACTIVITY: Overactive/Agitated, Underactive/ Slowed/Lethargic, Tics, unrremarkable

BUILD: Thin, Overweight, Small Stature, unremarkable/average build

COGNITION: Appears to be of at least average intellect, Awake and alert, Oriented to person, place, and time, Follows directions and simple commands, Immediate, short term, and long term memory intact

DEMEANOR: Defiant/Hostile, Guarded, Withdrawn, Uncooperative, unremarkable-cooperative and appropriate with examiner

EYE CONTACT: Avoidant, Intense, unremarkable

MOOD: Angry/Irritable, Anxious, Depressed, Elated/ Hyperthymic, Empty, Calm, Fearful, Despairing, unremarkable-euthymic

AFFECT: Blunted/Flat, Constricted, Labile, Inappropriate, Playful, Combative, Confused, Paranoid, Defensive, Hyperactive/Impulsive, unremarkable full range/appropriate

SPEECH: Normal rate and rhythm, Fluent/Age appropriate complexity, Immature/Low complexity for age, Rapid, Pressured, Slurred, Stuttering, Refusal to speak, Unable to speak, Latency of response

PERCEPTION: Auditory Hallucinations, Visual Hallucinations, unremarkable-no hallucinations

SUICIDAL THOUGHTS: Passive death wish, but denies suicidal ideation, plans, or intent, YES: active suicidal ideation with plan and/or intent, Willing to safety plan, no -none reported/ denies

VIOLENT THOUGHTS: Passive violent thoughts, but denies active plans or intent, YES: active homicidal ideation with plan and/or intent, Willing to safety plan, No-none reported/denies

THOUGHT CONTENT AND PROCESS: Psychosis, Disorganized, Loose Associations, Thoughts appear slowed, Racing Thoughts, Flight of ideas, Tangential, Hopeless, Distractibility, Delusional, Obsessive/Compulsive, Circumstantial, unremarkable: logical, goal directed, coherent

JUDGMENT: Poor, Limited, unremarkable; fair to good

INSIGHT: Poor, Limited, unremarkable; fair to good

5. If any High Risk factors are indicated below—further treatment required

Has current Suicidal Ideation or Homicidal Ideation with plan or intent:

☐ **Yes** ☐ **No**

Unable or refusal to safety plan:

☐ **Yes** ☐ **No**

First break psychosis with command hallucinations:

☐ **Yes** ☐ **No**

Use of or threatened with a firearm in the last 48 hours:

☐ **Yes** ☐ **No**

Safety Plan for:

(name) _____

List two things that are important to you and worth living for:

1.

2.

People whom you can ask for help from: Who can you contact that will help you during a crisis? (must be above the age of 21 years old)

name and contact numbers

name and contact numbers

name and contact numbers

name and contact numbers

A Safety Plan: a prioritized list of coping strategies & supportive services that a patient should use before or during a suicidal/self-injury crisis.

Warning Signs that a crisis might be developing: What you experience when you start to think about death/dying/suicide or begin feeling extremely depressed/down/sad? (thoughts, images, situations, moods or behaviors)

Internal Coping Strategies: What can you do on your own, if a crisis develops in order to keep yourself safe? (Relaxation techniques, distractions, etc)

People or places that provide distraction from the crisis: Who/what places help you take your mind off your problems at least for a little while?

Ways to make the environment safe/limit your risk of self-harm: How can we limit your access to lethal means/keep you safe during a crisis?

Professionals/Agencies to contact for help.

Out-patient Provider:

Emergency Services:
9-1-1

Crisis Hotline: Children/Teens:
614-722-1800

Adults: NetCare ACCESS
614-276-2273

Crisis Hotline: National Suicide Prevention Lifeline
1-800-273-8255

Crisis Text Line:
Text **"4Hope"** to **741-741**

APPENDIX 3: CINCINNATI CHILDREN'S HOSPITAL SOCIAL WORK EXAMPLE ASSESSMENT AND SAFETY PLAN

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Every patient with an elevated PHQ-9 score is seen by a member of the social work team for a same day face to face assessment. Education is provided to families and patients regarding diabetes and depression. Each interaction provides an opportunity to build relationship and develop interventions from simply increasing awareness to crisis coordination to ensure a patient's safety.

All patients are offered the opportunity to meet independently with a social worker for their assessment. In a pediatric population, it is often helpful to explain to parents why you are requesting this opportunity and what they can expect to be discussed while they are out of the room. Staff should not assume that young adult patients accompanied by a family member for the medical appointment are comfortable discussing emotional and mental health needs in front of that family member. It is important to ask and respect each patient's preference regarding who is present for this discussion.

Ideas to Start the Conversation

"I want to talk with (NAME) by herself if it's okay with you and her? Sometimes it is easier to talk about things when she is not worried about your reaction."

"Your score indicates you may be at an increased risk of depression, are you surprised by this? Have you had any concerns about your mood?"

"Your score is higher than last time, have things changed for you since we talked?"

"Your score is a bit lower than last time. Do you feel like your mood is improving?"

A standardized flow sheet is then used by our team for documentation after the face to face assessment. This flow sheet documents responses to questions regarding patient identified stressors, patient's support system, coping strategies, barriers to accessing further support, and if applicable suicidal ideation and suicidal plan. Each of these pieces help to create a full picture to assess for a patient's safety.

PATIENT IDENTIFIED STRESSORS

This part of the discussion explores what the patient perceives as impacting their mood. Areas explored include: diabetes management, social and academic success in school, relationships with peers, relationships with family, and impact of mental health diagnosis. It is important to use open ended questions and allow the patient to guide the conversation.

PATIENT'S SUPPORT SYSTEM

A patient who reports having friends and is observed to have involved family members does not always equate to the patient perceiving those individuals as a support. Explore a patient's relationships with parents, siblings, extended family members, friends, teachers, and any counselors they are already working with. These individuals may already be meeting our patient's emotional needs.

Ideas to start the conversation

"Have you ever talked to anyone about the things that upset you?"

"Is there anyone who understands how you are feeling?"

"Is there someone that you like to be around when you are feeling down?"

PATIENT'S COPING SKILLS

Coping Skills and support systems are two different things and patients may have one, both, or neither. Coping skills are strategies that help a patient reduce the distress they are feeling. Identify coping skills such as journaling, physical activity, talking with their support system, art, meditation, music, sleeping, and forms of distraction. If coping skills are limited this is an

opportunity to further develop them as well as consider accessing mental health services.

BARRIERS TO ACCESSING INCREASED SUPPORT

If during the course of the conversation it becomes apparent that a patient needs more support to manage their distress this is an opportunity to work with them to put that support in place. A plan identifies what mental health they will be linked to and makes sure they have ability to follow through. Barriers a family might experience to accessing services may be external to them including: transportation difficulty, insurance coverage, financial expense, and work or school schedules. Patients may also have internal barriers including lack of motivation and acceptance or a bias against talking to others about their problems. For patients who have mental health supports in place, this is a good time to assess if the services are helpful or if changes need to be made.

Suggestions

- Provide a list of local mental health providers and contact information.
- Educate on "walk in hours" if available at community mental health agencies.
- Refer to psychologists available within your hospital/clinic.
- Utilize search engines for families from an unfamiliar area such as https.www.findtreatment.samhsa.gov/

ASSESSMENT OF SUICIDAL IDEATION AND PLAN

This is best done by a Social Worker/Psychologist/Counselor who is comfortable with the subject matter. It may also be beneficial to increase staff trainings or finding tools that guide them through the conversation. Even a patient who denies suicidal ideation on the screening tool can benefit from further exploration of the subject. All thoughts of suicide and death should be taken seriously.

In our clinic setting, the social worker explores if the patient has ever wished to be dead or had thoughts of suicide. If the patient endorses suicidal thoughts, an assessment of frequency, duration, and intensity of the thoughts provides important information to assess safety. Assessment questions are asked to identify if the patient has ever created a plan and the details of their plan. It is also important to ask the patient if they have ever taken any steps to prepare for suicide or ever attempted to commit suicide.

Once suicidal thoughts are recognized, the focus shifts to ensuring a patient's safety and linking them to the appropriate level of follow up care. For pediatric patients, offer them control when choosing how this information will be shared with their caregiver. This can be done by rehearsing for the patient the words you will use. Give the patient the opportunity to tell you how and to whom they are most comfortable with the information being shared and what else is important to them for you to share. Often times, it is beneficial to review with family members how to respond if they become concerned for their child's safety.

Determining the patient's willingness to create and use a safety plan is also an important next step. It is beneficial to identify a support person that they can include in a safety plan. Safety plans can also be created for adults that don't have a support person easily identifiable. Review with the patient steps to take in crisis that can keep them safe such as calling a crisis phone number, calling 911, or going to the emergency department. Additionally, some communities have mobile support teams that will send trained mental health professionals to the home to assess them and help keep them safe. If there is ever any doubt as to a patient's safety after leaving the appointment coordinate with the mental health specialists in your medical facility or arrange for emergent assessment in an emergency department to further assess for imminent risk and coordinate an admission.

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