SW CEU_ Suicide Competency Training for Medical Social Work-20241127_115953-Meeting Recording

November 27, 2024, 5:59PM

1h 4m 32s

Murphy, Allison, D started transcription

Camerer, Michelle, H LSCSW, LCSW 0:16

Welcome everyone.

We're gonna get started with our presentation. If you haven't seen in the chat yet, I've included the.

KL

Kaushal, Nena, LMSW 0:38

Allison, I think you might be frozen or muted.

Davis, Stephanie, L LSCSW, LCSW, ACM-SW 1:28

Have been made aware that they froze their working on getting back up.

Camerer, Michelle, H LSCSW, LCSW 1:57

Our worst fear just happened.

Teams kicked us out.

Our apologies. OK.

So if you didn't catch that part, CME information is in the chat.

So that's where you can record your attendance and get the evaluation after.

So please be sure to see that and then we're going to get started, OK.

Well, welcome everyone.

Today is our core competencies psychosocial assessment. This is.

The suicide competency training designated for medical social workers, but I see that there are.

Many social workers outside of the medical social work team.

So we are so happy to have you.

Thank you for joining us.

Today, our objectives are going to be to identify the key components to be included in a targeted mental health assessment.

We're going to review the documentation expectations.

Additionally, you should walk away with understanding the importance of good safety planning and means restriction education.
So why are we screening patients for suicide in this graphic?
You will see that and it's a bit dated, but still remains.
Valid. The second leading cause of death in patients ages 10 to 15, the third leading cause of death in those 15 to 24, and then it is a second leading cause of death for those ages 25 to 34. And unfortunately, Missouri and Kansas do have.
Higher rates than the national average, as I was reflecting back.
This morning, before giving this presentation, it's been almost 10 years since we've started some sort of suicide screening at children's mercy.

Lockard, Michelle 3:44
I.

Camerer, Michelle, H LSCSW, LCSW 3:45
So for those of you who have been here that long.
You have seen some sort of iteration of this presentation several times, so we try to mix it up if we can, but it's it's not a light hearted topic so.
Just keeping that in mind, if anyone needs to step away.
So the asq is the suicide screening tool that we use.
It's our screening instrument for all medical patients and then mental health. CL clinics use an alternate validated tool.
It is a screening that is administered verbally verbatim and without the parent in the room.
And the one caveat is we wouldn't stop the screening if the parent does not leave the room.
We simply ask that the patient be allowed to answer the questions. The screening consists of four questions and then a fifth question which assesses current suicidality is only asked if one of the first four questions is positive.
It takes less than a minute to ask.
And when we surveyed parents, gosh, and this is probably been eight years or so ago, they 94% felt as if it was a good idea to screen for suicide.
So we've had a lot of really good buy in from the the community and families.
So these are the questions that are on the tool in the past few weeks.
Have you wished you were dead in the past few weeks?

Have you felt that you or your family would be better off if you were dead in the past week?
Have you been having thoughts of killing yourself?
Have you ever tried to kill yourself?
And then if any of the questions to the above are positive.
The the 5th question is asked which is are you having thoughts of killing yourself right now?
So we I we want to talk about the importance of screening versus assessment and I know it's probably.
A bit early to start talking about the Joint Commission, but during the last Joint Commission survey, this is something that we worked on prior to their arrival.
Knowing the difference between screening versus assessment.
So a screen is a tool used to identify individuals at risk for suicide who require further assessment and then the assessment is the process of estimated the likelihood for a person to attempt or die by suicide.
So because patience with suicidal ideation.
Vary widely in their risk for a suicide attempt.
This risk assessment is really an essential piece of the process.
So these are our current screening areas.
We screen at both our emergency departments at a Dell Hall in Kansas. We screen on our inpatient units at Adela, Kansas and all of our mental health clinics. And then the following ambulatory clinic screen as well.
Add in lesson specialty beacon gender pathway services, or GPS, infectious disease, neurology, pain management, Goldilocks, fit, PCC scan, sleep and teen so the clinics that are not listed, they do not formally screen patients. However we have shared with these areas that they need to continue to request social.
Work when?
About the mental health of the patient, so they don't need to be formally screening for them to know their patients. And if something doesn't seem quite right, it's a perfectly acceptable for them to reach out to us to complete a further assessment.
So the frequency is an ambulatory clinics.
It's at least every three months.
Mental health clinics monthly.
Inpatients they currently screen upon admission and weekly thereafter they screen at every Ed visit and then they screen 12 and up in these areas unless it's deemed

clinically inappropriate.
So clinically inappropriate would be if they have potentially an intellectual disability or if they've come into our emergency department.
And they're in some sort of crisis or they've just been in a trauma. Like, of course, we're gonna wait and screen them until it's appropriate.
OK.
So now we wanna open this up a little bit for discussion.
To kind of see.
It's how you approach these situations so.
Our first question is how do you approach the patient when they've indicated they don't want to talk to you?
Feel free to jump in or put something in the chat. I'm watching it.

Budke, Jessica 8:57
For me, when patients don't really wanna chat, I try to just, like, normalize the mental health questions and social work coming in.
And then usually I try to do a little bit more rapport building first.
Like not jump right into the questions about mental health, but just, you know, if they're wearing a tshirt like, you know, with a band name or something on it, like, you know, bring that up.
Just kind of like get them a little bit more at ease.
And then kind of start gradually moving into.
The questions and like I said, normalizing it too of like you know, I have these conversations a lot like we just wanna make sure you're good. Like just try not to make it like a huge thing.


Camerer, Michelle, H LSCSW, LCSW 9:38
And just do find that they're open and receptive to that. When you've done that in the past.

Budke, Jessica 9:43
Most of the time, yeah.
I mean, you know, occasionally you get people that are still little.
Hesitant to chat, but in general that usually helps people feel a little bit more comfortable and not feel as threatened with social work coming in.

And it's like reassuring them, too, that, like, I'm just here to make sure you're safe and make sure you have what you need.

Camerer, Michelle, H LSCSW, LCSW 9:57
Thank you.

Budke, Jessica 10:03
Like that's it, so.

Camerer, Michelle, H LSCSW, LCSW 10:05
I find that sometimes too.
Jess, in my experience, I'm just saying something like I understand you don't wanna talk to me.
But I just need to make sure that you're safe. And a lot of times that leads into further conversation if they think, oh, this is just gonna be short.
But a lot of times these patients are like, once they start telling you one thing they're more comfortable sharing more.
And just back to what you said.
It's that rapport building.
So if you can get them engaged in the conversation, it really opens up to more conversation there so.
I think that's great. Yeah, absolutely.
I see a question and hear from Jennifer about the 5th question.
Yes. So if the first four questions are answered, no, the 5th question is not asked at all.
It doesn't even show up the way in the pathway for the nurse to ask the question.
Ashley Severin said she likes to thank them for being open and honest and told them how brave they are.
That's a good thing as well.
Intra La Guzman, you could inquire about what the concern is.
And Samantha shared.
I try to acknowledge that this is uncomfortable and may feel awkward, but we are focused on their safety and thanking them for being honest with us.
Those are all really great things.
Yeah, those are great.

One last thing, Stephanie said.
I told them there may be topics they want to discuss and that's OK, but there are some questions that we will need for them to answer.
Yes, Jennifer said.
She provides universal education about suicide and resources. If they continue to not want to talk and remind them there were in a safe place.
These are all great.
Thank you so much for all of those.
Those things, it goes back to the bigger point of even if a patient says they don't want to talk, it's still our responsibility to complete some sort of assessment or.
You know, determine safety with them.
So there all of these are really great ideas on how you can continue that discussion if they don't want to. You know you can't force them at the end of the day to tell you all of the things, but there are still little little pieces of discussion that.
You can have with them to get the information you need to complete the assessment.
Absolutely. OK.
So Allison, I have a question for you.
How do you approach the Screener when they have inaccurately entered responses into the AS?
Qi know you and I.
Have both had this situation come up and I think it's helpful for those who maybe haven't run into this before.
Yeah. So there have been situations where.
A.
Whoever the Screener is in different areas, that's a different role.
But you know they have said things like.
They just hesitated when they answered no, so I put it down as a yes.
So I think the important thing is mostly to just remind them of the.
What we do, how we screen and that even if they have hesitated and they're concerned about that, they still need to answer.
Has the patient has answered?
And then they could still call social work and say, hey, I'm just concerned because this is how they presented, even though they said no, I think it would be great if social work checked in.

So just reminding them of the process, providing them with, you know, their what they can do, if they still have concern and then?
Ultimately, having them go back in and change what the response was to accurately reflect what the patient had answered, that doesn't mean that you don't do anything, but just that it needs to be the answer that the patient provided in the screen.
It needs to be accurate and certainly if you want to escalate that to your leader, it's helpful because sometimes we know of trends that might be going on that you might.
Be unaware of.
I know I've met with a patient before and.
He was screened.
Probably erroneously, because when I went back to look at all the other screens, they hadn't screened him because he had an intellectual disability and.
So I went presented to the clinic, talked with the mom 1st to see if he could.
Participate in the assessment and she said he absolutely could not, and in that case the nurse hadn't consulted with the with the parent prior to doing the screen. So.
Just ask them to take that screen out because it wasn't accurate.
So we just thought we'd mention that in case that comes up for any of you all.
There was a question about can can families decline the screening so?
Yes, I mean, ultimately we can't force them to do the screening. But again, I think having some of those talking points with them that we have shared out with the screeners in the different areas, you know this is important. We ask all of our patients.
Ask because we care.
Just trying to still be able to get it, but ultimately if they refuse, that's also documented in the chart.
Yeah. And just because they've refused at 1:00 appointment, like the next time they come, we're gonna screen again.
Because sometimes as they learn more information and they see that we're doing this 'cause, we care about the safety of our patients, they're more willing to answer.
So just because you've said.
No. At one point that we will continue to try to screen.
OK.
Great discussion, everyone. We're gonna continue.
OK response and engagement.

So we've done the screening, now they had a positive response somewhere on there.
So we are going to see that review the screen to know what the yeses were.
We are going to communicate with the multidisciplinary team to create a plan for completing the assessment.
So again, this looks different in the different clinical areas.
It may be that you were able to go in at the beginning of the appointment and complete the assessment.
Maybe you're going in with the provider to complete the assessment.
But the biggest pieces to communicate with them and come up with a plan to complete it, reviewing the patient's chart is really important because maybe this is the first time they've been screened, but maybe this is the 15th time they've been screened this year and reviewing those.
Past assessments will be really helpful to guide your assessment today.
One important note here that it is not up to the other members of the multidisciplinary team to quote, clear the consult. OK, so they may tell you, oh, they're already in therapy, so they don't need to be seen or oh, we already talked about it. So they Don.
Need to be seen. So for example you could respond with you know.
Thank you for that information.
I really appreciate it. However, it is within our process that we are still meeting with. Gather this information so I'll let me know when I can meet with him. Is now a good time and still go and complete that?
I know that that could be difficult if you're trying to get some push back, but if you need if that is helping a lot, just like Michelle said with earlier with changing the screening questions, please escalate that to your leader 'cause. We want to know about those Tre.
And can address it is a big bigger area within the clinic if needed.
OK.
So you're going in, you're going to complete your targeted assessment and what does that look like you're going to introduce yourself. Hi, I'm Allison.
I'm a social worker here at children's mercy. How are you today?
I I'm here because you answered some screening questions at the beginning of your appointment and you had indicated yes to feeling that others would be better off without you.
I'd like to talk to you a little bit more about that today.

You're going to want to meet with the patient and parent separately if possible.
Sometimes they're already separated, sometimes they're not.
This is more of a statement than an ask.
So you're looking at the parent and saying hi. I wanna talk to your child today about this. And I would like to take you to another place to sit while I talk with them.
And then I'm gonna come find you and talk with you about it as well. So reassuring them that you're still gonna follow up with them is usually helpful.
And then if they absolutely refuse, they're not gonna leave.
Just being clear with that caregiver that you want the patient to answer the questions. So I'm gonna ask them a lot of questions. I'd really like for them to respond.
So complete the targeted assessment using the cssrs. If you are not as familiar with all the questions, maybe you don't have these screenings happening a lot in your area. You're covering for someone else that has them come up a lot, but you don't necessarily have that.
Print, print it off and just look at it and talk through it.
It is easy to make this conversation.
But you have to practice at it. So it's your first time using it or you hadn't used it for six months.
Just print it off and take it with you.
And then that way you're able to ensure that you've asked all of their questions. The important distinction here is that this is not a full psychosocial assessment, but just an assessment to determine the acuity and get the patient connected with the appropriate resources.
So here are some symptoms you may want to consider when assessing like depression, anxiety, their impulsivity and their hopelessness.
We have included just some brief phrases in here that you can consider using when you're completing your assessment.
Some other questions that you can ask, do they have a plan to kill themselves?
Do they have means available to have they tried to and do they wish to die?
You need to keep in your mind.
Their thought?
The thoughts, the plans and the intent, do we have those three things?
And that will determine what our safety planning looks like.
Continuing with our targeted assessment, the goal of using the CSSRS should be that

the questions are asked in a conversational manner. Like I mentioned earlier and it doesn't have to necessarily go in the order that the questions are listed. If the patient starts talking about you know a.
Past suicide attempt, but that wasn't the next question on your sheet.
It's OK to just continue along.
That path of conversation.
By using the CSS.
You are determining what level of care is needed and the targeted assessment should be geared toward the patient's current suicidal ideation at risk.
Some things to assess.
So the current symptoms and behaviors as far as the duration and frequency identify their mental status and the history of mental health issues and their severity. So very important with their or how the patient is presenting, did they?
How was their speech?
Did they make eye contact?
What was their mood like?
Pay close attention to all of these things.
And then at the end you can also ask is there anything I didn't ask you that you would like to tell me?
That opens up opportunity if there's something else that they want to share that will be important for your assessment.
Once you've met with the patient, you're going to meet with the parent again.
Ideally this is separate.
I'm usually upfront with patients that I'm going to do this.
You know, I'm going to.
I'm going to go meet with your caregiver now and.
If the patient has disclosed.
Any any concern that you know they've they've had an attempt they you know, we are considering inpatient psych.
I do find it important to let the patient know that upfront that I will be sharing that information with their caregiver.
It it doesn't always go over well and that's your opportunity to have a bit more conversation with them about, you know, what is it that is making you uncomfortable about this?
How can I share this in a way that does make you more comfortable?

Not a question of if you're going to do it, you are going to do it.
So talking to them about how it makes them most comfortable, sometimes patients want you to do it with them in the room, sharing that information. Of course you want to talk safety and and planning separately and allow the parent to share.
Their concerns with you away from the patient, but some of the conversation could happen together.
So some potential scripting for when you're meeting with the parents, like, you know, at Children's mercy, we screen our patients 12 and over.
For suicidality today, your child answered yes to this question.
I've talked with them about that and they've shared some things. I just wanted to talk to you more about that.
Have you had any concerns?
Have you been aware that they've been struggling?
What can you tell me about the situation?
And sometimes they're like, yes, I've been really concerned.
I've got them connected to a therapist, and sometimes they're just completely blown away.
They had no idea, which is why we ask, right?
That is why.
So important, because sometimes the caregivers don't know which puts them at increased risk.
Some things to consider there.
What's the level of inside? Is there a family history of mental health?
Is anyone close to them recently attempted or died by suicide?
Is the parent comfortable and able to keep the patient safe if the patient's going home? Is there someone available to be available to be with the patient and closely monitor them?
If the parent is unaware of the historical attempt, I cannot emphasize enough how important it is for you to be very gentle and.
Sympathetic and understanding. When you're having that conversation 'cause that being a parent on the end receiving end of that information has got to be absolutely horrific, right?
And really hard to hear. So just saying, you know, I know this is going to be hard.
I need to talk to you about this and giving them the space in the moment to just let that sink in, being supportive if they're very upset.

And talking through what that feels like in that moment, you were there to be their support person at that time.
I had another thought, but I lost it. OK, moving on.
OK. Confidentiality. So we just kind of briefly talked about this, but we every time there is a safety concern, we have to share that with the caregiver. If the patient is under the age of 18.
So if there's been a previous attempt, that's something we need to be sharing with the caregiver. If there's currently a plan, but maybe they don't have intent, that still needs to be shared with the caregiver.
These are acute safety concerns and are responsible.
Adult needs to be aware of those.
Other specific information to be shared by the patient does not necessarily have to be reviewed.
You know, if questions arise, please address with your leader. So I think, Michelle, you had a good example from.
So I had a patient that I saw in our GPS clinic and they shared that they.
Identified as trans.
And they were living with a caregiver that wasn't their parents, and they shared that. They would prefer if I wouldn't share that with the caregiver because I could put them at additional risk for harm and so.
That was something that I just in my note was very vague about and and did not share that information. So.
So and that actually was something that had come out when I said, is there anything I didn't ask you that you'd like to tell me? And so that's why I've always included that in my assessments because of that very situation that arose.
We have some more questions in the chat.
One question, if the patient says not really to one of the ask screening questions instead of answering yes or no, how's the Screener supposed to chart that?
I mean, the screeners have been educated to if they are hedging or if they said not really like tell me some more about that like yes or no.
The nurses can clear the consult if it was done in error. Yes, yes, yes.
We just didn't want him clearing consoles by the family saying, Oh well, we're already in services. We don't need to see the social worker.
And then Anna just commented, when a patient is hesitant, I told them to talk to their parent.

Lockard, Michelle 27:41
Oh yeah, I'll do that.

Camerer, Michelle, H LSCSW, LCSW 27:43
Oh, this is as probably as it relates to an historical attempt. I'll tell the patient. I will only tell the parent information they need to know.

Lockard, Michelle 27:43
Oh well.
No.
Hey, good.
How are you? Good.

Camerer, Michelle, H LSCSW, LCSW 27:53
To keep the child safe and usually the child accepts that answer.
So thank you for those things in the chat. Great discussion.

Lockard, Michelle 27:59
Do what?

Camerer, Michelle, H LSCSW, LCSW 28:01
Did someone else have a question?
OK.

Lockard, Michelle 28:06
Oh yeah, I meant to fall into that training and I forgot. Dang it.

Camerer, Michelle, H LSCSW, LCSW 28:11
Oh, we're hearing someone.
So if you're muted, just a reminder to mute yourself.
OK.
We're gonna move on. OK, good.
So now we're gonna talk about some safety planning.
So when you're beginning to talk with safety planning with the patient, it's important

to establish if they have a trusted adult with whom they can talk.
And sometimes that's brainstorming with them.
That trusted adult isn't always necessarily going to be the parent.
Could be.
A grandparent. I know a lot of patients have shared like they have a close relationship with a teacher.
School or a counselor or a coach?
So sometimes it's getting creative with them, but it is important that they have an adult with whom they can talk, and then we have the option to complete a written safety plan.
You know, I always use the opportunity to talk about safety planning and means restriction even when my console isn't related to a positive suicide screen.
Let's just say I'm called to talk and meet with a patient and.
Asthma or allergy?
I think that means restriction discussion should happen in a myriad of settings and so I use that opportunity to talk about how they store medications, how they store guns, how they keep things put up from teams who are.
Can be quite impulsive and I'll jump in here too. I think. Again, this goes back to that conversational piece of hey, I'd like to review safety tips with all the families I meet with.
Mm hmm, where are you storing your medication?
Please store your if you have any guns at home that they're separated from the ammunition and locked up and just reviewing those things.
Again, it's just conversational.
It should flow through your assessment pretty easy, but that is the piece of safety planning that you know, it doesn't have to be this formal written out form that we print off for them, but that is a piece of safety planning we can do with every time with.
Every patient we're meeting with.
Yeah, I agree that I agree with that. Yeah, safety planning.
It should be incorporated into really everything that we do.
It could be a wide range of things, depending on the presenting situation, and it's never a bad thing for them to hear it in multiple venues.
OK.
So this is a copy of the Stanley Brown Safety Plan, which I hope all of you are

acquainted.
We talked about warning signs, internal coping strategies, people in social settings that provide distraction and people that they can ask for help during a crisis.
And then listing those people directly as far as are they already connected to services with that one of those people be their therapist if they go to like, let's say, Johnson County mental health, do they have the crisis number?
Do they know how to use it?
Talking to them about their local Ed.
And then the steps to make the home safe from lethal means, like Allison mentioned.
Like, how are your firearms stored?
And then asking them what's in it.
Thing that's important to them that they think is worth living for.
And also just as a reminder, the safety plan.
The Stanley Brown Safety Plan is linked on page ten of our mental health assessment skills and knowledge.
So if you ever have that pulled up and just want to take a look, see there it is.
OK.
So risk management really it's just important to have some sort of a safety plan regardless of the outcome, whether that's they're connected to services, they've had a historical positive in the past, which makes them more at risk for additional concerns down the road or an outpatient referral it.
Just important that there's a plan to maintain safety.
When a patient is being.
Referred for evaluation or admission. We are gonna have a little deeper discussion about transportation because transportation sometimes can be a point of contention.
I think there's a place for patients to be transported by their parents, but I would say it's in a very limited scope.
So for example, I wanna just call out Emily Riley and the eating disorder center, who follows her patients over the long term.
And knows the family knows what the concerns are.
And she had a situation not that long ago where a patient needed to go to inpatient psych.
There was a bed for them and we discussed the idea of the parents transporting her.
The entire team felt confident that that was something that the parents could

accomplish.
And because they had known them over time, that seemed like a good option for them.
But please always like reach out.
Your leader, if you need further consultation or you're unsure how to proceed, like keep in mind that this is a team decision.
We also wanna make sure that we have a really clear discussion with the family about what may occur if they don't reach the destination.
So for example.
Sometimes parent or social workers will ask the parents, you know, please call me when you've reached merleak or wherever it may be that they're going.
Or we may call the facility to determine that they've made it in some instances.
Parents may get scared and decide, Oh my gosh, what have I done?
I don't want to take them, so it's it's important to say like we will need to make some additional phone calls to assure safety should you not arrive at your destination.
IE there may be a hotline call.
There may be a welfare check because again, at the end of the day, the most important thing is the patient's safety.
But generally speaking, if they need admission and inpatient psychiatric facility, we're gonna recommend they be transported by ambulance.
So if they've had a recent suicide attempt, if they're actively suicidal with a plan, if they're currently exhibiting behaviors of with high risk for concern of safety, we're gonna want them to go by transport and then.
If we have a concern about the caregivers ability or willingness to provide a secure transfer.
Then we need to also consider using transport.
And we want to provide support and resources to family. We want to make sure, again, as we talked about in the Stanley Brown safety plan, that they're identifying trusted adults with whom they can speak.
We want to provide the crisis number so the 988 number, the local Ed local inpatient facilities.
As well as educating on means, restriction and the reason we need the means, restriction, discussion to be separate from the patient is because.
We are not trying to give the patient a list of ways in which they could die by suicide so.

And I like the way I like to approach the discussion around firearms is just assuming that everyone has firearms.
So I will say something.
You know, we just recommend here Children's mercy that people keep their firearms locked separately from the ammunition.
Now you better believe that if they don't have firearms, are pretty quick to say, oh wow, we don't keep guns in the home.
But that way you don't put anybody on the defensive and you're just sharing kind of universal education, if you will. And then just reminding the families that they need to provide an appropriate level of supervision as it relates to their patient or their their child.
OK.
I guess I got ahead of myself. Another thing that.
I caught myself early on saying and so that is that's a reminder I like to share with others as well.
Use the word firearms and not the word weapons.
Early on in my discussion, I said do you keep any weapons in the home and the person I asked this to did not take too kindly to that.
And so I've been cautious to use the word firearms.
And then just also making sure we limit quick access to medications, alcohol, ropes and sharps, the way I've liked to approach medication safety.
In my practice is talking more about me, so I'll say, you know, I don't know about you, but lots of people keep.
You know, big bottles, 300 tablets of, you know, ibuprofen or Tylenol, you know, and kids and kids.

Thomas, Kei-Lisha, M 37:37
And they are killed.
His grandmother.
Is that when they lived there?

Camerer, Michelle, H LSCSW, LCSW 37:39
Someone's not muted again.

Thomas, Kei-Lisha, M 37:40

I don't know.
I can't remember the boy's name, but he might be right.
But anyway, they had she.

Camerer, Michelle, H LSCSW, LCSW 37:48
K OK.
Got that figured out.
So and then I will say, you know, adolescents really just need a small access to just a few.
So I'll talk with them about those pill organizers and say like, maybe you can just put, you know, a couple of Tylenol in there, a couple of Advil, a couple of Benadryl, so that they don't have access to the entire bottle.
I also like to say I don't know about you, but I'm not sure if my son bring somebody over.
I don't know if their friend might be struggling, and I sure would hate.
For them to take an overdose of medication on medication.
I failed to to keep locked up.
So people are typically pretty open to that discussion, and that's a way not to put people on the defensive.
OK, alright, I know it probably seems kind of.
Silly that I would put a picture of the Golden Gate Bridge on what is means restriction. But this is just an example of when we limit access to means.
It can help for for the adolescent or young person not to die by suicide. So people were jumping off the Golden Gate Bridge at alarming rates and once they put the barrier up, that was no longer a possibility.
And death by suicide on the Golden Gate Bridge.
Diminished significantly.
Also, gun safe, reminding people that we have gun locks it children, all of our children's mercy locations and that there's no questions asked.
We just want to make sure that.
Any potential?
Her arms are locked up and then this is the example of the pill box that I shared with you.
Like keeping just a few medications in there so people don't have access to so many.
So really, the rationale for mains restriction?

Many suicidal crises are short lived, and we know that suicidal thoughts and actions are often impulsive. And when people have access to lethal means, such as firearms, medications or potentially lethal objects, this is a risk factor for suicide. Restricting or limiting access.
To means of suicide results in young people who cannot immediately act on an impulsive thought.
So the method uses critically important to the outcome. If we have a chance to interrupt the attempt.
Then the risk for death is going to be lower.
And I think it's also important to note that 90% of those who survive an attempt will not go on to die by suicide.
Also, that delaying an impulsive act reduces the likelihood that the suicide will be attempted.
I am thinking about a couple of patients in the last few months who've taken like toxic doses of Tylenol and they have gone on to need a liver transplant and had they not had access to so many of of those medications like, they might not be in the. Situation that they're in now, so.
That's why I just feel so passionately about discussing means restriction at every opportunity.
Then I know you're all familiar with our medication. Lockboxes. You know, this has really been.
A great service that we can offer to families who would not otherwise have the means by which to buy them. But we need to limit them to one box per person.
We truly need to be good stewards of our resources and need to assess the family's need for a lock box. If a lock box is given.
We need to provide the following documentation in the medical records.
And also like letting them know it's not 100% guarantee for sure. One of the things that has been escalated to us from the CFCC leadership is that if we as a social worker are going to complete the mental health assessment, we need to complete the needs.
Assessment prior to handing off to the CCC FCC if we need them to deliver the medication lock box.
These are just a few additional questions.
And it makes sense that if we're already doing that, that we would ask those questions.

And then we need to determine the acuity which.
When you're inside of the cssrs, there's really some guidance on on helping you with that, but based on your assessment, you will determine the acuity and develop a plan for discharge.
So as a reminder, collaboration with the multidisciplinary team is key.
You're not alone in your decision making, and it's you're not the sole person responsible to determine the disposition. Some of the things that we've done on cases.
That are a little trickier as we've convened a huddle with both you, the primary provider, your leader, and also even inviting psychiatry.
It's really important for us to reach out and troubleshoot when we're when we are unclear about how to proceed in the next steps with the patients and I think it's important to trust your clinical skills.
In in that decision making, we want you to know you're not alone, but also it's OK if you are the one saying.
I think this patient needs to go inpatient and here's why.
'Cause, you were the one doing that assessment and you have the skills to determine that as well.
We we have some more questions in here.
Gosh, and some of these, I don't know that we know the answers to, but will there be any differences in the transport process with camber opening?
I.
I don't think so.
I don't think so either, but if that happens, we will definitely communicate that out.
Did you see Jennifer's question about the denied disclosure? Yeah.
Jennifer asked if there's a way to do a denied disclosure for content like gender identity that may still impact continuity of medical care, but might endanger the child.
That is one I need to probably think on for a moment.
I think we certainly could do that, but I think.
Not just blasting it out there in the note.
Being more vague in our assessment.
What are your thoughts, Alison?
Yeah, I agree.
I definitely see how it can be pertinent to continued medical care, and it may be

something that you're completing the assessment or and maybe you need to put in an additional.
Note that could be part of a denied disclosure.
So I think there's ways to work around that if needed, and those would be things that if they're coming up like phoning a friend 'cause. I know when I had that situation, I reached out to a colleague and we talked it through.
Samantha has a clarifying question.
Can the family decline social work assessment after a positive screening?
I think that's one of our questions that's gonna be.
Coming up, it is so stay tuned on that one and then Angela Guzman had just put in a plug about the how helpful it is to use the Stanley Brown in the EMR because it pulls forward and parents and patients have access to it.
So great reminder, Angela.
Yes, thank you.
OK.
Going.
OK. So coordinate care and collaborate with a multidisciplinary team which we've touched on.
It's important to circle back around and close that loop.
Meet with the provider or the nurses. Whoever is working with this patient in clinic and determine the best position you're going to communicate your recommendations of that discharge plan with the team. And like I said, this is based on your clinical assessment.
Recommended plan of care.
If the patient is actively suicidal with a plan and intent with means, this is going to typically result in an inpatient psychiatric stay. If the patient denies current suicidal ideation and there is no plan but and there's no plan to keep the patient safe. Oh, I'm sorry, I.
Kept reading that wrong, that didn't make sense.
And there's a plan to keep the patient safe.
Then typically they would discharge home with a plant.
So maybe they're already connected with the therapist, or you're going to give them resources.
If there's been a previous attempt, but no current concerns and there's a safety plan in place, again, can discharge home with some other recommendations. Every case is

different, so use your best clinical judgement and your team to make the best decision for the particular patient you're working with.
OK, I'm gonna do some case discussions again.
What talking points have you found helpful? When a parent is resistant to an inpatient psychiatric admission?
So this is your chance to weigh in again.
We'll monitor the chat, but if you want to get on.
And and talk to us.
Give us your opinion. That'd be great.
And we're not afraid to call people out either, so.
But talking points have you found helpful? When a parent is resistant to an inpatient psychiatric admission?

Wilson, Cassie, M 47:58
This is Kathy. I don't mind.
Kind of speaking up about this.
I will say typically I try to obviously see the pros and cons to.
Their reasoning? I think sometimes they've had. Maybe not so good experiences at certain facilities to try to have a conversation about.
Alternative options obviously.
We need to be inside the unit at Mira Loma.
This would be a first time going, but I really just attempt to hear the pros and cons.
Kind of what their biggest concern is, I think sometimes all of families just are worried about other kids, their kids going in there and picking different things up.
Maybe some, you know, maladaptive behavior.
So I just try to cultivate that conversation and then, you know, I try to be open minded in regards to.
Do I need to necessarily force the inpatient psych recommendation? Candid family potentially keep his kids safe with like aphp and I op, so they're no longer those lines if they've had significant negative experience in the past, so.
To be open and and and work with them in a comedy kind of where they're coming from, validate their feelings.
And then obviously kind of look at their risk factors, identify strengths where their conversation.

Camerer, Michelle, H LSCSW, LCSW 49:15
Yeah. Thanks so much, Cassie.
Looks like justice has her hand up.

Mang'Anda, Justice, LPC 49:23
Yeah, he's handout, so.

Camerer, Michelle, H LSCSW, LCSW 49:24
Oh, I'm sorry.

Mang'Anda, Justice, LPC 49:26
You're good.
So yeah, I I just kinda like building up on what she said.
I think with some parents, sometimes it could be a thing of shame that I'm, you know, I'm I failed as a parent that my child has reached to this extent and therefore.
Some resistance to be in a hospitalized can be as a result of that.
So just kind of normalizing that to say.
Hey, just kind of helping them see through that.
Shame to say this might be the best. You know, the most loving thing to do for their child.
And justice.
Kind of in using a lot of empathy in there because.
Lot of times when a child is going through that, the parent is also dealing with that too.
So just kind of helping the parent see beyond that and allowing them to process, you know, through that too if they need support to in that time to just kind of help them understand this is maybe the most loving thing to do for their child.

Camerer, Michelle, H LSCSW, LCSW 50:28
Thank you. I I like that.
I really like that too.
Angela Guzman said to remind the family it's a multidisciplinary recommendation and it wouldn't be made if it wasn't necessary to keep your child safe.
Yeah, that's also.

Katie about hear out their concerns and walk through each I think that's really great too.
Yeah, for sure.
Empathize the great discussion.
What to what do you do when a parent does not see the seriousness and a previous suicide attempt?
How do you approach that with a parent?
Come on.
I know some of you have experienced this before. What did you do?

Stallbaumer Rouyer, Jennifer, S 51:24
I'll speak up.
I do the universal education again.
I pull out some stats.
You know that it's whatever number killer in Kansas and Missouri and and just try to share with them the seriousness that we've seen.

Camerer, Michelle, H LSCSW, LCSW 51:40
Thank you, Jennifer. It's great.

Thomas, Kei-Lisha, M 51:43
I I agree with you, but I also would grow in.
Sort of like exploring how the parent feels about it, like with their perspective was on what happened, just to see where like the disconnect is.

Camerer, Michelle, H LSCSW, LCSW 51:58
Yes, for sure.
I thought I saw somebody's hand up.
Yeah, I thought.
Angela, did you? Angela Collins, did you have your hand up? You mean you don't have to talk if you don't want to, but just didn't want to ignore your comment.

CA

Collins, Angelia 52:10
I appreciate that.
I actually was gonna say the same thing. I wanted to kind of get an idea on where the

parent is in that in why they're feeling that way. And just to be where they are and understand that. And then I, I love the idea of throwing in the.
Stats and the realization that we don't know the child as much as they do, but because of how they're presented, this is how we're needing to move forward.
So I do believe hearing them out and you know.
Going with what they say, but understanding to the importance of what we see in the safety of the need.

Camerer, Michelle, H LSCSW, LCSW 52:45
Like, yeah.

CA **Collins, Angelia** 52:45
Sorry, I'm a little distracted, but yeah, thank you.

Camerer, Michelle, H LSCSW, LCSW 52:48
It's OK.
It's great answer. Thank you.
Aurelia said.
Explain that they're at higher risk for another attempt to say, yeah, important for too very good. I feel like I answer it. The next question already.
Yeah. How do you navigate the discussion with a family when they are transporting their child by private vehicle to an inpatient psychiatric facility?
Is there anything else that any of you frequently mention or or try to talk to a family about that we haven't already covered.

BJ **Budke, Jessica** 53:20
For me, that situations came up more like I have one where I had to do a telehealth like assessment too and.
There, like we had to do a lot of follow up and like that was just kind of.
Making sure Mom knew like, OK, I'm gonna check in with you this time.
Like you guys said.
And sometimes too, like with the telehealth piece of like, I think it'd be really helpful if somebody like met with them in person just to kind of be able to get you know.
A more accurate assessment, but it's encouraging.

Like that face to face contact.
Again, speaking specifically from like the the telehealth times that I've had to do that.

Camerer, Michelle, H LSCSW, LCSW 53:56
Great.
That's a good call out because we do have a lot of telehealth in our areas, so for sure,
OK, I'm gonna speed us along just a little bit because I think we're gonna be crunched on time.
OK.
So with outpatient treatment, if the recommendation, make sure you have a clear plan set up.
Give them resources.
Maybe they already have or connected to a therapist.
When's the next appointment?
Getting that information and then providing the necessary resources. If not so we have that mental health resource packet.
I find it very helpful.
Instead of just like tossing it at the family that you like, look through it with them, right?
So OK.
These are the community.
Agencies in your area, and sometimes I even circle the ones or cross out ones that aren't appropriate.
And then also showing them that Backpage where it's like Psychology Today and leaning on their insurance plan, those types of things.
I've even gone so far as to pull up Psychology Today in the room on the computer and walk them through the steps on how to identify someone. You can use filters you know.
Do you want a therapist who specializes in these certain things or takes this type of?
Insurance so it it can be more of again that conversation with them and beyond.
Just here's a packet.
Good luck.
OK, documentation.
So you're gonna document your suicide assessment and the social work consultation.
Note the you're always going to check and I'll show this on the next screen.

The suicide risk button under the mental health screen. If this was for a positive asq that is the only way it post to a report that an assessment was completed.
For a positive asq so always check that suicide risk button.
There.
Will be follow up case management calls that are also documented in the mental health follow up note documentation for an acute positive suicide screen should always be documented by the end of your shift. So if this kid is going inpatient that needs to be done by the end.
Of your shift.
Here's that screen that shows that button for suicide risk. This is under the patient behavioral and Mental health tab within the social work consultation note.
OK.
So the multidisciplinary care planning, this is an important piece of the note that you can.
Complete.
Children's Mercy as an enterprise loves the US News and World Report recognition, as I'm sure you all have seen, the screensaver that's currently up. So our best practice.
According to care coordination within the US News and World Report is that we are escalating these acute concerns to the primary therapist.
So you would need a release of information to get that, but this is where you can document who that person is and their contact information, and then again, don't forget that.
ROI.
Follow up case management. You're gonna have some sort of follow up for the patient. The 24 hour call or weekly calls or both?
Here is the criteria for that.
This is also in our.
Mental health procedures document.
OK, frequently asked questions. Oh, I wanna make a note about documentation as well. If you are. If you are going in and even if the family has denied like I'm not going to talk to you about this, but you have done some sort of assessment with them whether.
It's just to review the safety planning or they've, you know, you've acknowledged that they had the positive and you're talking to the family.

Please document that in social work consultation. Note you don't have to spend. You know 20 minutes with them. There's no there's no time. There's no certain questions that have to be answered.
But if you were doing something, some sort of intervention with that consultation for the positive asq, please document that in the social work consultation note.
And then if you are completing a mental health assessment not because of an asq that still needs to go in the social work consultation note and you can still complete the cssrs.
OK.
There were some comments, I think that came through before FAQ S.
That's good. Jennifer says that when she sees a patient for a mental health assessment at the urgent cares, she goes ahead and sends a message to their PCP through the message center. If that exists, or for future appointment providers.
Yeah, that is great.
Wonder if we should go to the next slide because.
OK, since we're talking more about the charting.
Which one what?
And we will allow you to just kind of look through the FAQ S we do have a bit of a practice change.
At the end of the slide presentation that we want to cover.
Yes.
OK.
So our our this last FAQ.
What do I do if a patient has had an historical attempt that has already been addressed?
How do I document this?
So this this has been different for different areas for many, many years now. Our current recommendation is going to be that you document this in a suicide screening note.
So hopefully you all can see this pretty well.
I pulled this directly from a chart, but taken out the patient identifiers, so we've checked and I've highlighted the social work consult on category one.
Category Two is other.
If you're whatever box you're checking.
I think the social work consult is appropriate if there's other things in there that you

want to check, that's fine too.
We are saying that this is a screen negative because it is a historical attempt that's already been assessed, but in the bottom in the screening cons com comments.
Just commenting in there that you've reviewed the EMR and noted that the historical attempt has been addressed in a social work mental health assessment On this date.
Or maybe it's in the crisis screening note from the Ames has done in the Ed On this date.
Or even a psychology note, wherever it is so that when they pull this up for future, they can reference back that this particular.
Concern was addressed.
OK.
We will.
We will send out our slides with some of the other FAQs.
We didn't really answer Samantha's question then, so we'll go back to that really quick. 'cause, we didn't get to that talking point, but I know we're at time. And for those of you that need to drop off, that is fine. But if you have other questions, right. Now or other comments, other helpful tips that you think would be beneficial for your colleagues to hear.
When they completing their mental health assessment, we will hang on for a couple of minutes and talk through those things.
With you. OK. Just to repeat Samantha's question was.
Can the family decline social work assessment after a positive screen?
If no, can you speak to how to address that with the family?
I think we just always make an attempt to meet with them and again come.
With the idea that safety is always our number one concern, I like to come at families if they don't want to meet with me, like, what can we agree on?
I think we can both agree that we want your child to be safe.
Is that right?
And then just see if there's any room for us to potentially meet.
If not, I'm gonna make a note of it depending on what question they answered.
Yes, like if they answered them all.
Yes, if they answered question five, yes, I'm gonna be.
Looking at placing a hotline making you know, calling a local law enforcement to do a welfare check cause those things are pretty concerning.
But you know, certainly we can't hold somebody down and make them do an

assessment with us.
We just do our very best to make an attempt to bridge that gap and.
Provide the safety information.
I think it's important too.
This isn't gonna work every time, but don't ask a question that you don't want to have an answer to.
So it's, it's about the phrasing.
So hi, I'm here to talk with you today about this.
Could you please go to the other room and I'll come get you in a minute.
It's not.
Will you step out or can I talk to you about this today?
Because then they could very well say no.
And then you're just stuck so.
Just keeping in mind how your how you're approaching it and how you're phrasing things, but.
Michelle's right at the end of the day, you can't force them to talk to you.
And you can't hold them hostage. So just do your best, emphasize the importance and the safety concern, and hopefully you can accomplish at least part of the assessment.
Anything else right now?
Someone had asked about the code for the CEU.
I will copy and paste it again in the message cuz I think maybe you wouldn't have gotten it if you logged on later, so I'll copy and paste it again in the chat.
Thank you all for attending today and happy Thanksgiving.

◉ **Murphy, Allison, D** stopped transcription