

UVM Project ECHO School Nurses: Mental Health in the School Setting

April 14th, 2022

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- RECORDING OF SESSION TO BEGIN



Agenda

- Introductions
- Objectives
- Didactic Presentation (~20-30 min)
- Case presentation
 - Clarifying questions
 - Participants – then faculty panel
- Discussion
- Recommendations
- Summary
- Closing Announcements
 - Submission of new cases
 - Completion of evaluations



Series Objectives

Learning objectives for this ECHO series include the ability to:

- Apply wellness and self-care techniques to personal and professional life.
- Describe best practices in managing anxiety, psychiatric emergencies, oppositionality and disruptive behaviors, and eating disorders.
- Identify ways to apply strategies learned about caring for mental health in the school setting to school nursing practice.
- Use the resources available in your community in school nursing practice.



CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.5 AMA PRA Category 1 Credits.

UVM CMIE is accredited by the American Nurses Credentialing Center (ANCC) to provide CE for the healthcare team. This program has been reviewed and is acceptable for up to 1.5 Nursing Contact Hours.

Participants should claim only the credit commensurate with the extent of their participation in the activity.



CME Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.



Managing Psychiatric Emergencies

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Managing Psychiatric Emergencies

Session Objectives:

1. Identify common psychiatric diagnoses and symptoms that can lead to a psychiatric emergency.
2. Discuss screening, assessing, and triaging for suicidal ideation.
3. Discuss de-escalation techniques that could be used in the school setting.
4. Understand the process that occurs within the UVMHC Emergency Department for pediatric patients with psychiatric complaints.



Consider these situations in the educational setting.
Are these psychiatric emergencies?

- A first grader this morning attacked a peer for taking his toy, leaving a bruise. He is also dysregulated in the nurse's office.
- A 13 y/o female is found to have 25-30 fresh superficial cuts on her upper thighs.
- A 15 y/o male shares active suicidal thoughts but becomes agitated and tries to leave when you suggest a crisis evaluation.
- A middle school transgender female endorses hopelessness and fears she will harm herself if she goes home.



What constitutes a psychiatric emergency?

Risk to self

- Suicidality
- Self-harm
- Risky substance use
- Nutritional deficiency

Risk to others

- Aggression/violent behavior
- Homicidality



What
diagnoses
might
precipitate a
psychiatric
emergency?

Risk to self

- Depression
- Anxiety
- Substance Use Disorders
- Psychosis
- Autism/Developmental Disorders
- Anorexia Nervosa/ARFID

Risk to others

- Impulse Control Disorders
- Oppositional Defiant or Conduct Disorders
- Substance Use Disorders
- Psychosis
- Autism/Developmental Disorders



Suicidality in the student population

Prevalence of behavioral health problems is over 20% in adolescents.

Suicide is 2nd leading cause of death for persons aged 10-24.

CDC Youth Risk Behavior Survey (2019) of high school students:

- 18.8% of high school students seriously considered attempting suicide
- 15.7% made a plan about how they would attempt suicide (13.4%*)
- 8.9% actually attempted suicide (6.5%*)
- 2.5% had a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse
 - Data is in reference to time point during the 12 months before the survey
 - *VT numbers are statistically significantly lower than the national average



Screening for safety concerns

Screen appropriate students for suicidal ideation to help guide next steps.

Validated screening tools may include:

- Ask Suicide Screening Questions (ASQ)
- PHQ-9 (modified for adolescents)



Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

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

If yes, how? _____

When? _____

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

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

If yes, please describe: _____

Next steps:

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

Provide resources to all patients

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



PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?

Yes No

If you are experiencing any of the problems on this form, 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

Has there been a time in the past month when you have had serious thoughts about ending your life?

Yes No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes No

If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.

Office use only: Severity score: _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)



Assess Risk and Triage to appropriate level of care

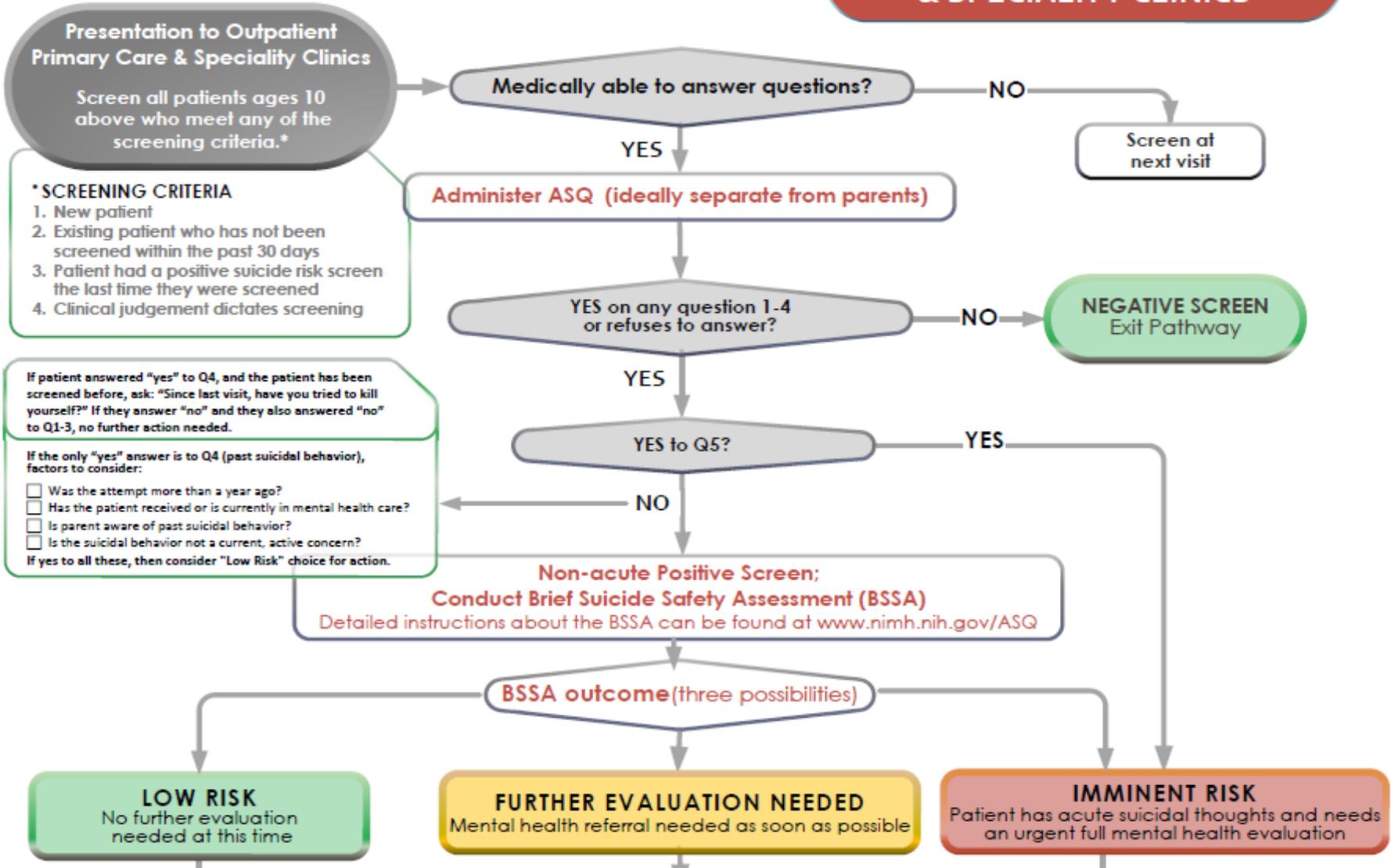
The level of risk has been assessed and best next steps have determined to do one of the following:

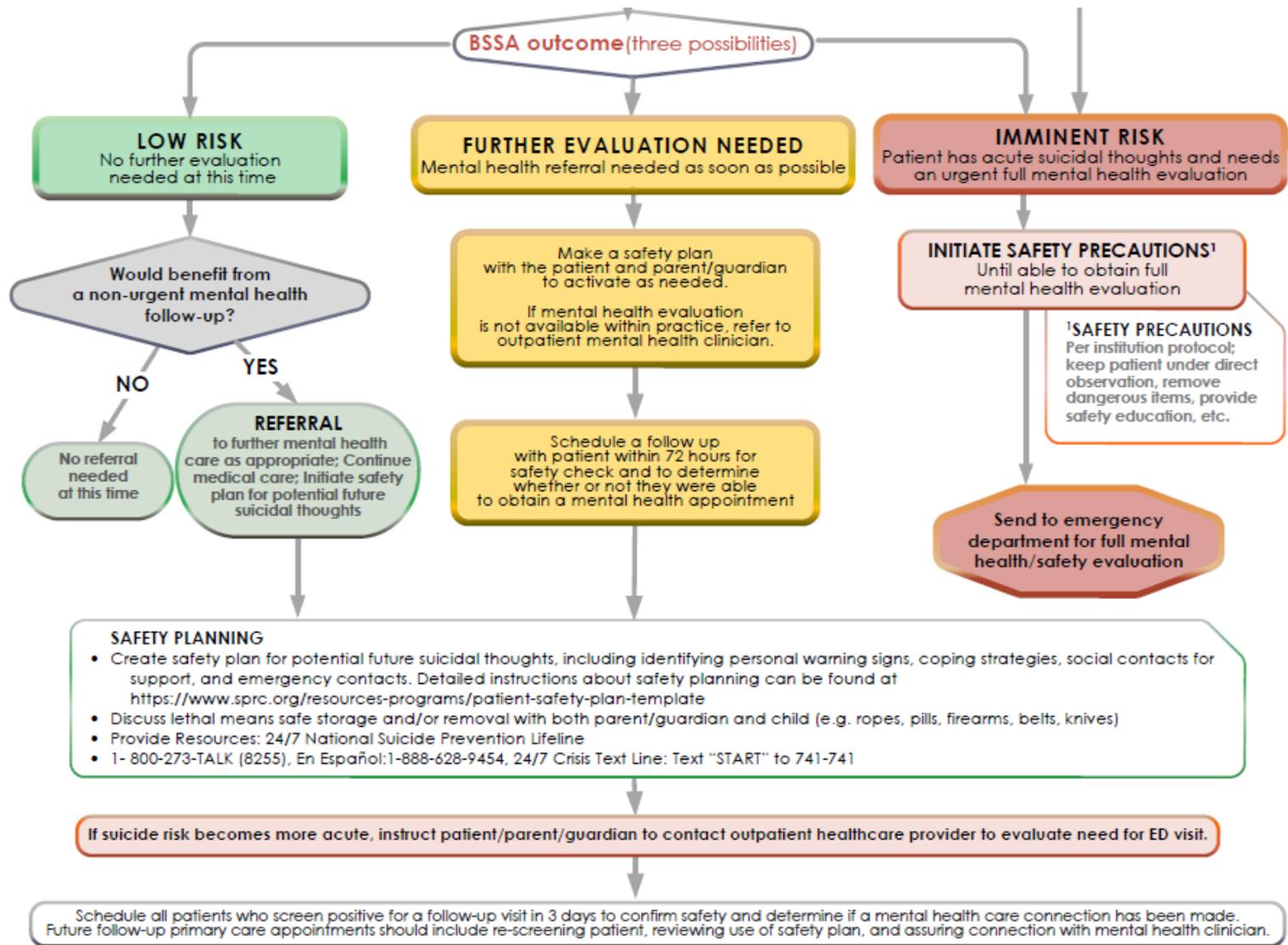
- Safe to send home (outpatient with safety plan)
- Crisis evaluation (In Chittenden County – First Call)
- Emergency Department psychiatric evaluation (UVMHC ED) via parent or EMS/911 transport



SUICIDE RISK SCREENING PATHWAY

OUTPATIENT PRIMARY CARE & SPECIALITY CLINICS





asQ -V- 4/2/2021



Safety Plan

Increased supervision: 24/7 supervision; doors open/unlocked

Reduce access: medications (prescription and OTC) locked away; sharps and firearms secured

Adaptive Coping Strategies (e.g. listening to music, drawing, relaxation techniques)

Reliable persons for support (e.g. parent, therapist, school counselor)

Outpatient mental health provider follow-up

Local crisis and national hotline access

Phone app:
Safety Plan



Entering the situation



Empathic approach. Be aware of your own emotional responses. Try not to take anything personally.



Self-monitor and be sure you feel safe before approaching an escalated child.



Have appropriate number of staff available.



Consider developmental level and unique communication needs.



Assume that they are hurting and coping the only way they know how.



Verbal De-escalation



Powerful



Safe



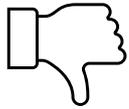
Trauma-informed



Can be completed in 5
minutes; may require
multiple cycles



Barriers to Communication



Pre-judging

Not Listening

Criticizing

Name-Calling

Engaging in Power Struggles

Ordering

Threatening

Minimizing

Arguing



De-escalation Strategies

Always have two sets of eyes on the child.

Respect personal space while maintaining a safe position.

Try not to stand over kids or look down on them as you talk.

Be concise. Keep the message clear, simple and brief.

Do not be confrontational or raise your voice.

Identify aloud the child's wants and feelings.

Approach with curiosity rather than judgment.

Consider altering the environment (including people present).

Offer foods/liquids.
Offer distractions.

If possible, let the child move in the room.

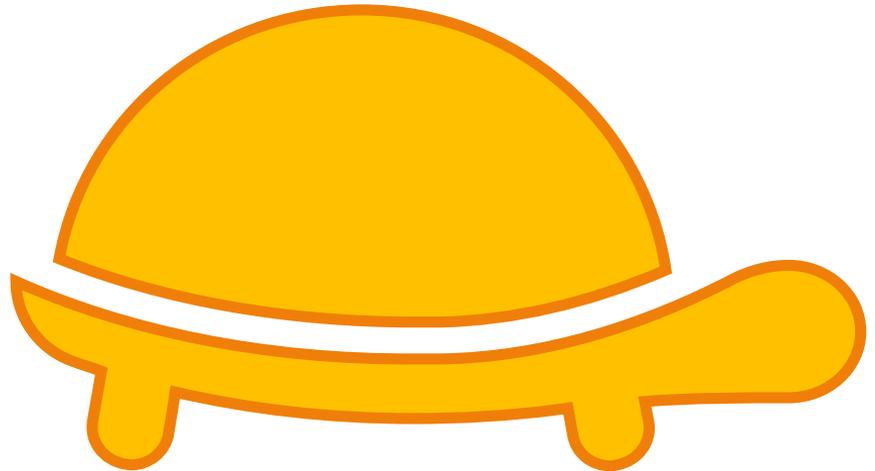
Avoid power struggling and honor reasonable requests.

Provide reassurances of safety.

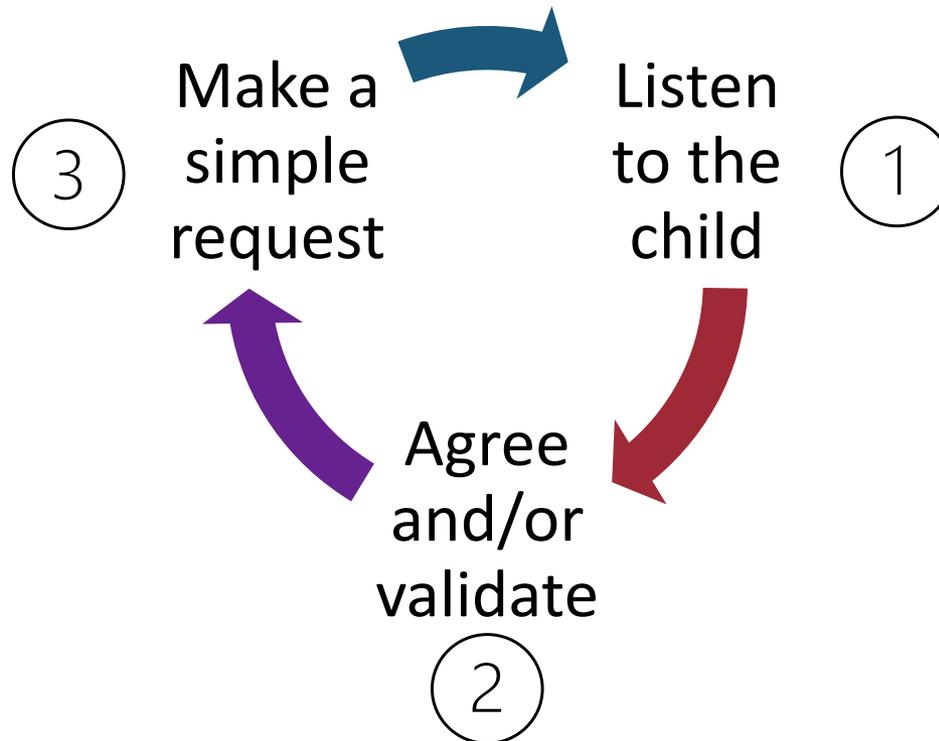


Take it SLOW.

De-escalation
takes time.



Verbal de-escalation skills: Multiple **loops** of listening-validating-directing the child.



Modified from material provided by Northwell Health: Zucker Hillside Hospital, Child Psychiatry

Listening is far more important than talking.



- We must do whatever we can to help a person feel heard. This is how humans build rapport and relationships.
- **Actively listen** and then reflect back or paraphrase what they said.
 - "I'm hearing that..."
 - "It sounds to me like..."
 - "Can you help me understand better?"
 - "Tell me if I heard this right..."
 - "I want to make sure I'm not missing anything you're trying to tell me."
- **Allow for silence.** A stressed nervous system takes longer to process information.



Listening closely does not mean you agree, but rather that you understand where someone is coming from.



- Miller's law: **“To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of.”**

Stay empathically engaged.

- Good eye contact
- Allow personal space (2 arms lengths)
- Unintrusive gestures that show you're paying attention:
 - Nodding
 - Occasionally saying "ok" or "yes" in agreement.
- **Remember that your body may be sending a message that your words are not.** Try to avoid:
 - Finger pointing
 - Dismissive shrugging
 - Clenched jaw or fists
 - Crossed arms
 - Squaring off shoulders with child
 - Standing over child



Identify wants and feelings.

- “I really want to understand what is going on for you right now.”
- “It sounds like you’re feeling...”
- “I’m confused. Help me understand.”
- **Focus on the behaviors not the student.**
 - “That language is making it hard for me to process what you’re saying”
NOT “you are being rude.”
- **Create opportunities for the student to agree with you.**
 - “Am I right that you’re feeling XYZ?”
 - “So you are feeling frustrated because of XYZ, right?”
- Ignore challenging questions.
 - Q: “Why is that other nurse such a _____?”
 - Redirect: Tell me more about your belly pain.



NEVER IN THE HISTORY OF
CALMING DOWN HAS ANYONE
EVER CALMED DOWN BY BEING
TOLD TO CALM DOWN.



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- **Avoid** telling the child that you “know how he or she feels.” (though this has exceptions depending on developmental level)
- **Avoid** saying “you shouldn’t” or “you need to”
- **Avoid** saying “I understand.” This can often backfire because it shuts down conversation and jumps to solutions.



Set Respectful, Clear Limits & Offer Choices

“I want to continue listening to you but it’s important for you to be calm for us to talk. How can we work together to make that happen? “

“I understand you are (*use emotion the child has identified*) but it’s not ok to throw things. If you do that again, we will have to hold you. Let’s keep talking.”

“We cannot allow you to hurt yourself here and we will have to hold you to keep you safe if you do so.”

Offering choices empowers kids and helps them feel in control.

- “Would you like to continue our conversation in a calm manner, or take a break then resume in a few minutes?”
- “Could I get you a water and then we can continue?”
- “Would it be helpful to call XYX? It seems like they’re a supportive person for you?”
- Offer real choices only.



Setting limits is about offering choices with consequences.

Setting limits is NOT about making threats and giving ultimatums.



Use “I” statements

- Use “I feel” statements followed by instruction:
- “I feel frightened when you pace, and I can't pay full attention to what you are saying. I bet you could help me understand if we could sit and talk.”
- “I feel frustrated when you pull the blanket over your head because I can't fully understand what you're trying to tell me. I can do better listening if you show me your face.”



Attune to your own stress response

- REMEMBER TO BREATHE!
- Appear calm, centered, and self-assured even though you probably don't feel it. Your anxiety can make the student feel anxious and unsafe which can escalate aggression.
 - Maintain natural contact, neutral facial expression, and a relaxed body
- Ask for help or a break if needed.
- Position yourself for safety.

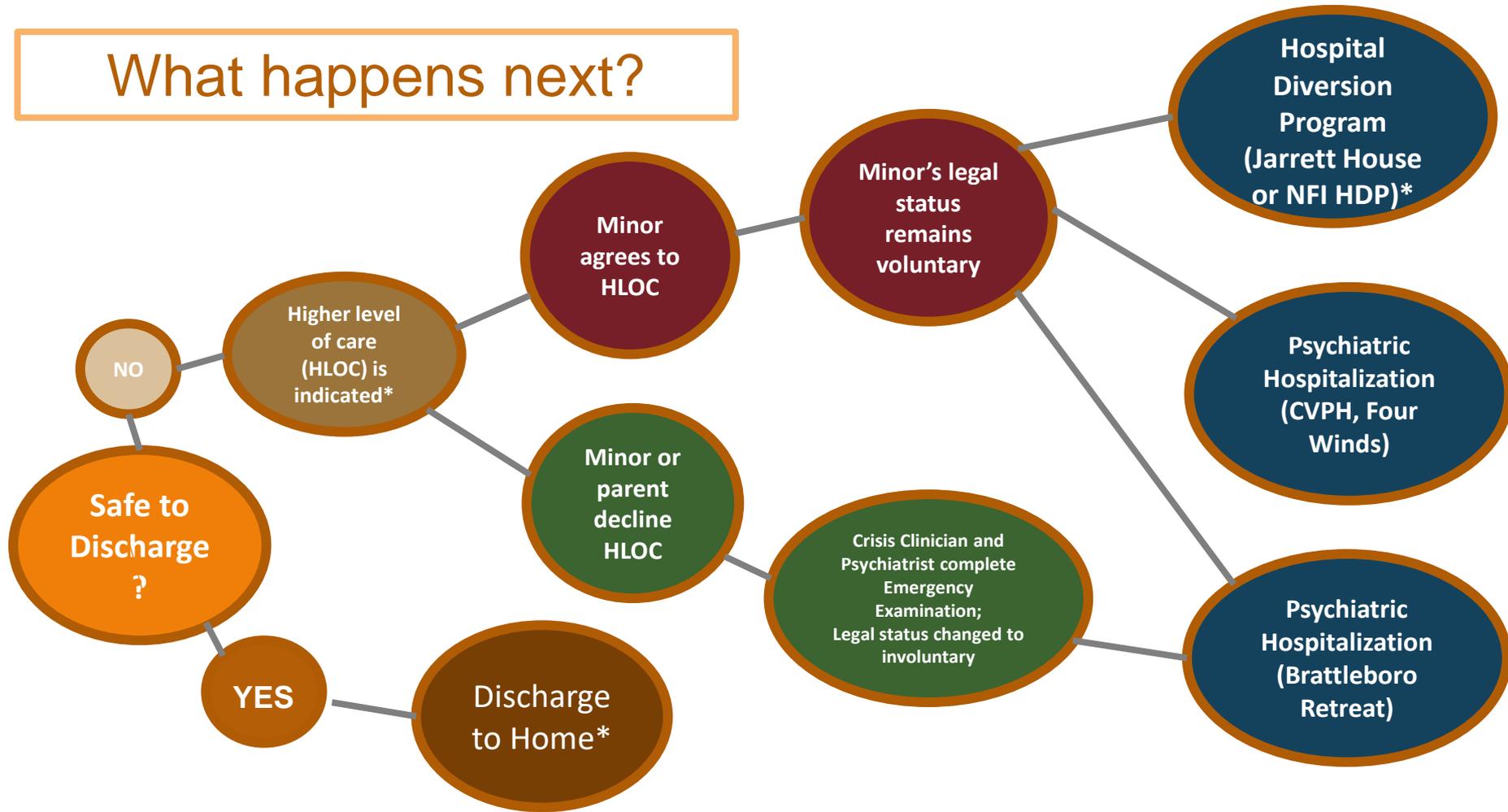


Emergency Psychiatric Evaluation at UVMHC

- Triage
- 1:1
- Seen by PA or MD
- Crisis (First Call) assessment
- Psychiatry evaluation when indicated
- Safety planning → Home
- **OR** referral to higher level of care; voluntary vs involuntary status



What happens next?



Jarrett House

(Burlington, VT)

Crisis stabilization beds for Vermont children and youth ages 5-13 who are experiencing an acute mental health emergency. Jarrett House provides short-term, out-of-home care in a staff-secured setting.

NFI Hospital Diversion Programs

(S. Burlington and Brattleboro, VT)

Short term inpatient facilities for adolescents experiencing acute psychiatric crisis. Two staff secured facilities serve individuals ages 10 through 18; approximately 7 to 10 days.

Brattleboro Retreat

(Brattleboro, VT)

Inpatient psychiatric hospitalization provides acute crisis stabilization, assessment, treatment and aftercare planning for children and adolescents ages 5-18.

Champlain Valley Physician's Hospital

(Plattsburgh, NY)

Inpatient psychiatric hospitalization provides assessment, stabilization and discharge planning for children and adolescents ages 6-18. Voluntary status only for VT kids.



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Discussion and Q & A



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Cases/HIPAA

DO NOT INCLUDE:

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #



The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.



Case Presentation Format

Case presentation from a participant (a *real-world case, from the field*)

Then

Clarifying questions about the case from group to case presenter

Then

Ideas, suggestions, recommendations from participants

Then

Ideas, suggestions, recommendations from ECHO faculty team

Then

Additional discussion, if any (All)

Then

Summary of case discussion

(course co-directors: Michael Hoffnung, DO and Katherine Mariani, MD, MPH)



- RECORDING TO BE STOPPED FOR CASE PRESENTATION



Questions and Discussion from the group....



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Prep for Next Session

Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

****SESSIONS ARE ON THURSDAYS FROM 3:00PM TO 4:30PM****

DATES	SESSION	DIDACTIC TOPICS (in addition to case review)
Jan 13	TeleECHO Session 1	Wellness and Self Care for Ourselves and Our Students (Michael Hoffnung, DO)
Feb 10	TeleECHO Session 2	Eating Disorders (Katherine Mariani, MD)
Mar 10	TeleECHO Session 3	Addressing the Non-compliant Child: Oppositionality and Disruptive Behaviors (Margaret Spottswood, MD and Rebecca Ruid, PhD)
Apr 14	TeleECHO Session 4	Managing Psychiatric Emergencies (Haley McGowan, DO and Yasmeen Abdul-Karim, MD)
May 12	TeleECHO Session 5	Managing Anxiety: What School Nurses Need to Know (Stephanie Fosbenner, MD and Cynthia LaRiviere, PhD)



Conclusion

- Slides are posted at www.vtahec.org
- Volunteers to present cases (this is key to the Project ECHO model)
 - Please submit cases to lizmanzvt@gmail.com
- Please complete evaluation survey after each session
- Once your completed evaluation is submitted, CE information will be emailed to you.
- Please contact us with any questions, concerns, or suggestions
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 - Elizabeth.Cote@uvm.edu

