Presented by the Partners for Child Fatality Prevention
An AAP-OC Project

Youth Suicide: Too Young To Die 2022

Thursday, December 8, 2022
6:30 PM – 7:30 PM
Webinar

American Academy of Pediatrics-Orange County Chapter
A collaboration with the National Center for Fatality Review and Prevention and AAP Section on Child Death Review and Prevention & Clinic in the Park, a fiscally sponsored project of AAP-OC

American Academy of Pediatrics
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Partners for Child Fatality Prevention

American Academy of Pediatrics Orange County Chapter (est 2021)

Goal: Create a sustainable partnership between our CDRT and AAP-OC and our partners to inform local prevention interventions and advocacy

1. Review OC CDRT data & recommendations (0-17 years of age)
2. Conduct Webinar(s) for pediatricians, and community health, education and social service providers to inform on
    i) Role of CDRT
    ii) Causes of child fatalities
    iii) Prevention at the individual, community and policy levels
        - ➢ Webinar 1: Child Death Review Teams
        - ➢ Webinar 2 & 5: Childhood Drowning
        - ➢ Webinars 3 & 4: Youth Suicide

3. "Partners for Child Fatality Prevention": Sustainability

Funding provided by: National Center for Fatality Review and Prevention and AAP Section on Child Death Review and Prevention 2021. Hoag Hospital Community Benefit Grant for Clinic in the Park, a fiscally sponsored project of AAP-OC.

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Faculty

Phyllis Agran, MD, MPH

Professor Emeritus UCI School of Medicine, American Academy of Pediatrics Former member Executive Committee National Council on Injury, Violence, & Prevention, AAP and Chair of the AAP-OC Committee

Van Nguyen Greco, MD

Associate Clinical Professor, UCI School of Medicine, Child Abuse Pediatrician. OC Child Death Review Team; Child Abuse Services (CAST). We CAN Coalition. Partners for Child Fatality Prevention and Drowning Prevention Team Lead

Heather Huszti, PhD

Chief Psychologist at Children's Hospital Orange County (CHOC). Oversees mental health programming. Works with children with suicidal ideation. CHOC is one of 16 hospitals nationally in the Zero Suicide initiative.

Joan Jeung, MD, MPH

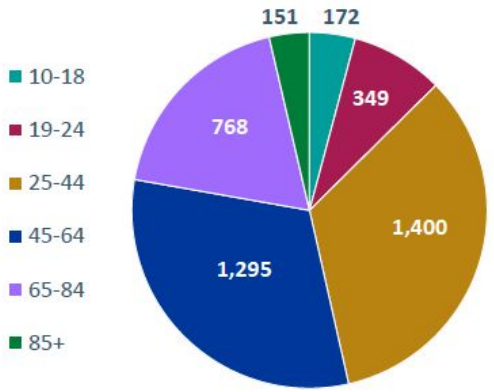
HS Clinical Professor, Department of Pediatrics Division of Developmental Medicine, University of California San Francisco (UCSF) School of Medicine, UCSF Benioff Children's Hospitals. Senior Associate Director of UCSF's Child and Adolescent Psychiatry Portal, a mental health care access portal. AAP Exec Council on Mental and Emotional Health.

Objectives

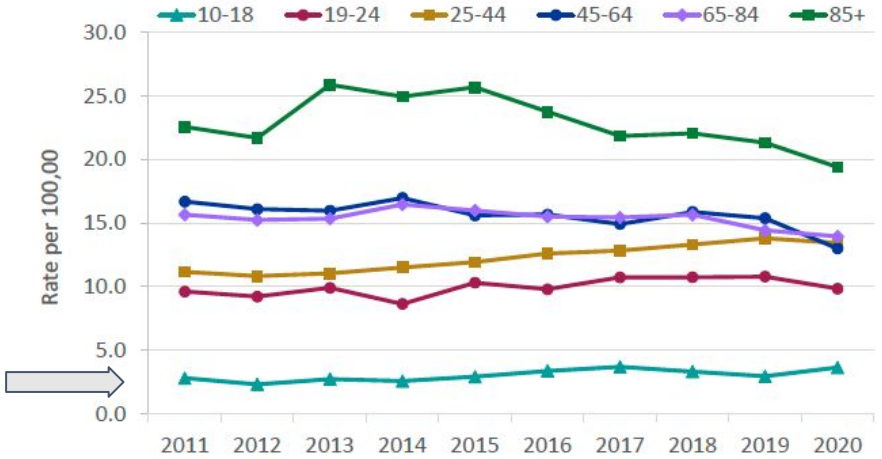
1. Discuss the epidemiology of youth suicide including risk and protective factors and clinical interventions
2. Define the role of Child Death Review Team in youth suicide prevention
3. Be prepared with an intervention plan based on acuity of situation and community resource availability

Suicide Counts (Burden) and Rates (Risk) by Age Group in California

Suicide Counts (Burden) by Age Group, 2020



Suicide Rates (Risk) by Age Group, 2011-2020



Source: 2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2020 deaths: CDPH, CA Comprehensive Master Death File (CCMDF); CA Dept. of Finance P-3 Population Projection File (2010-2060)

5 Leading Causes of Injury Deaths, Children 0-17 Years of Age: California Residents (2018-2020)

Age <1 (N=239)	Ages 1-4 (N=329)	Ages 5-9 (N=196)	Ages 10-14 (N=391)	Ages 15-17 (N=930)
Suffocation (128)	Drowning (139)	MVT, Unspec. (41)	Suicide (102)	Suicide (257)
Homicide (46)	Homicide (66)	Drowning (32)	MVT, Unspec. (64)	Homicide (202)
MVT, Unspec. (18)	Pedestrian (44)	Homicide (26)	Homicide (48)	Poisoning (131)
Drowning (10)	MVT, Unspec. (34)	MV Occupant (25)	Pedestrian (43)	MVT, Unspec. (123)
All Other (37)	Suffocation (26)	Pedestrian (20)	MV Occupant (22)	MV Occupant (69)

1. "Homicide" – Assaults & Homicides
2. "MVT, Unspec." – Motor Vehicle Traffic, Unspecified
3. "MV Occupant" – Motor Vehicle Occupant
4. "Pedestrian" – Pedestrian, Traffic & Nontraffic

N = total # of fatalities for age group

Source: EpiCenter, CA Department of Public Health

Agran P. Winn D. Bhalla J.

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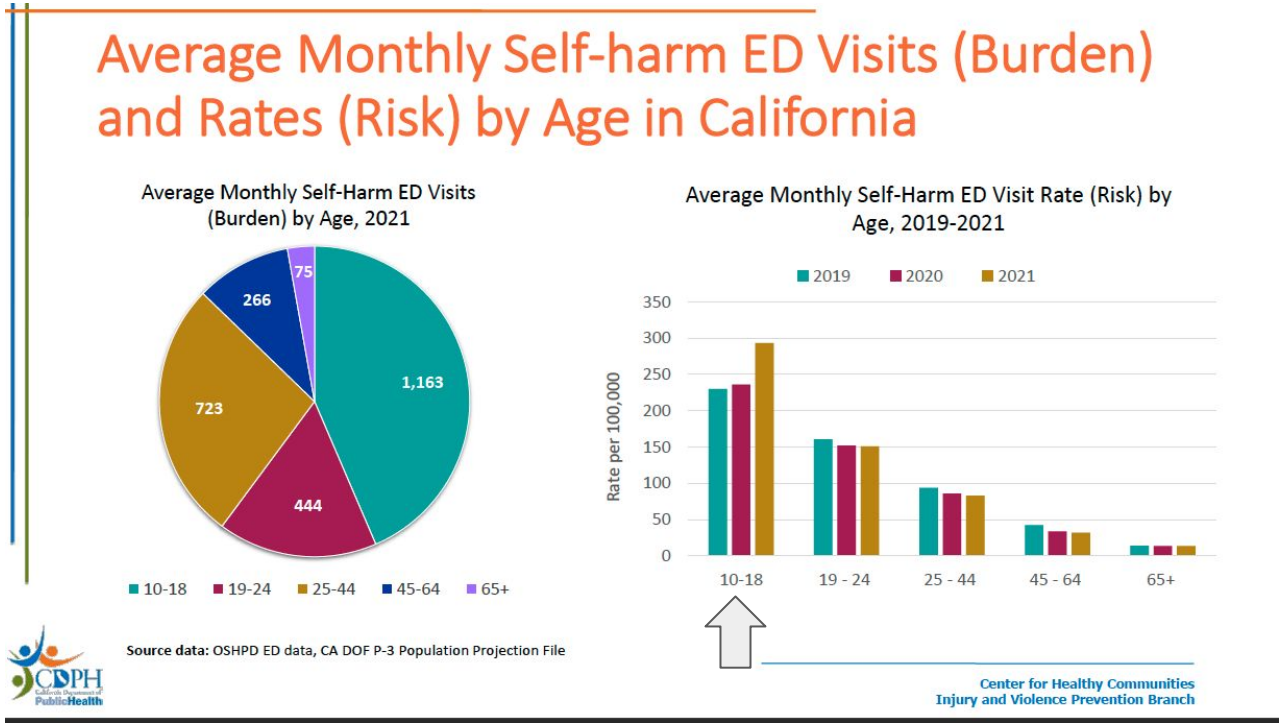
Suicide and Self-Harm Emergency Department (ED) Visit Trends in California



Suicide Prevention Program.Injury and Violence Prevention Branch. California Department of Public Health.
https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/SuicideAndSelfHarmTrendDataPPT_ADA.pdf

ARTICLE | APRIL 01 2018

Suicide After Deliberate Self-Harm in Adolescents and Young Adults FREE

Mark Olfson, MD ✉; Melanie Wall, PhD; Shuai Wang, PhD; Stephen Crystal, PhD; Jeffrey A. Bridge, PhD; Shang-Min Liu, MS; Carlos Blanco, MD

CONCLUSIONS:
After nonfatal self-harm, adolescents and young adults were at markedly elevated risk of suicide. Among these high-risk patients, those who used violent self-harm methods, particularly firearms, were at especially high risk underscoring the importance of follow-up care to help ensure their safety.

Mark Olfson, Melanie Wall, Shuai Wang, Stephen Crystal, Jeffrey A. Bridge, Shang-Min Liu, Carlos Blanco; Suicide After Deliberate Self-Harm in Adolescents and Young Adults. Pediatrics April 2018; 141 (4): e20173517. 10.1542/peds.2017-3517

UCSF Benioff Children's Hospitals

Suicidal Ideation in Pediatric Primary Care

Joan Jeung, MD MPH, Shelly Nakaishi NP, Hohui Wang, MD

UCSF Child and Adolescent Psychiatry Portal

American Academy of Pediatrics, California- Chapter 4 |

8 December 2022

Disclosure

No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose

Learning Objectives

By the end of this lecture, participants will be able to:

- Use suicide risk screening tools for youth in the primary care setting.
- Recognize protective factors and risks for youth suicide attempts and death by suicide.
- Describe important next steps when safety concerns arise during an in office and telehealth visit.

Suicide Ideation (SI) and Attempts

- Suicide rates among youth have been rising for decades[1]
- Worse during the pandemic?[2-4]
  - Behavioral/mental health issues
  - Youth SI and attempts during the COVID-19 pandemic

Sources:

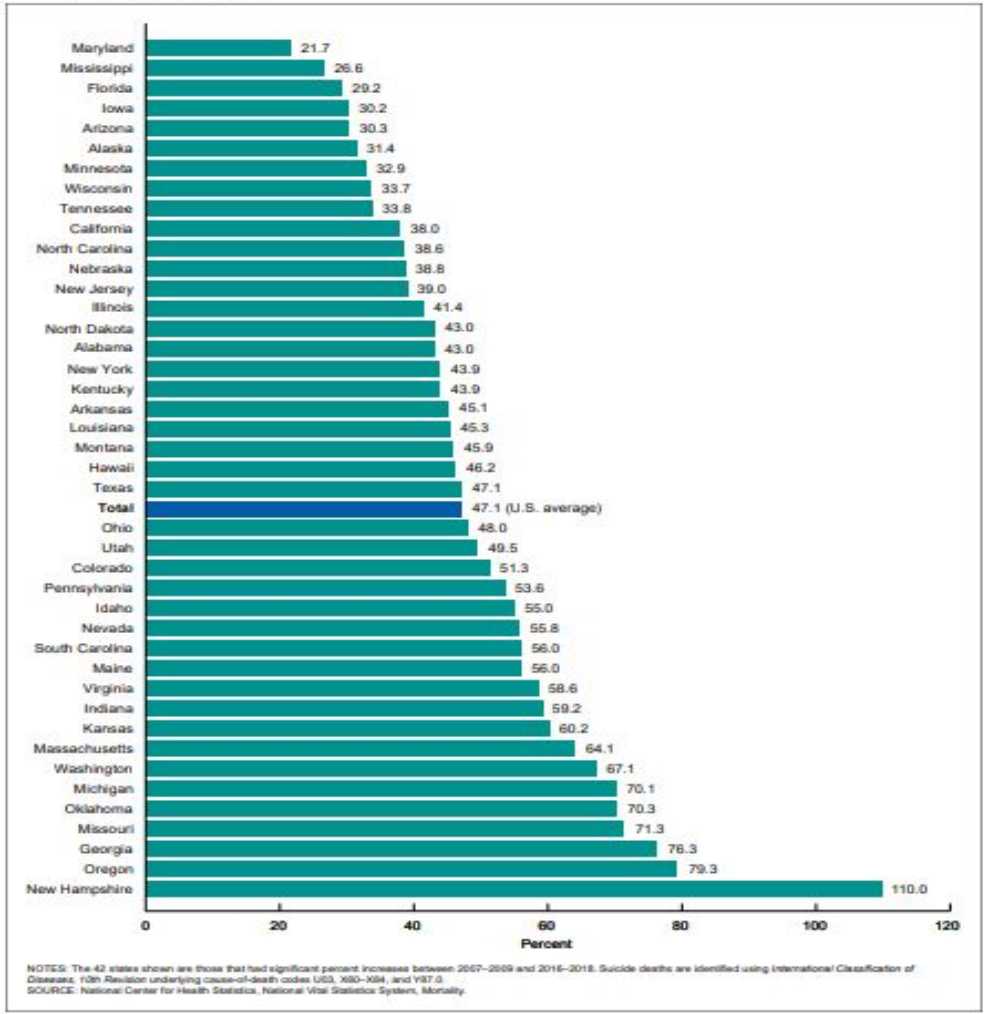
1. National Vital Statistics Reports 2020. https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf
2. Hill RM, Rufino K, Kurian S, et al. Suicide Ideation and Attempts in a Pediatric Emergency Department Before and During COVID-19. *Pediatrics*. 2021;147(3): e2020029280
3. Leeb RT et al. Mental Health Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic—US January 1 – October 17 2020. *MMWR.* November 2020.
4. Silliman-Cohen RI et al. Vulnerable Youth and the COVID-19 Pandemic. *Pediatrics.* July 2020.

Increase in state suicide death rates among youth ages 10-24

Figure 1. **Percent Increase in suicide death rates among persons aged 10-24 years**: United States and selected states, 2007-2008 to 2016-2018

Source: CDC, 2020
https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf

Figure 1. Percent increase in suicide death rates among persons aged 10–24 years: United States and selected states, 2007–2009 to 2016–2018



NOTES: The 42 states shown are those that had significant percent increases between 2007–2009 and 2016–2018. Suicide deaths are identified using International Classification of Diseases, 10th Revision underlying cause-of-death codes U03, X60–X84, and Y87.0.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

From: **Suicide Ideation and Attempts in a Pediatric Emergency Department Before and During COVID-19**

Pediatrics. 2021;147(3). doi:10.1542/peds.2020-029280

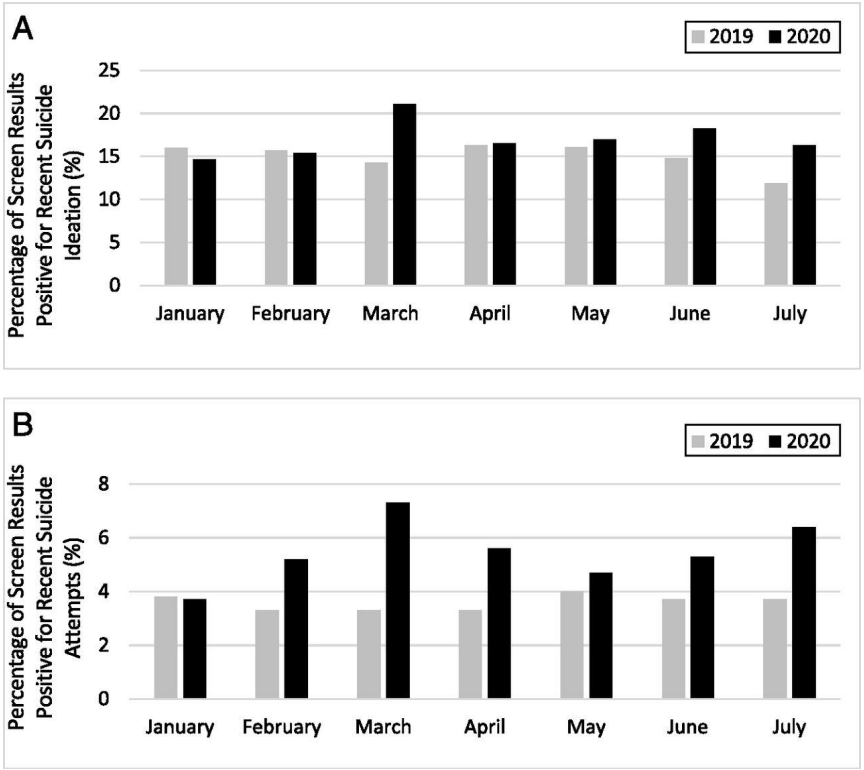


Figure Legend:

A and B, Rates of screen results positive for suicide ideation (A) and attempt (B), January to July.

Suicide is Preventable

- 83% of suicides (all ages) had contact with a primary care clinician in the preceding year
- 66% had contact in the preceding month
- Over 90% have a psychiatric disorder
- Over 80% of these are untreated at time of death

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry*. 2002;159:909-916.

Health Equity

- Research shows significant disparities in suicide rates, risk, and care for youth across cultures and communities.
- Suicide rates are not directly tied to race, gender, or any other social construct. Rather, youth may experience discrimination or long-standing health, social, or systemic inequities that may impact their development and risk for suicide.
- **Systemic inequities that impact youth mental health**
  - Racism
  - Homophobia or transphobia
  - Economic inequities
  - Under-resourced schools
  - Medically underserved communities

American Academy of Pediatrics

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American Foundation for Suicide Prevention

AAP Blueprint for Youth Suicide Prevention

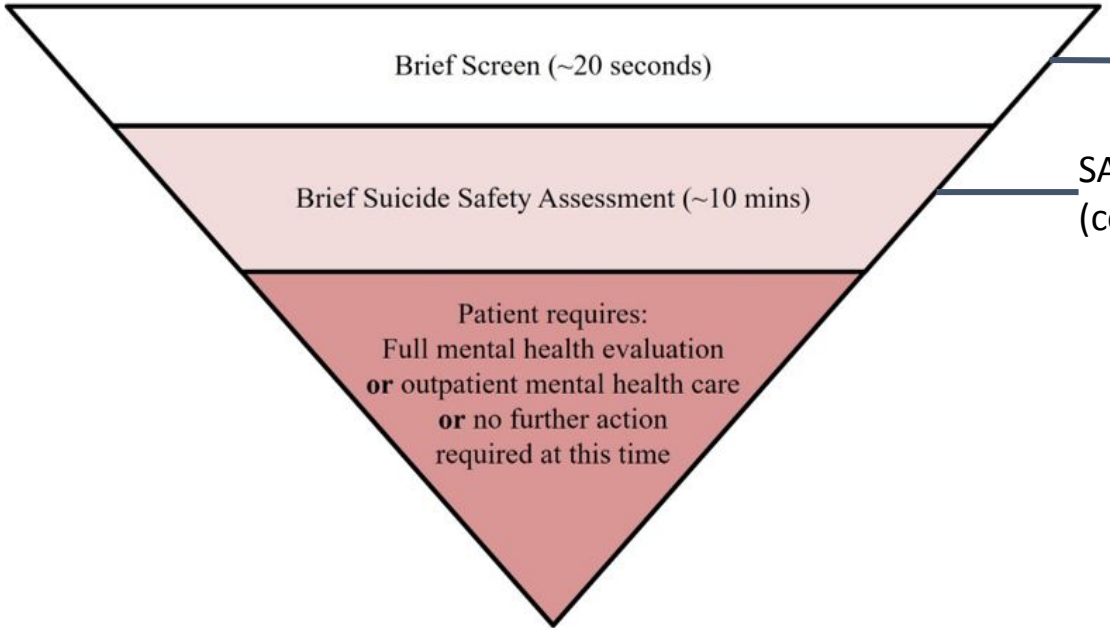
https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/

The American Academy of Pediatrics (AAP) and American Foundation for Suicide Prevention (AFSP), in collaboration with experts from the National Institute of Mental Health (NIMH), created this Blueprint for Youth Suicide Prevention as an educational resource to support pediatric health clinicians and other health professionals in identifying strategies and key partnerships to support youth at risk for suicide.

Universal Screening helps support equity in suicide prevention efforts –AAP Blueprint Recommendations

1. Universal screen all patients ages 12+ years
   - *No hx of suicide risk recommend no more than 1x/month & no less than 1x/year*
2. May screen 8-11 y/o presenting with behavioral health symptom with targeted strategies – screen when clinically indicated
3. <8 years should not be screened for suicide risk, BUT we can still assess for suicide risk when a parent reports suicidal behavior, or when patient presents with depressed mood, severe irritability, or suicidal ideation or history of suicidal behaviors

Suicide Screening and Suicide Assessment



Universal screen: ASQ, SBQ-R

SAFE-T, ASQ-BSSA, C-SSRS
(collateral input may be necessary)

ASQ Suicide Screen Questionnaire

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: _____

If ”NO” to 1-4, done

If “YES” to 1-4 or no answer, = Positive Screen

- If ”YES” to 5 = acute positive screen (imminent risk, full safety evaluation & maintain safety
- If “NO” to 5 = non-acute positive screen. Complete brief suicide safety assessment. Patient cannot leave until evaluated for safety.

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient Review patient's responses from the asQ

❑ Frequency of suicidal thoughts

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_____(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" _____

❑ "Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

❑ Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

❑ Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

2 Assess the patient Review patient's responses from the asQ

ASQ-BSSA

❑ Symptoms Ask the patient about:

- ❑ **Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"
- ❑ **Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"
- ❑ **Impulsivity/Recklessness:** "Do you often act without thinking?"
- ❑ **Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"
- ❑ **Anhedonia:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"
- ❑ **Isolation:** "Have you been keeping to yourself more than usual?"
- ❑ **Irritability:** "In the past few weeks, have you been feeling more irritable or grouchier than usual?"
- ❑ **Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol?"
  If yes, ask: "What? How much?"
- ❑ **Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"
- ❑ **Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"
- ❑ **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

❑ Social Support & Stressors *(For all questions below, if patient answers yes, ask them to describe.)*

- ❑ **Support network:** "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/ counselor?" **If yes, ask:** "When?"
- ❑ **Family situation:** "Are there any conflicts at home that are hard to handle?"
- ❑ **School functioning:** "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"
- ❑ **Bullying:** "Are you being bullied or picked on?"
- ❑ **Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"
- ❑ **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join. Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

"Your child said... (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."

"Does your child seem:

- ❑ Sad or depressed?" ❑ Anxious?" ❑ Impulsive? ❑ Reckless?" ❑ Hopeless?" ❑ Irritable?"
- ❑ Unable to enjoy the things that usually bring him/her pleasure?"
- ❑ Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: ❑ Sleeping pattern?" ❑ Appetite?"

"Does your child use drugs or alcohol?" ❑ Yes ❑ No

"Has anyone in your family/close friend network ever tried to kill themselves?" ❑ Yes ❑ No

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)

4 Make a safety plan with the patient Include the par

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than makir "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or giv sense of security. **Say to patient:** "Our first priority is keeping you safe. Let's work together to develop plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will hotline." "I will call_____."

- ❑ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-so techniques).
- ❑ **Discuss means restriction** (securing or removing lethal means): "Research has shown that limitir to dangerous objects saves lives. How will you secure or remove these potentially dangerous items medications, ropes, etc.)?"
- ❑ **Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response doe indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

ASQ-BSSA

5 Determine disposition

For all positive screens, follow up with patient at next appointi

After completing the assessment, choose the appropriate disposition p *with a check-in phone call (within 48 hours) with all patients who screene*

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suic** Send to emergency department for extensive mental health evaluation (mental health provider is possible and alternative safety plan for immine
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as s (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

Youth Suicidality: Some Protective Factors

- Good problem-solving abilities
- Strong social connections
- Restricted access to highly lethal means
- Cultural and religious beliefs that discourage suicide and that support self-preservation
- Ready access to appropriate clinical intervention
- Effective medical and behavioral health

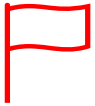
Shain B and AAP COMMITTEE ON ADOLESCENCE. Suicide and Suicide Attempts in Adolescents. Pediatrics. 2016;138(1):e20161420

Youth Suicidality: Some Risk Factors

Previous attempt	Presence of psychiatric disorders	Family history of depression or suicide
Loss of a parent to death or divorce	Social loss	Physical and/or sexual abuse
Lack of a support network	Bullying	Substance use

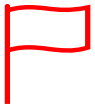
Shain B and AAP COMMITTEE ON ADOLESCENCE. Suicide and Suicide Attempts in Adolescents. Pediatrics. 2016;138(1):e20161420

Look for Red Flags



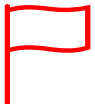
Plan

- “Do you have a plan for how you might try to end your life?”



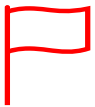
Intent

- “Lately, have you felt that you want to act on your thoughts and do something to end your life?”

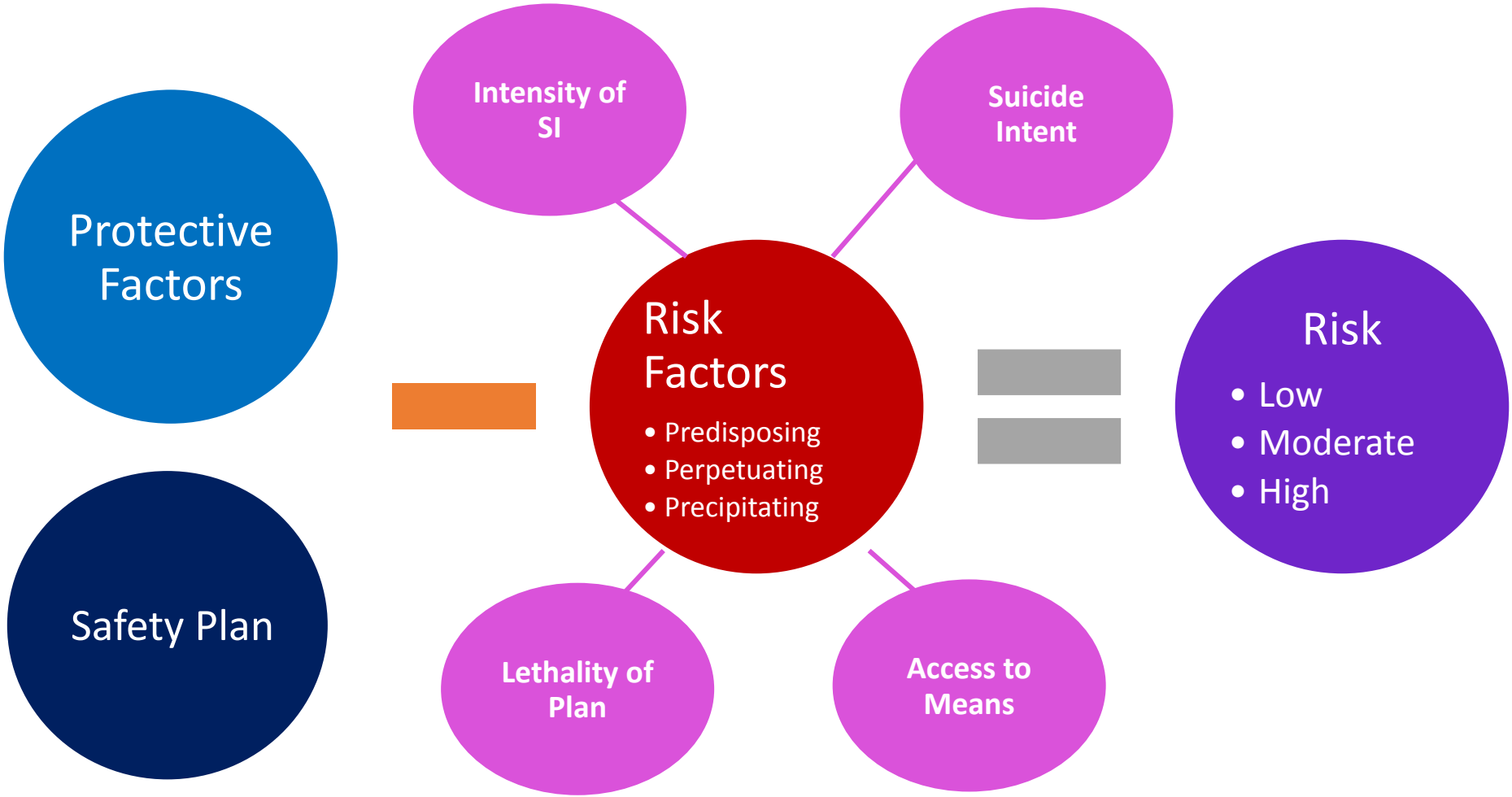


Attempt

- “Have you ever tried to end your life?” *past few days, weeks*



Access to lethal means


Protective Factors
Safety Plan
Intensity of SI
Suicide Intent
Risk Factors
• Predisposing
• Perpetuating
• Precipitating
Lethality of Plan
Access to Means
Risk
• Low
• Moderate
• High

Low Suicide Risk

1. Patient may benefit from non-urgent mental health follow-up
2. Provide parents, caregivers, and families with resources to support them:
   - 988 Lifeline and Crisis Text Line

While many young people think about suicide, and detection is necessary to ensure safety and assess risk, suicidal behavior is a relatively rare event. Most youth who have suicidal thoughts will not require emergency care.

- Only the patients who are assessed to be at imminent or acute risk of suicide need full safety precautions (eg, a 1:1 observer and searched belongings)

- Patients who are not at imminent risk of suicide but require further evaluation, do not require safety precautions

- The majority of young people who screen positive for suicide risk are non-acute cases

- Regardless of level of risk, all patients and their parents/caregivers should be given the National Suicide Prevention Lifeline and Crisis Text Line

Moderate Suicide Risk

1. Refer to outpatient mental health
2. Conduct safety planning with the family, and counsel about reducing access to lethal means
3. F/u with the patient within 72 hours or ASAP for a safety check
4. If mental health f/u is not available then you will check in with them until they are evaluated by a mental health clinician
5. If the family doesn't feel they can keep their child safe at home then you may need to send them to the ED
6. Give patient/family the National Suicide Prevention Lifeline and Crisis Text Line
7. Provide parents, caregivers, and families with resources to support them:
   - AFSP: Teens and Suicide- What Parents Should Know
   - Seize the Awkward
   - National Alliance on Mental Illness: Family Members and Caregivers

Collaborative Safety Planning

1. Warning signs/triggers
2. Coping strategies
3. Social supports
4. Professional supports
5. Lethal means safety counseling
   (guns, sharps, cleaning products, meds/otc)
6. Follow-up plan
7. Communication plan

BE AS SPECIFIC AS POSSIBLE

Completing a Safety Plan helps to determine suicide risk level

Avoid using "safety contract"

https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

High Suicide Risk

1. Praise the patient for sharing their feelings
2. Implement immediate safety precautions using trauma informed principles
3. Connect with the patient's mental health clinician and see if they have a safety plan
4. If there is not an onsite MH in your practice, transfer the patient to the ED, community mobile crisis team, or acute mental health evaluation center for emergency evaluation
5. Conduct a follow-up phone call check within the next 72 hours to inquire about mental health treatment linkage

Emergencies in the office and telehealth setting

- The clinician will need an adult to stay with the patient.
- Assess safety to be transported to emergency department (ED) by caregivers.
  - If the family is able, encourage them to call for emergency services and stay connected with the family until help arrives.
  - Call the ED to give history and concerns of the patient – this helps to maintain continuity of care.
- What does your community 911 response look like?
  - Police officer only +/- crisis intervention training.
  - Officer partnered with behavioral/mental health professional.
- Are crisis services to home available?

AAP Resources

- AAP Suicide Prevention Resources
- AAP/AFSP: Blueprint for Youth Suicide Prevention
  - American Foundation for Suicide Prevention Project 2025
  - AAP Suicide Prevention Campaign Toolkit
- American Academy of Child and Adolescent Psychiatry (AACAP)
  - Facts for Families – Suicide Safety: Precautions at Home
  - Facts for Families – Suicide in Children and Teens
  - Patient Safety and Emergency Management in Telepsychiatry with Children and Adolescents – Video
  - Suicide Resource Center
- Creating an Emergency Plan – HHS.gov
- Bright Futures National Center
  - *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*
  - Promoting Mental Health - Health Promotion Theme
  - Integrating Adolescent Health Screening into Health Supervision Visits
  - Tips to Link Your Practice to Community Resources
- Telehealth Tips: Managing Suicidal Clients During the COVID-19 Pandemic
- Virtual Office Hours: Considerations for Safety and Suicidality in a Telehealth Environment (Recording of live session on 2/24/2021)
- Suicide: Pediatric Mental Health Minute Series
- National Suicide Line: 1-844-493-TALK; or text “Talk” to 38255

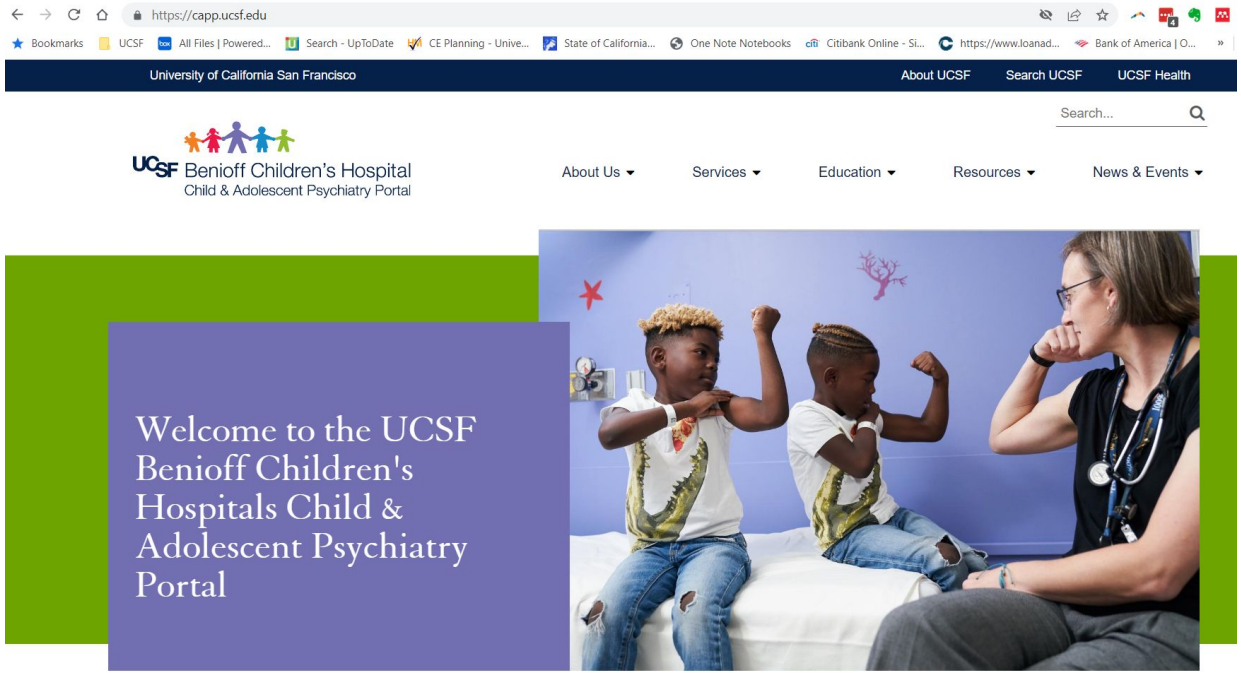
CDC's Suicide Prevention Resource for Action

- *Updated, expanded, and renamed* and includes strategies with the best available evidence to make an impact on saving lives.
- The Suicide Prevention Resource has three components:
  - **Strategies** are the collection of actions to achieve the goal of preventing suicide.
  - **Approaches** are the specific ways to advance each strategy.
  - **Policies**, **programs**, and **practices** show evidence of impact on suicide, suicide attempts, or risk and protective factors.

Other Resources:

- Comprehensive Suicide Prevention
- CDC's Suicide Prevention Infographic
- Comprehensive Suicide Prevention: Program Profiles
- Learn the Five Steps for how to talk to someone who might be suicidal

Resources: UCSF Child & Adolescent Psychiatry Portal



Orange Child Death Review Team

Van Nguyen Greco, MD, Professor UC Irvine, Child Abuse Pediatrician
Tiffany Williams, Sr. Deputy Coroner. Orange County Child Death Review Team

- What is CDRT?
- Review suicides and identify risk factors for completed suicide
- Use of CDRT to acutely recognize increase in suicide rates in Orange County

Clinic in the Park
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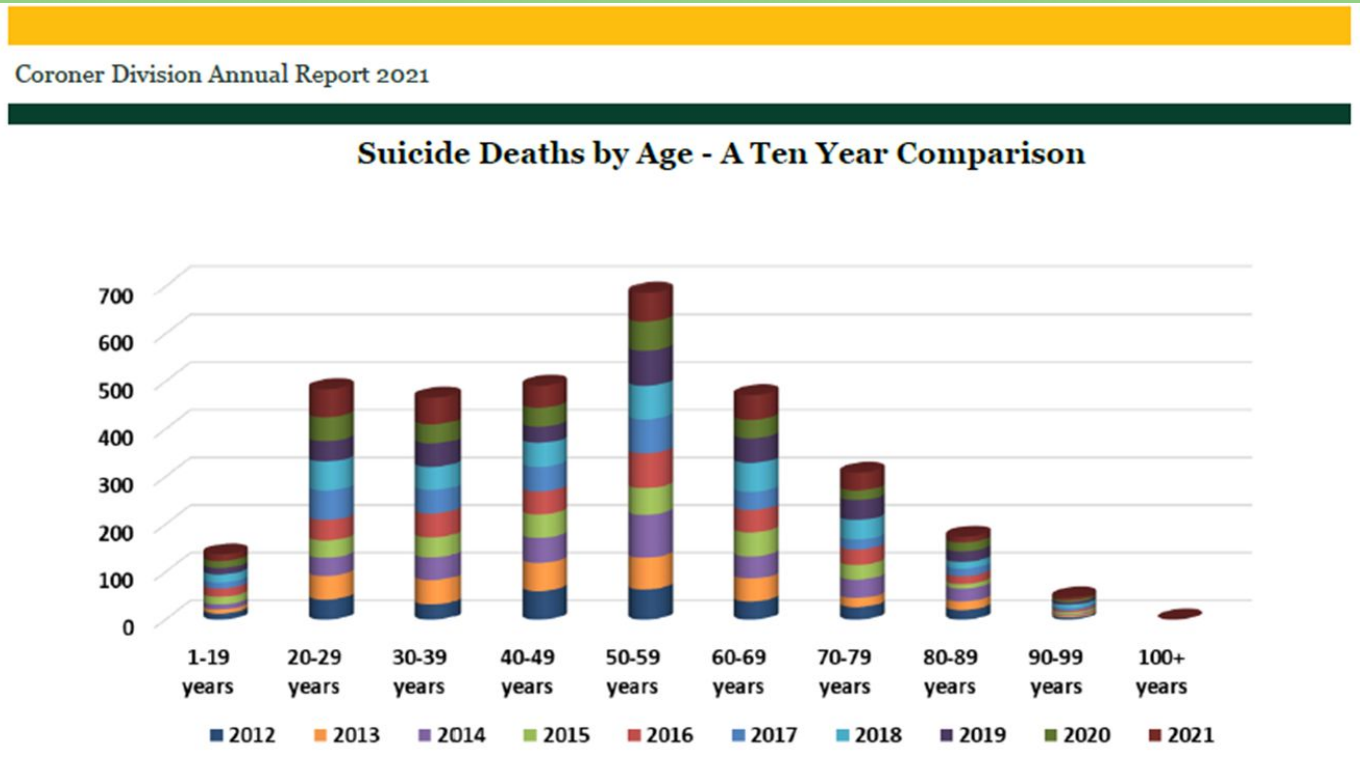


	1-19 years
2021	14
2020	15
2019	13
2018	17
2017	13
2016	17
2015	16
2014	11
2013	8
2012	13

OC Coroner Annual Report 2021

American Academy of Pediatrics
Orange County Chapter
INCORPORATED IN CALIFORNIA

ORANGE COUNTY SHERIFF'S DEPARTMENT

Coroner Division

Quarter 1 Comparison Report

Report time frame: January - March 2022
(comparing to: January - March 2021)

Total cases
861
(+1% from 849 in 2021)
Q1 Total include 4 cases pending and 13 cases undetermined

Accident
397
(+9%)

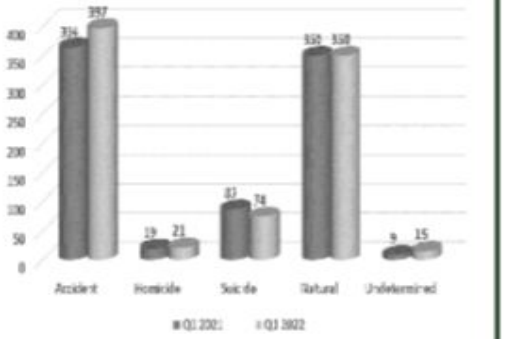
Homicide
21
(+10%)

Suicide
74
(-14%)

Natural
350
(0%)

MANNER OF DEATH

Comparing Quarter 1 of 2021 to 2022, accidental deaths have increased by 9%, homicides were up by 10%, suicides were down by 14%, and natural deaths falling under the jurisdiction of the Coroner remained the same.



Accidents

Unintentional prescription and illicit drug related deaths increased in 2022 to 57% of all accidental deaths when compared to the same time frame in 2021. Traffic related deaths accounted for 20% while falls were at 15%.

Unplanned deaths due to illicit or prescription drugs and/or ethanol toxicity increased by 8% in the first quarter of 2022 compared to the same time period in 2021 (210 to 227).

Methamphetamine appeared in 61% of all overdose cases which was a 13% increase compared to the first quarter of 2021.

Fentanyl related deaths also showed a 9% increase (154 to 168).

Falls decreased 3% in 2022 compared to 2021 (62 to 60) which makes them the third highest of all accidental death cases. Same level falls were most prevalent at 63% of all falls in 2022 which is 3% lower than 2021.

Vehicular traffic related deaths increased by 14% in comparison to 2021 (70 to 80) with Auto vs. Auto up 29% from 2021 (17 to 22).
Pedestrian deaths accounted for 25% of all vehicular deaths in Quarter 1 of 2022 while in 2021 they were at 41%.
Motorcycle related deaths saw a 43% increase (7 to 10).

Homicides

10%

INCREASE

In 62% of the cases a firearm was used.

Suicides

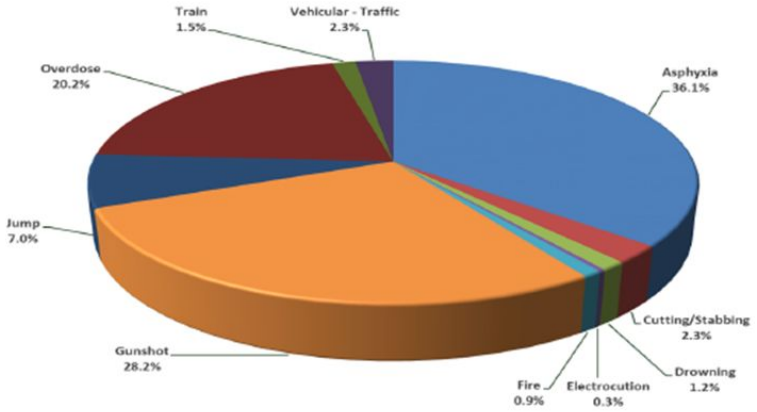
In Quarter 1 of 2022 there was a 14% decrease in suicides compared to Quarter 1 of 2021.

During this time frame gunshot was the leading method at 31% followed by asphyxia at 28%.

The work of the Coroner Division is largely based on Government Code § 27491, which states that all unnatural deaths including homicides, suicides, accidents, and deaths in custody are under the coroner/medical examiner's jurisdiction to investigate. Also falling under our jurisdiction are infectious diseases reaching epidemic proportions, deaths in state or local institutions, and deaths believed to be natural but that occurred suddenly and unexpectedly where the decedent had not seen their health care provider in the last 20 days of life. Note: All deaths that fall under § 27491 are also subject to whether the facts indicate the death occurred under natural circumstances and the physician of record has sufficient knowledge to reasonably state the cause of death occurred under natural circumstance. Therefore, not every death that falls under one of these categories will be investigated by the Coroner's office. See Govt Code § 27491.

*Due to some cases still under investigation within the quarter, manner of death counts and associated insights may adjust slightly as those cases are closed

Suicide Deaths by Cause, 2021



Type of Suicide	Number of Cases
Asphyxia	123
Cutting/Stabbing	8
Drowning	4
Electrocution	1
Fire	3
Gunshot	96
Jump	24
Overdose	69
Train	5
Vehicular - Traffic	8

Mental Health Connection

- Majority with hx depression/SI
- Many known to friends/family
- Some under current treatment at time of suicide
- Significant number with no previous history but with life stressors(social/school)
- Developmental disorders



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Youth Suicide Prevention in a Medical Setting

Heather Huszti, PhD

12.08.22



Disclosures

- I have no actual or potential conflict of interest in relation to this program/presentation

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Mental health disorders affect 1 in 5 US children each year

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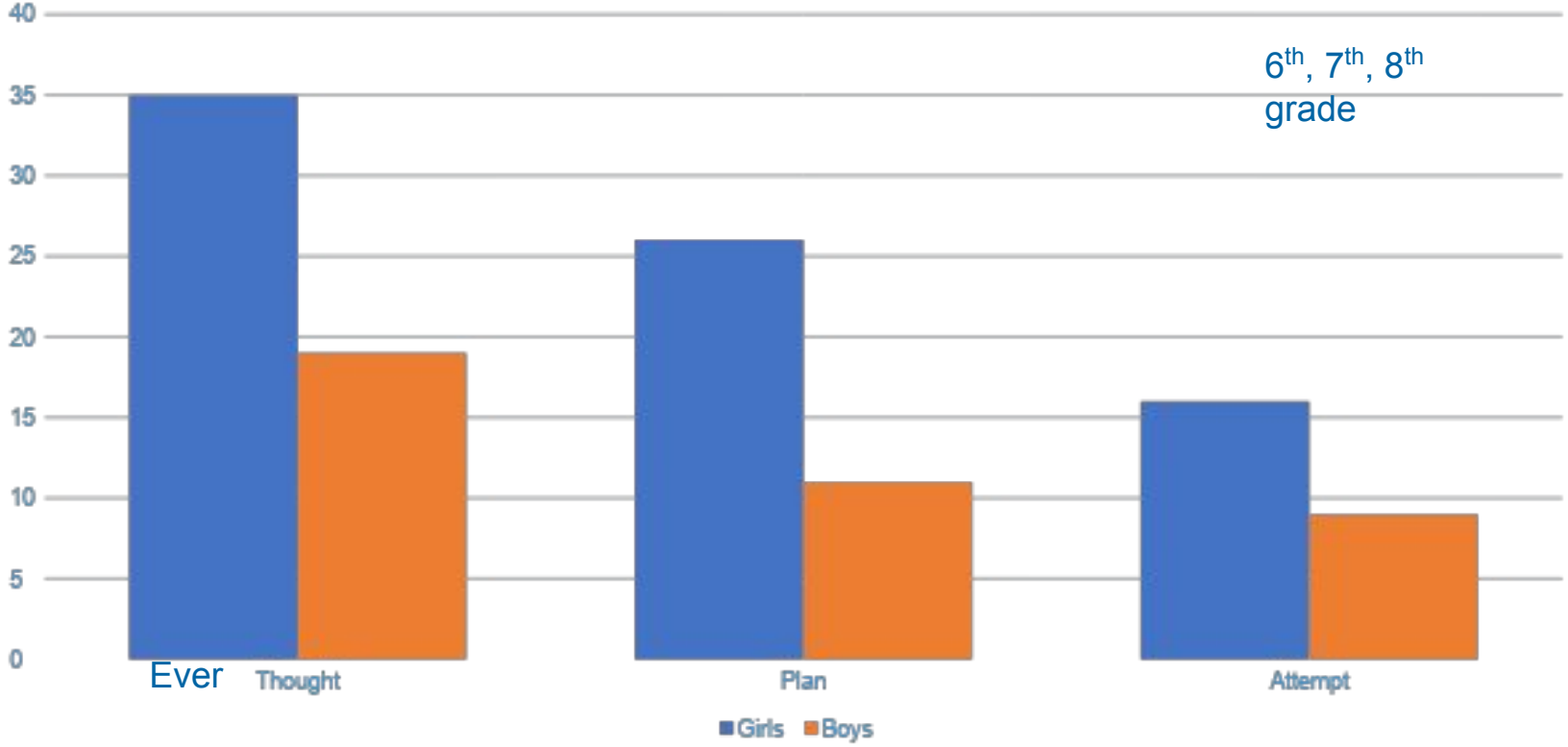
MENTAL HEALTH AND SUICIDE VARIABLES*

THE PERCENTAGE OF HIGH SCHOOL STUDENTS WHO:	2009 Total	2011 Total	2013 Total	2015 Total	2017 Total	2019 Total	Trend
Experienced persistent feelings of sadness or hopelessness	26.1	28.5	29.9	29.9	31.5	36.7	
Seriously considered attempting suicide	13.8	15.8	17.0	17.7	17.2	18.8	
Made a suicide plan	10.9	12.8	13.6	14.6	13.6	15.7	
Attempted suicide	6.3	7.8	8.0	8.6	7.4	8.9	
Were injured in a suicide attempt that had to be treated by a doctor or nurse	1.9	2.4	2.7	2.8	2.4	2.5	

Source: National Youth Risk Behavior Surveys, 2009-2019
*For the complete wording of YRBS questions, refer to Appendix.

In wrong direction | No change | In right direction

Middle School Students – Suicide Risk - 2019



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Pediatric Mental Health

- Growing concern prior to pandemic
- Review of 35 studies children and teens post COVID-19
  - Anxiety (28%) & depression (23%) most commonly reported
- Adolescent Behaviors and Experiences Survey (CDC)
  - Jan – June 2021; 9-12 grade; 7,705 national sample
  - More than 1/3 students experience poor mental health
  - 44% experienced persistent sadness 2 weeks or longer
  - 12% of female students, 25% of LGB students, 5% of male students attempted suicide during past year
  - 10% reported physical abuse in the home in past year
  - More than 1/3 reported negative treatment at school due to race or ethnicity

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Why Should Health Systems Be Involved?

- Claims reviewed patients with Medicaid, New York
- In the year before hospitalization for self-harm
- Primarily female, ages 15-34
- 69% received medical services 30 days before hospitalization
  - Medical more common than behavioral visits
  - Outpatient more common that ED or inpatient care
- 97% had services in the year before hospitalization
  - 73% behavioral, 90% medical

Kammer et al, 2021, J Behavioral Health Services Research

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Leading Causes of Death in 10-to 24-year-olds: United States, 2016-2020

Cause	% of Deaths
Accidents	70,310
Suicide	32,866
Homicide	26,893
Cancer	9,002
Heart Disease	5,023
Congenital anomalies	2,719

Data Source: Centers for Disease Control and Prevention WONDER data: Underlying Cause of Death, 1999-2020 Results Form (cdc.gov)

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Patient Opinions about Suicide Screening

- Asked series of questions about suicide risk
- Asked if ER nurses should ask the question
- All 156 patients supported idea that nurses should ask youth about suicide
- Themes:
  - (1) identification of youth at risk
  - (2) a desire to feel understood and known by clinicians
  - (3) connection of youth with help and resources
  - (4) prevention of suicidal behavior
  - (5) lack of other individuals to speak with about these issues

Patients' Opinions About Suicide Screening in a Pediatric Emergency Department

Elizabeth D. Ballard, MA,† Abigail Bosk, BA,* Deborah Snyder, LCSW, MSW,* Maryland Pao, MD,* Jeffrey A. Bridge, PhD,‡ Elizabeth A. Wharff, PhD,§|| Stephen J. Teach, MD, MPH,¶ and Lisa Horowitz, PhD, MPH**

Objective: Understanding how children react to suicide screening in an emergency department (ED) can inform implementation strategies. This qualitative study describes pediatric patients' opinions regarding suicide screening in that setting.

Methods: As part of a multisite instrument validation study, patients 10 to 21 years presenting with both psychiatric and nonpsychiatric complaints to an urban, tertiary care pediatric ED were recruited for suicide screening. Interviews with subjects included the question, "do you think ER nurses should ask kids about suicide/thoughts about hurting themselves…why/why not?" Responses were transcribed verbatim and uploaded into NVivo8.0 qualitative software for coding and content analysis.

Results: Of the 156 patients who participated in the study, 106 (68%) presented to the ED with nonpsychiatric complaints and 50 (32%) presented with psychiatric complaints. The patients' mean (SD) age was 14.6 (2.8) years (range, 10–21 years), and 56% of the sample was female. All patients answered the question of interest, and 149 (96%) of 156 patients supported the idea that nurses should ask youth about suicide in the ED. The 5 most frequently endorsed themes were as follows: (1) identification of youth at risk (31/156, 20%), (2) a desire to feel known and understood by clinicians (31/156, 20%), (3) connection of youth with help and resources (28/156, 18%), (4) prevention of suicidal behavior (25/156, 16%), and (5) lack of other individuals to speak with about these issues (19/156, 12%).

Conclusions: Pediatric patients in the ED support suicide screening after being asked a number of suicide-related questions. Further work should evaluate the impact of suicide screening on referral practices and link screening efforts with evidence-based interventions.

Key Words: suicide risk, screening, qualitative, patient opinion

(*Pediatr Emerg Care* 2012;28: 00–00)

Youth suicide is a global public health problem and the third leading cause of death among 10- to 24-year-olds in the United States.[1] According to the most recent Youth Risk Behavior Survey, 13.8% of high school students seriously thought about suicide in the past year, and 6.3% made an actual suicide attempt.[2]

Routine screening of pediatric patients in medical settings has been suggested as a way to identify youth with undetected mental health needs.[3] As a result, universal suicide screening has been proposed in both primary care settings and emergency departments (EDs).[4] For millions of children and adolescents, the ED is their only contact with health care providers.[5] As such, the ED may be uniquely situated to rapidly detect children and adolescents with unmet mental health needs presenting to the ED for both psychiatric and nonpsychiatric chief complaints.[4]

The onus of assessing suicide risk in a pediatric ED, regardless of chief complaint, falls mainly on nonpsychiatric clinicians because most pediatric EDs are not staffed with mental health professionals.[6] Unfortunately, brief instruments assessing suicidality in pediatric nonmental health patients are lacking. Although a large, multisite study aiming to develop such a tool to detect suicidality in nonpsychiatric patients is underway, it is essential to understand how children and adolescents will react to being questioned about suicide during an ED visit before implementing universal screening efforts. Whereas limited data suggest that pediatric patients are supportive of mental health screening[7] and there is no evidence that asking about suicide increases thoughts of suicidal ideation[8] or negative mood states,[9] there is little qualitative research assessing adolescent patients' opinions about suicide screening in the ED. Data on how pediatric patients respond and react to suicide screening in the ED are necessary to create the most effective, appropriate, and realistic strategies for intervention. Specifically, these data have the potential to inform screening practices and to provide assurance to nonpsychiatric clinicians that suicide assessments will be acceptable to patients. Therefore, the aim of this qualitative analysis was to describe the opinions of psychiatric and nonpsychiatric patients, aged 10 to 21 years, regarding universal suicide screening in the ED.

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Disclosure: The authors declare no conflict of interest.

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The research for this article was supported by the Intramural Research Program of the NIMH National Institutes of Health and the National Institute of Mental Health.

The views expressed in this article are those of the authors and do not necessarily represent the views of the National Institutes of Health, the Department of Health and Human Services, or any other government agency or official.

ISSN: 0749-5161

METHODS

Participant Population

As part of an ongoing, larger, multisite instrument validation study, a convenience sample of ED patients with both medical and psychiatric presenting complaints were recruited to participate in a suicide screening study. Participants included patients, aged 10 to 21 years, seeking care in an urban, tertiary care pediatric ED, with an annual census exceeding 80,000 visits. This age limit was chosen based on the ages of most patients seen at this particular pediatric ED. The study was conducted between September 2008 and April 2009. During the study period, trained study staff members were stationed in the ED during the week between the hours of 1:00 and 9:30 PM. To obtain target numbers of psychiatric and nonpsychiatric patients, every psychiatric patient and every second nonpsychiatric patient who entered the ED were approached for recruitment into the study.

LGBTQIA+ Differences

- Higher levels of suicide related risks
- 3x more likely to have attempted suicide
- Higher family rejection 8.4 times more likely to report having a suicide attempt
- LGBT and ethnic/racial differences
  - Asian Americans and Black Americans reported less ideation, planning, and self-harm that European American youth
  - NA/PI and Latinx reported more attempts than European American youth
- LGBT and gender
  - Females higher risk for all suicidal-related bx except attempts
- LGBT, ethnicity and gender
  - Asian American and Black American females less likely to have been involved in suicide-related behaviors than European American youth

CHOC

Bostwick, W.B., Meyer, I., Aranda, F., Russell, S., Hughes, T., Birkett, M., and Mustanski, B. (2014). Mental health and suicidality among racially/ethnically diverse sexual minority youths. American Journal of Public Health 104(6); 1129-1136

How Do I Screen?

- Ask Suicide Questions (ASQ) and BSSA follow-up
  - www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
  - Brief Suicide Safety Assessment (BSSA): www.nimh.nih.gov/research/research-conducted-at-nimh/bssa_outpatient_youth_asq_nimh_toolkit.pdf (nih.gov)
- PHQ-9-A
  - IHC MHI Depression Fact Sheet: Children and Adolescents (aacap.org)

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NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

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

   If yes, how? _____

   _____

   _____

   When? _____

   _____

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

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

   If yes, please describe: _____

Next steps:

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

Provide resources to all patients

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

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PHQ-A (Modified for Adolescents)

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)

How can you do this in busy office?

- Does not add time to visit
- Children will usually tell you if asked directly
- Do need to have plan for how to refer and to where for families and patients
- Identify and leverage resources in your community (County Behavioral Health, managed Medicaid plans, schools, community clinics)
- CA is making an investment in children's mental health, now is the time to make connections

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One model of screening

- Goal: screen all children 12 and older annually for depression, explicitly asking about suicide
  - Screen all children 8 and older with ASQ in ED regardless of reason for visit
- Automatic task to complete PHQ-9-A in clinics
- Scored and given to provider who reviews results
- Orders for mild, moderate, severe and suicidal risk patients
- Suicidal risk
  - Screen by behavioral health providers (psychologists or social workers)
  - Referral to Crisis Clinic (ideation without active plan)
  - Send to Emergency Dept if active plan

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We are not ready to screen, what else can I do?

- Using handouts from resources (following page) can provide anticipatory guidance
- Can let families know mental health is important and what symptoms to look for
- Can discuss depression and suicide as being more common during teen years and increase awareness
- Can ask if child or family is aware of counseling resources at school
- Can ask parents if they have ever asked their child about their mental health functioning to open a dialogue

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Questions/Dialogue Examples

- I know a lot of parents have asked me about depression and suicide as they are seeing more information about that in the news. Tell me what you know about those topics?
- Have you had a conversation with your child about mental health/wellness? If not, what are some things that get in the way of that? If so, what have you talked about (and praise parents for the conversation)
- Ask the teenager: What have your friends at school been saying about mental health issues?

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Resources

- Mental Health Toolkit
  - Depression - CHOC - Children's health hub
  - www.choc.org/MentalHealthToolkit (resources for providers, parents and children)
- AAP: Suicide: Blueprint for Youth Suicide Prevention
  - www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/
- Zero Suicide Institute
  - www.Zerosuicide.edc.org
- American Academy of Child and Adolescent Psychiatry: Suicide Resource Center
  - Suicide Resource Center (aacap.org)

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If we do not aim for zero deaths from suicide, how many deaths are we saying are acceptable?

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Questions

LONG LIVE CHILDHOOD

Contact: Heather Huszti, PhD / hhuszti@choc.org

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Need Help? Know Someone Who Does?

Contact the National Suicide Prevention Lifeline

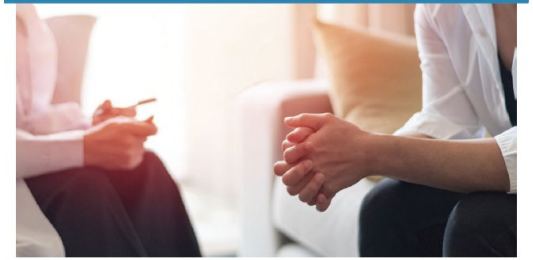
- Call 1-800-273-TALK (1-800-273-8255)
- Use the online Lifeline Crisis Chat

Both are free and confidential. You'll be connected to a skilled, trained counselor in your area.

For more information, visit the National Suicide Prevention Lifeline.

Didi Hirsch
MENTAL HEALTH SERVICES

Suicide Survivor Support Services



Health care providers, schools, therapists, and any other providers who identify/assess suicidal risk for their clients can refer directly to these programs:

- Individual/family counseling for children, teens, and adults who have had a suicide attempt or ideation
- Group counseling for individuals who have survived a suicide attempt
- Individual/group counseling for caregivers of survivors of suicide attempts and/or people experiencing suicidal thoughts
- Specialized outpatient counseling program for patients discharged from Orange County Hospitals, Emergency Departments and/or Crisis Stabilization Units

Services available AT NO COST to Orange County Residents

Make a Referral or Get Help Today

714-989-8311

crisiscare.org

Didi Hirsch
MENTAL HEALTH SERVICES

Individual/Family Therapy

The team at Didi Hirsch Counseling Services is comprised of clinicians who specialize in suicide prevention, intervention, and postvention. They are trained in CT-SP (Cognitive Therapy for Suicide Prevention), an evidence-based modality meant specifically to reduce suicidal thoughts and behaviors.

Specialized therapy is available for those who are struggling with suicidal thoughts or survived a suicide attempt. We help people enhance their resilience and develop strategies to keep themselves safe.

We are not afraid of discussing thoughts of suicide. We work collaboratively with clients to help them develop a comprehensive and effective safety plan unique to each individual; *hospitalization is a last resort*.

Care is available for children, teens and adults, as well as for caregivers who are supporting a person in need.

Contact us today:

714-989-8311

If you or a loved one is currently experiencing an emotional or suicidal crisis, call or text the 988 SUICIDE & CRISIS LIFELINE:

DIAL 9-8-8

988 SUICIDE & CRISIS LIFELINE

TAKE ACTION FOR MENTAL HEALTH · health CARE AGENCY · StigmaFreeOC

Resources

https://www.childrenshospitals.org/Newsroom/Press-Releases/2021/Mental-and-Behavioral-Health-Crisis-in-Children

https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Mental-Health/2021/strengthening_kids_mental_health_now_policy_one_pager_041221.pdf

https://www.beckershospitalreview.com/hospital-management-administration/this-is-our-epidemic-mental-health-crisis-is-kids-long-haul-covid-children-s-hospital-leaders-say.html

https://gazette.com/health/childrens-hospital-colorado-declares-state-of-emergency-over-mental-health-suicide/article_fdb821fe-bd9c-11eb-adfc-57c6f23e9b64.html

https://www.usnews.com/news/live-events/webinar-managing-childrens-mental-health-a-pediatric-hospital-imperative

https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_w#F1_down

https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_x

Thank You For Attending

Evaluation Form *(Please complete even if not needing CME):*
www.surveymonkey.com/r/CMEYouthSuicideUpdate120822

MOC-2 Post-Test *(Board Certified Pediatricians Only):*
www.surveymonkey.com/r/MOCYouthSuicideUpdate120822

The American Academy of Pediatrics, California Chapter 4 is accredited by the California Medical Association (CMA) to provide continuing medical education for physicians.

Successful completion of this CME activity, which includes participation in the activity and individual assessment of and feedback to the learner, enables the learner to earn up to 1 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABP MOC credit.

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