

# Emergency Mental Health Screening

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January 19, 2022

## Pediatric Mental Health Emergencies

- Suicidal ideation/intent
- Homicidal ideation/intent
- Psychosis

# Depression

- GLAD guidelines for Adolescent Depression in Primary Care
- Active monitoring
  - Schedule Frequent Visits
  - Recommend Peer Support Group (NAMI)
  - Review Self Management Goals (sleep, exercise, socialization)
  - Follow up with parents via telephone
  - Provide educational materials

## Depression (cont)

- Supportive Counseling and Problem Focused Therapy
  - Evidence Based Psychotherapy
    - CBT (cognitive behavioral therapy)
    - IPT-A (interpersonal Therapy for Adolescents)
- Evidence Based Pharmacotherapy
  - Fluoxetine/Prozac – First Line. 10 mg starting dose increase weekly to maximum of 60 mg.
  - Escitalopram/Lexapro – Second line. 5 mg starting dose increase weekly to 20mg daily

## PHQ-A

## PHQ-9: Modified for Teens

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling asleep, staying asleep, or sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Poor appetite, weight loss, or overeating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling tired, or having little energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things like school work, reading, or watching TV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <b>past year</b> have you felt depressed or sad most days, even if you felt okay sometimes? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you are experiencing any of the problems on this form, how <b>difficult</b> have these problems made it for you to do your work, take care of things at home or get along with other people? <input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult				
Has there been a time in the <b>past month</b> when you have had serious thoughts about ending your life? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you <b>EVER</b> in your <b>WHOLE LIFE</b> , tried to kill yourself or made a suicide attempt? <input type="checkbox"/> Yes <input type="checkbox"/> 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.*

## Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult...) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score  $\geq 10$  (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year...) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 as well as the two additional suicide items **MUST** be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	Depression Severity
0-4	No or Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

**COLUMBIA-SUICIDE SEVERITY RATING SCALE**  
Screen with Triage Points for *Primary Care*

Ask questions that are in bold and underlined.	Past month	
	YES	NO
<b>Ask Questions 1 and 2</b>		
<b>1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>		
<b>2) <u>Have you actually had any thoughts of killing yourself?</u></b>		
<b>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</b>		
<b>3) <u>Have you been thinking about how you might do this?</u></b> e.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."		
<b>4) <u>Have you had these thoughts and had some intention of acting on them?</u></b> as opposed to "I have the thoughts but I definitely will not do anything about them."		
<b>5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></b>		
<b>6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b>		Lifetime
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		Past 3 Months
<b>If YES, ask: <u>Was this within the past 3 months?</u></b>		
<b>Possible Response Protocol to C-SSRS Screening</b>		
Item 1 Behavioral Health Referral		
Item 2 Behavioral Health Referral		
Item 3 Behavioral Health Referral		
Item 4 Behavioral Health Consultation and Patient Safety Precautions		

## Safety Planning for ALL Adolescents with Depression

- Encourage Adolescent and Parents to make their home safe
  - ALL guns, ropes, cables should be removed from the home
  - All medications in the home secured in a lock box
- Ask about suicide – every visit
- Watch for suicidal behavior
  - Expressing self destructive thoughts
  - Drawing Morbid or death related images
  - Death as a theme during play (younger children)
  - Music that centers on death
  - Video games with self-destructive theme
  - Books/Television/Internet centered on Death
  - Giving away possessions
- Watch for signs of drinking/drug use
- Develop Safety Plan

## High Risk Teen Suicide Attempters

- SAD PERSONS (developed for use of all ages in the Emergency Room setting)
- Sex
  - More females attempt
  - More males complete (more lethal means)
- Age over 16
- Depression and comorbid conduct disorder/impulsive aggression/anxiety
- Previous attempts
- Ethanol use (substance use)
- Rational thinking lost (intoxication/psychosis)
- Social supports lacking
- Organized plan
- No significant other (confidante or trusted plan)
- Sickness (stressors)
- And First Degree Relative of a completer

## Suicide

- Higher Rates of Suicide
  - American Indian/Native Alaskan highest suicide rate
  - Sexual minority youth (lesbian, gay, bisexual, transgender or questioning)
- Leading methods for suicide
  1. Suffocation/hanging – 43%
  2. Discharge of firearms – 42%
  3. Poisoning – 6%
  4. Falling – 3%

## Fixed Risk Factors of Suicide

1. Family history of suicide attempts
2. History of adoption
3. Male gender
4. Parental mental health problems
5. Lesbian, gay, bisexual or questioning sexual orientation
6. Transgender identification
7. History of physical or sexual abuse
8. Prior suicide attempt
9. Personal mental health problems (sleep disturbance, depression, bipolar disorder, substance intoxication or substance use disorder, psychosis, post-traumatic stress disorder, panic attacks, history of aggression, impulsivity, severe anger and pathological internet use)
10. 70% increased in acute suicidal behavior in adolescent with psychosis.

## Social/Environmental Risk Factors of Suicide

- Bullying (both victimization and perpetration)
- Impaired parent-child relationship
- Living outside the home (homeless, living in corrections facility or group home)
- Difficulties in school
- Neither working nor attending school
- Social isolation
- Presence of stressful life events (legal or romantic difficulties/argument with parents)
- Unsupported social environment (for lesbian, gay, bisexual or transgendered adolescents)
- Internet use (>5 hours daily associated with higher depression and suicidality)

### Patient Safety Plan Template

<b>Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:</b>
1. _____
2. _____
3. _____
<b>Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):</b>
1. _____
2. _____
3. _____
<b>Step 3: People and social settings that provide distraction:</b>
1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____
<b>Step 4: People whom I can ask for help:</b>
1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____
<b>Step 5: Professionals or agencies I can contact during a crisis:</b>
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)
<b>Step 6: Making the environment safe:</b>
1. _____
2. _____
<small>Safety Plan Template ©2008 Barbara Stanley and Gregory G. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@cornell.edu or gregbrown@mail.med.cornell.edu</small>

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

\_\_\_\_\_

#### SAFETY PLAN

**3 THINGS** you like to do that help distract you from your problems and help your current mood.

1: \_\_\_\_\_

2: \_\_\_\_\_

3: \_\_\_\_\_

**2 FRIENDS** that you feel safe with and offer a healthy distraction.

1: \_\_\_\_\_

2: \_\_\_\_\_

**2 PLACES** that help you feel safe.

1: \_\_\_\_\_

2: \_\_\_\_\_

**3 HEALTHY CARING ADULTS** who you can trust and turn to for help.  
(i.e. an aunt/uncle, a friend's parent, your teacher, a school counselor, coach etc.)

<b>Name:</b>	
<b>Number:</b>	
<b>Name:</b>	
<b>Number:</b>	
<b>Name:</b>	
<b>Number:</b>	

#### OTHER RESOURCES

**Suicide Prevention Hotline (1-800-273-8255)**  
**Crisis Text Line: Text HOME to 741741**

**CHEO**  
**MY SAFETY PLAN**



A safety plan can help keep you safe, if you are feeling overwhelmed and having thoughts of ending your life. Making a plan like this will help you to understand yourself better, keeping you safer. It's important to share this plan with your parents or guardians and people close to you, so they can support you. If your needs or triggers change, revise your safety plan with your counsellor or therapist. If you don't have one, call your local Youth Crisis Line for help.

If you're still having trouble keeping yourself safe, you can always come back. Some youth like to get creative with their safety plans. Use art, music, scrapbooking or writing- whatever helps you to express yourself!

**My triggers**  
What are some things that set me off? How can I manage my triggers?

**My warning signs**  
What are my warning signs that tell me I'm starting to get overwhelmed? (for example, withdrawing from others or sleeping more)

<b>Thoughts</b> (example: thinking negative dark thoughts, or about ways to harm yourself)	<b>Emotions</b> (example: starting to feel hopeless guilty or angry)	<b>Body sensations</b> (example: a racing heart, feeling I'm suffocating)	<b>Behaviours</b> (example: pacing, spending lots of time sleeping)
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If parents and caregivers notice any of my warning signs, they can help by:

#BestLife for every child and youth

This reference is for educational purposes only. If you have any questions, ask your health care provider. August 2019 | Form PS608E | www.cheo.on.ca

**CHEO** **MY SAFETY PLAN**

**My coping strategies**  
What are some helpful things that will take my mind off the problem? (eg. going for a walk, calling a close friend to just vent, watching a movie, sleeping)

**Reasons for living**  
Who are the people or animals I live for? (eg. mother, father, brother, sister, friends, relatives or pets)

**What are other things I have to live for?** (eg. remembering that things will get better one day, future goals like school, career, travel or family goals)

Sometimes, when people are feeling sad, they have a hard time seeing the reasons for living. If this is the case for you right now, what are some reasons that others might point out for you?

**My support network**  
Who are main people that I can turn to for support if I am overwhelmed? (people to whom I can say, "Hey, I'm not feeling good right now, I really need someone to talk to. I don't need advice, I just need you to listen. Can we talk?")

**Someone to spend time with to take my mind off things:**

**Someone who can help with practical things (ex. taking me to appointments):**

**Someone who is a good listener:**

**Crisis plan and resources**  
If no one is available, what are the local telephone crisis lines in my area? Check the ones you like best.

- Child, Youth and Family Crisis Line for Eastern Ontario 613-260-2360 or toll-free, 1-877-377-7775
- Kids help phone: 1.800.668.6868 Live chat also available at www.kidshelpphone.ca
- Good2Talk: 1-866-925-5454 (for college and university students in Ontario).
- Ottawa and Region Distress Centre: 613-238-3311
- Youth Service Bureau 24/7 Crisis line: 613-260-2360

#BestLife for every child and youth

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- o [Diagnostic Folders](#)
- o [Education](#)
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- ▶ [Crisis Support](#)
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[North Dakota PMHCA Program](#) > [Resources](#)

## Crisis Support

If this a mental health emergency, call 9-1-1.



[Crisis Text Line](#)

Text HOME to 741741 to connect with a Crisis Counselor



[FirstLink](#) - Get Help Now

Offers free, confidential services in North Dakota and parts of Minnesota.



[National Helpline](#)

SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders.



[National Suicide Prevention Helpline](#) - 1-800-273-8255

Provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.



# Psychosis

- Delusions or hallucinations (auditory or visual)
  - Delusions more frequent in youth
- Onset 14-35
- 30% of those with schizophrenia make suicide attempt in lifetime

## Psychiatric symptoms associated with psychosis in children and adolescents

- Alcohol intoxication/withdrawal
- ADHD
- Autism
- Bipolar
- Brief Reactive Psychosis
- Catatonia
- Delirium
- Factitious disorder/malingering
- Major Depression with psychotic features
- Obsessive Compulsive Disorder
- Parasomnia
- Personality Disorder
- Post Traumatic Stress Disorder
- Schizophrenia/Schizoaffective Disorder
- Severe Stress

## Medical workup of psychosis

- Urine Drug Screen
- CBC/CMP
- EEG
- Structural imaging IF neurological findings

## Treatment of psychosis

FDA approved medications for Children 13 and older

- Aripiprazole
- Olanzapine
- Paliperidone
- Quetiapine
- Risperidone