Welcome to UVM/AHEC ECHO: Children’s Mental Health

Date: May 20th, 2021

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David Rettew, MD
Kathy Mariani, MD, MPH

Presenters:
Haley McGowan, DO
Yasmeen Abdul-Karim, MD
• RECORDING OF SESSION TO BEGIN
Managing Psychiatric Emergencies in the Primary Care Setting

Haley McGowan, DO
Yasmeen Abdul-Karim, MD
Agenda

• Introductions
• Objectives
• Didactic Presentation (15-20 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
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 1.0 AMA PRA Category 1 Credits. Participants should claim only the credit commensurate with the extent of their participation in the activity.

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.
Series Objectives

• By the end of this series, the learners should be able to:

  • Feel more comfort and confidence in identifying, treating, and referring a variety of complex children's mental health presentations.
Session Objectives

• By the end of this activity, the learners should be able to:
  • Identify common psychiatric diagnoses and symptoms that can lead to a psychiatric emergency.
  • Discuss screening, assessing, and triaging for suicidal ideation.
  • Discuss de-escalation techniques that could be used in the primary care setting.
  • Understand the process that occurs within the UVMMC Emergency Department for pediatric patients with psychiatric complaints.
Consider these primary care situations. Are these psychiatric emergencies?

- A 6 y/o boy this morning attacked his 3 y/o sister for taking his toy, leaving a bruise. He is also dysregulated in the office setting.

- A 13 y/o female is found to have 25-30 fresh superficial cuts on her upper thighs.

- A 15 y/o male screens positive for active suicidal thoughts but becomes agitated and tries to leave when you suggest a crisis evaluation.

- A 12 y/o 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
Screening for safety concerns

Screen all appropriate patients for suicidal ideation

Validated screening tools may include:

- Ask Suicide Screening Questions (ASQ)
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- PHQ-9 (modified for adolescents)
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).
- 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

The University of Vermont
LARNER COLLEGE OF MEDICINE
OFFICE OF PRIMARY CARE & AHEC PROGRAM
COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Primary Care

<table>
<thead>
<tr>
<th>Question</th>
<th>Past month</th>
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<tbody>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>2) Have you had any actual thoughts of killing yourself?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td>YES  NO</td>
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<tr>
<td>3) Have you been thinking about how you might do this?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>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.”</td>
<td>YES  NO</td>
</tr>
<tr>
<td>4) Have you had these thoughts and had some intention of acting on them?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>as opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
<td>YES  NO</td>
</tr>
<tr>
<td>5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td>YES  NO</td>
</tr>
<tr>
<td>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.</td>
<td>YES  NO</td>
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<tr>
<td>If YES, ask: Was this within the past 3 months?</td>
<td>YES  NO</td>
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Response Protocol to C-SSRS Screening
- Item 1 Behavioral Health Referral
- Item 2 Behavioral Health Referral
- Item 4 Behavioral Health Consultation and Patient Safety Precautions
- Item 5 Behavioral Health Consultation and Patient Safety Precautions
- Item 6 Behavioral Health Consultation (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions
### PHQ-9 modified for Adolescents (PHQ-A)

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling down, depressed, irritable, or hopeless?</td>
</tr>
<tr>
<td>2. Little interest or pleasure in doing things?</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much?</td>
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<tr>
<td>4. Poor appetite, weight loss, or overeating?</td>
</tr>
<tr>
<td>5. Feeling tired, or having little energy?</td>
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<tr>
<td>6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?</td>
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<tr>
<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
</tr>
<tr>
<td>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?</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>(0) Not at all</th>
<th>(1) Several days</th>
<th>(2) More than half the days</th>
<th>(3) Nearly every day</th>
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</table>

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)
Assessing the level of risk can help determine the level of care required and if a higher level of care is needed.

- Outpatient
- Crisis evaluation
- Emergency psychiatric evaluation

ASQ/Brief Suicide Safety Assessment (BSSA)

- Tool that can help with determining the level of risk and best next step
Assess the patient

Review patient’s responses from the asQ

- **Symptoms**
  - **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 groucher 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**
  - **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 a 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?
- Angry?
- Impulsive?
- Reckless?
- Hopeless?
- Irritable?
- Unable to enjoy the things that usually bring him/her pleasure?
- Withdrawn from friends or not being kept up with by him/herself?”

“Have you noticed changes in your child’s: 
- Eating pattern?
- Sleeping pattern?
- Appetite?”
“Does your child use drugs or alcohol?”
“Has anyone in your family/close friend network ever tried to kill themselves?”
“How are potentially dangerous items stored in your home?” (e.g., guns, medications, poisons, etc.)

“Does your child have a trusted adult they can talk to?” (Normalize that youth are often more comfortable talking to adults who are not their parents)
“Are you comfortable keeping your child safe at home?”

At the end of the interview, ask the parent/guardian: “Is there anything you would like to tell me in private?”

4. Make a safety plan with the patient

Include the parent/guardian, if possible.

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

- Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- Discuss means restriction (securing or removing lethal means): “Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?”
- Ask safety question: “Do you think you need help to keep yourself safe?” (A “no” response does not indicate that the patient is safe; but a “yes” is a reason to act immediately to ensure safety.)

Comments

NIH National Institute of Mental Health

asQ Suicide Risk Screening Toolkit

7/1/2020
5 Determine disposition

For all positive screens, follow up with patient at next appointment.

After completing the assessment, choose the appropriate disposition plan. If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.

- Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).
  Send to emergency department for extensive mental health evaluation (unless contact with a patient’s current mental health provider is possible and alternative safety plan for imminent risk is established).

- Further evaluation of risk is necessary:
  Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (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.

Comments

6 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
SUICIDE RISK SCREENING PATHWAY

Presentation to Outpatient Primary Care & Speciality Clinics
Screen all patients ages 10 above who meet any of the screening criteria.*

* SCREENING CRITERIA
1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening

Medically able to answer questions?

Administer ASQ (ideally separate from parents)

YES on any question 1-4 or refuses to answer?

YES to Q5?

Non-acute Positive Screen:
Conduct Brief Suicide Safety Assessment (BSSA)
Detailed instructions about the BSSA can be found at www.nimh.nih.gov/ASQ

BSSA outcome (three possibilities)

LOW RISK
No further evaluation needed at this time

FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible

IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation

OUTPATIENT PRIMARY CARE & SPECIALITY CLINICS

Screen at next visit

NEGATIVE SCREEN
Exit Pathway
**BSSA outcome**

- **LOW RISK**
  - No further evaluation needed at this time
  - Would benefit from a non-urgent mental health follow-up? Yes → **REFERRAL**
    - No referral needed at this time
      - No referral needed at this time
    - Yes → Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a mental health appointment
  - No referral needed at this time

- **FURTHER EVALUATION NEEDED**
  - Mental health referral needed as soon as possible
  - Make a safety plan with the patient and parent/guardian to activate as needed.
  - If mental health evaluation is not available within practice, refer to outpatient mental health clinician.

- **IMMINENT RISK**
  - Patient has acute suicidal thoughts and needs an urgent full mental health evaluation
  - **INITIATE SAFETY PRECAUTIONS**
    - Until able to obtain full mental health evaluation
    - Per institution protocol: keep patient under direct observation, remove dangerous items, provide safety education, etc.
  - Send to emergency department for full mental health/safety evaluation

**SAFETY PLANNING**

- Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
- Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
- Provide Resources: 24/7 National Suicide Prevention Lifeline
  - 1-800-273-TALK (8255)
  - En Español: 1-888-626-9454
  - 24/7 Crisis Text Line: Text “START” to 741-741

If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to evaluate need for ED visit.

Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made. Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.

*asQ -V- 4/2/2021*
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 (UVMMC ED) via parent or EMS/911 transport
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
De-escalation Strategies

- Always have two sets of eyes on the patient.
- Respect personal space while maintaining a safe position.
- Try not to stand over patients 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 patient’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 patient move in the room.
- Avoid power struggling and honor reasonable requests.
- Provide reassurances of safety.
Emergency Psychiatric Evaluation at UVMMC

- 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
• RECORDING TO BE STOPPED FOR CASE PRESENTATION
Cases/HIPAA

- 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
Questions and Concerns/Discussion
Conclusion

• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to Michael.Hoffnung@uvmhealth.org

• Please complete evaluation survey after each session

• Claim your CME at www.highmarksce.com/uvmmmed

• Please contact us with any questions, concerns, or suggestions
  • Michael.Hoffnung@uvmhealth.org
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  • ahec@uvm.edu