When The Kids Aren’t Alright

Evaluation and treatment strategies for childhood anxiety and depression
in primary care

Megan Chiarelli, MD
Child & Adolescent Psychiatry, General Psychiatry
Medical Director - Ambulatory Behavioral Health
Learning Objectives

- Gain familiarity with diagnostic criteria for depression and anxiety disorders in children
- When to consider the use of medications in children
- Understanding and discussing the “black box warning”
Disclosures

- None
Depression

- Clinical picture similar between children, adolescents, and adults
- Same DSM5 diagnostic criteria
- Children may have
  - Mood lability
  - Irritability
  - Low frustration tolerance
  - Tantrums
  - Somatic complaints
  - Social withdrawal
Children
- Mood lability
- Irritability
- Low frustration tolerance
- Boredom
- Behavior problems/tantrums
- Somatic complaints
- Social withdrawal
- Separation anxiety
- Phobias

Adolescents
- Mood lability
- Irritability
- Low frustration tolerance
- Boredom
- Behavior problems
  - “Atypical” symptoms
- Premenstrual dysphoria
- Suicidal ideation/attempts

Adults
- Major incidence of:
  - Melancholy
  - Psychosis
  - Suicide
Screening

- US Preventive Service Task Force recommends depression screening annually in all patients age 12 and older
- PHQ2 and PHQ9 (or PHQA) have shown good reliability for screening purposes
Screening

- US Preventive Service Task Force recommends depression screening annually in all patients age 12 and older
- PHQ2 and PHQ9 (or PHQA) have shown good reliability for screening purposes
## Screening - PHQ2

**Instructions:** How often have you been bothered by each of the following symptoms during the past 2 weeks? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th>Clinician Use Item score</th>
<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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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

1. Feeling down, depressed, irritable, or hopeless?

2. Little interest or pleasure in doing things?
Screening - PHQ2

- Screen for depression
Screening - PHQ2

- Screen for depression
  - NOT establish diagnosis
Screening - PHQ2

- Screen for depression
  - NOT establish diagnosis
  - NOT monitor symptoms
Screening - PHQ2

- Screen for depression
  - NOT establish diagnosis
  - NOT monitor symptoms
- Optimal cut point score of 3

<table>
<thead>
<tr>
<th>PHQ-2 Score</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Predictive Value (PPV(^*))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder (7% prevalence)</td>
<td>1</td>
<td>97.6</td>
<td>59.2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>92.7</td>
<td>73.7</td>
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<tr>
<td></td>
<td><strong>3</strong></td>
<td><strong>82.9</strong></td>
<td><strong>90.0</strong></td>
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<td></td>
<td>4</td>
<td>73.2</td>
<td>93.3</td>
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<td></td>
<td>5</td>
<td>53.7</td>
<td>96.8</td>
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<tr>
<td></td>
<td>6</td>
<td>26.8</td>
<td>99.4</td>
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</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>Any Depressive Disorder (18% prevalence)</td>
<td>1</td>
<td>90.6</td>
<td>65.4</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>82.1</td>
<td>80.4</td>
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<tr>
<td></td>
<td><strong>3</strong></td>
<td><strong>62.3</strong></td>
<td><strong>95.4</strong></td>
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<tr>
<td></td>
<td>4</td>
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<td>97.9</td>
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<tr>
<td></td>
<td>5</td>
<td>31.1</td>
<td>98.7</td>
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<tr>
<td></td>
<td>6</td>
<td>12.3</td>
<td>99.8</td>
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</tbody>
</table>
Screening - PHQ2

- Screen for depression
  - NOT establish diagnosis
  - NOT monitor symptoms
- Optimal cut point score of 3
- Administer PHQA or 9

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<tr>
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<td>92.7</td>
<td>73.7</td>
<td>21.1</td>
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<tr>
<td><strong>3</strong></td>
<td><strong>82.9</strong></td>
<td><strong>90.0</strong></td>
<td><strong>38.4</strong></td>
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<tr>
<td>4</td>
<td>73.2</td>
<td>93.3</td>
<td>45.5</td>
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<td><strong>62.3</strong></td>
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### Screening - PHQA

**Instructions:** How often have you been bothered by each of the following symptoms during the past 2 weeks? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th></th>
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<td>Little interest or pleasure in doing things?</td>
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<td>Trouble falling asleep, staying asleep, or sleeping too much?</td>
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<td>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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<td>7.</td>
<td>Trouble concentrating on things like school work, reading, or watching TV?</td>
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<td>Moving or speaking so slowly that other people could have noticed?</td>
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<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
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**Total/Partial Raw Score:**

**Prorated Total Raw Score:** (if 1-2 items left unanswered)
## Screening - PHQA

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**Clinician Use Item score**

**Total/Partial Raw Score:**

**Prorated Total Raw Score:** (if 1-2 items left unanswered)
Screening - PHQA or PHQ9

- Score from 0-27
- If 3+ questions are unanswered, you can’t use the score
- If 1-2 are unanswered, you can calculate a prorated score

<table>
<thead>
<tr>
<th>Total Raw Score</th>
<th>Severity of depressive disorder or episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>None</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe</td>
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Anxiety

- Generalized Anxiety Disorder
- Panic Disorder with/without Agoraphobia
- Agoraphobia
- Specific Phobia
- Social Anxiety Disorder
- Separation Anxiety Disorder
- Selective Mutism
- Obsessive Compulsive Disorder
- Posttraumatic Stress Disorder
Anxiety

- Generalized Anxiety Disorder
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What’s the difference?!
Anxiety

What’s the Fear?

- Generalized Anxiety Disorder
- Panic Disorder with/without Agoraphobia
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## Anxiety

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## What’s the Fear?

- Multiple
Anxiety

- Generalized Anxiety Disorder
- Panic Disorder with/without Agoraphobia
- Agoraphobia
- Specific Phobia
- Social Anxiety Disorder
- Separation Anxiety Disorder
- Selective Mutism
- Obsessive Compulsive Disorder
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What’s the Fear?

- Multiple
- The fear/panic attacks themselves
Anxiety

- Generalized Anxiety Disorder
- Panic Disorder with/without Agoraphobia
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- Social Anxiety Disorder
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What’s the Fear?

- Multiple
- The fear/panic attacks themselves
- Inability to escape or get help
Anxiety

- Generalized Anxiety Disorder
- Panic Disorder with/without Agoraphobia
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What’s the Fear?

- Multiple
- The fear/panic attacks themselves
- Inability to escape or get help
- One thing - eg heights, public speaking
Anxiety

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- Specific Phobia
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- Separation Anxiety Disorder
- Selective Mutism
- Obsessive Compulsive Disorder
- Posttraumatic Stress Disorder

What’s the Fear?

- Multiple
- The fear/panic attacks themselves
- Inability to escape or get help
- One thing - eg heights, public speaking
- Judgment
Anxiety

- Generalized Anxiety Disorder
- Panic Disorder with/without Agoraphobia
- Agoraphobia
- Specific Phobia
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What’s the Fear?

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- Speaking
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<tr>
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<tbody>
<tr>
<td>Multiple</td>
</tr>
<tr>
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</tr>
<tr>
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<tr>
<td><em>Losing major attachment figure</em></td>
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<tr>
<td><em>Speaking</em></td>
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Booted from the “Anxiety Disorders” chapter from DSM IV-TR to DSM 5...
Anxiety

- Generalized Anxiety Disorder
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- One thing - eg heights, public speaking
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- Speaking

Booted from the “Anxiety Disorders” chapter from DSM IV-TR to DSM 5...
The Disorders
Formerly Known as
Anxiety
The Disorders Formerly Known as Anxiety

- Obsessive Compulsive Disorder
- Posttraumatic Stress Disorder
The Disorders
Formerly Known as Anxiety

- Obsessive Compulsive Disorder

- Posttraumatic Stress Disorder

What’s the Fear?
The Disorders Formerly Known as Anxiety

- Obsessive Compulsive Disorder

- Posttraumatic Stress Disorder

What’s the Fear?

- Obsessions - ideas, thoughts, impulses, or images that produce marked anxiety

- Compulsions - repetitive behaviors or mental acts that relieve the anxiety
The Disorders Formerly Known as Anxiety

- Obsessive Compulsive Disorder
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What’s the Fear?

- Obsessions - ideas, thoughts, impulses, or images that produce marked anxiety
- Compulsions - repetitive behaviors or mental acts that relieve the anxiety
- Reexperiencing of an extremely traumatic event
  - Exposure to actual or threatened death, serious injury, or sexual violence
- Increased arousal
- Avoidance
- Negative alterations in cognitions and mood
The Disorders Formerly Known as Anxiety

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Video games and movies don’t count

- Increased arousal
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What’s the Fear?

- Obsessions - ideas, thoughts, impulses, or images that produce marked anxiety
- Compulsions - repetitive behaviors or mental acts that relieve the anxiety

Video games and movies don’t count
Stop watching “Five Nights at Freddy’s”

- Increased arousal
- Avoidance
- Negative alterations in cognitions and mood
The Disorders Formerly Known as Anxiety

- Obsessive Compulsive Disorder
- Posttraumatic Stress Disorder

What’s the Fear?

- **Obsessions** - ideas, thoughts, impulses, or images that produce marked anxiety
- **Compulsions** - repetitive behaviors or mental acts that relieve the anxiety
- **Reexperiencing of an extremely traumatic event**
  - Exposure to actual or threatened death, serious injury, or sexual violence
- **Increased arousal**
- **Avoidance**
- **Negative alterations in cognitions and mood**
Anxiety - What Is It?

- Brain response to danger
Anxiety - What Is It?

- Brain response to danger
- Not typically pathological, actually adaptive
Anxiety Can Be Your Friend

Yerkes-Dodson Correlation

Adapted from Yerkes & Dodson (1908)
Assessment of Anxiety

- ~20% of children and adolescents with diagnosable anxiety disorder
- Many more with subclinical symptoms
- Often low concordance between child and parent reports of anxiety
- Mothers tend to over-report anxiety symptoms
- Girls tend to report more than boys
Normal Fear and Worry

- Infants
  - Fear of loud noises
  - Fear of being startled
  - Fear of strangers (around 8 - 10 months)
Normal Fear and Worry

- Toddlers
  - Fears of imaginary creatures, animals
  - Fears of darkness
  - Fears of fire, water, thunder, lightning
  - Nightmares
  - Normative separation anxiety
Normal Fear and Worry

- School-age Children
  - Fears of imaginary creatures, animals, monsters, ghosts
  - Fears of fire, water, thunder, lightning, natural disasters
  - Fear of death/dying, traumatic events (e.g., getting hit by a car)
  - School anxiety
  - Performance anxiety
Normal Fear and Worry

- Adolescents
  - Fears related to school
  - Fears related to social competence/rejection
  - Fears related to health issues
Clinical Presentation

- Children with anxiety disorders may present with fear or worry but may not recognize their fears as unreasonable.
- Younger kids often cannot articulate their feelings, and so we often see physical symptoms (somatic) presenting first.
What To Look For

- Physical complaints/somatic symptoms
- Sleep
- Change in eating
- Avoidance of outside and interpersonal activities
- Excessive need for reassurance
- Inattention and poor school performance
- Not necessarily pervasive - some areas of function remain intact
- Explosive outbursts
Screening - SCARED
Screen for Child Anxiety Related Disorders

- Parent and Child Version

**SCORING:**
A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific. \[ TOTAL = \]
A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder or Significant Somatic Symptoms. \[ PN = \]
A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder. \[ GD = \]
A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety SOC. \[ SP = \]
A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder. \[ SC = \]
A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance. \[ SH = \]
## Mental Health Privacy

While Washington State’s general age of majority for health care is 18 (RCW 26.28.010), a single, unemancipated* minor can receive treatment without parental consent in the following areas:

<table>
<thead>
<tr>
<th>Service needed</th>
<th>Minor Consent Sufficient for Confidential Care</th>
<th>Parent/ Guardian Consent Required</th>
<th>Parent / Guardian Notification Required</th>
<th>Source and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical services:</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Non-emergency medical services:</td>
<td>No, unless minor meets Mature Minor Doctrine (see Source and Notes section)</td>
<td>Yes, unless minor meets Mature Minor Doctrine</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Immunizations:</td>
<td>No, unless minor meets Mature Minor Doctrine</td>
<td>Yes, unless minor meets Mature Minor Doctrine</td>
<td>No</td>
<td>Minor may receive immunizations without parental consent under the Mature Minor Doctrine summarized above.</td>
</tr>
<tr>
<td>Sexually transmitted disease testing/treatment (excluding HIV):</td>
<td>Yes, if over 14 + See Source and Notes section</td>
<td>No</td>
<td>No</td>
<td>Minor may obtain tests and treatment for sexually transmitted diseases if they are 14 years of age or older without the consent of a parent or guardian. RCW 70.64.110. *Public Health – Seattle &amp; King County will test and treat individuals regardless of age due to mandate to prevent and control the spread of communicable diseases.</td>
</tr>
<tr>
<td>Birth control services:</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Minor may obtain or refuse birth control services at any age without the consent of a parent or guardian. RCW 70.52.100(9).</td>
</tr>
<tr>
<td>Abortion services:</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Minor may receive an abortion and abortion-related services at any age without the consent of a parent, guardian or the father of the child. RCW 70.52.100(1), 70.52.505, 70.58.093(1979).</td>
</tr>
<tr>
<td>Prenatal care services:</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Minor may seek prenatal care at any age without the consent of a parent or guardian. RCW 70.52.100(1979).</td>
</tr>
<tr>
<td>Outpatient mental health treatment:</td>
<td>Yes, if over 13</td>
<td>No</td>
<td>No</td>
<td>Minor may receive outpatient mental health treatment if they are 13 years of age or older without the consent of a parent or guardian. The parents will not be notified without minor consent. RCW 70.54.250.</td>
</tr>
<tr>
<td>Inpatient mental health treatment:</td>
<td>Yes, if over 18</td>
<td>No</td>
<td>Yes</td>
<td>Minor 18 years of age or older may receive inpatient mental health treatment without parental consent. The parents must be notified. However, RCW 70.54.250.</td>
</tr>
<tr>
<td>Outpatient substance abuse treatment:</td>
<td>Yes, if over 13</td>
<td>No</td>
<td>See Source and Notes section</td>
<td>Minor 13 years of age or older may receive outpatient substance abuse treatment without parental consent. The provider will inform the parents that the minor is receiving outpatient treatment within seven business days if the minor gives written consent or if the provider determines that the minor is not capable of making a rational choice to receive the treatment. RCW 70.54.250.</td>
</tr>
<tr>
<td>Inpatient substance abuse treatment:</td>
<td>No, unless child is determined to be CHINS - Child in Need of Services</td>
<td>Yes, unless CHINS determination</td>
<td>Yes, unless CHINS determination</td>
<td>Minor 13 years of age or older may receive inpatient substance abuse treatment without parental consent if DSHS determines he or she is a &quot;child in need of services.&quot; RCW 70.54.250(3)(a)(iv). If school district personnel refer a child to inpatient chemical dependency services, they must notify the parents within 48 hours RCW 70.54.250. Parental notification is required if parental consent is required.</td>
</tr>
</tbody>
</table>
Mental Health Privacy

- It's about access for teens, not restricting access for parents
- Ideally, discuss limits and scope of confidentiality with both teen and parent present
- When to break confidentiality:
  - Imminent risk of harm to self
  - Imminent risk of harm to others
Mental Health Privacy

- RCW 71.05.012 (1a)
  - Legislative intent is to protect the health and safety of persons suffering from mental disorders and to protect public safety through use of the parens patriae and police powers of the state

- RCW 71.34.410
  - Liability for performance of duties under this chapter are limited...provided that such duties were performed in good faith and without gross negligence
Mental Health Privacy

- Some grey areas about breaking confidentiality
  - Non suicidal self injury
  - Substance use
  - Engaging in risky behaviors
- Partner with the teen about disclosing to parents
- Try the cross examination test
- Call risk management
Why treat

- Academic, interpersonal, and family complications
- Increased risk for suicide and other psychiatric problems (Eg conduct problems, abuse of substances)
- 35-50% of depressed teens make a suicide attempt
Young Adolescents as Likely to Die From Suicide as From Traffic Accidents

By SABRINA TAVERNESE NOV. 3, 2015

WASHINGTON — It is now just as likely for middle school students to die from suicide as from traffic accidents.

That grim fact was published on Thursday by the Centers for Disease Control and Prevention. They found that in 2014, the most recent year for which data is available, the suicide rate for children ages 10 to 14 had caught up to their death rate for traffic accidents.

The number is an extreme data point in an accumulating body of evidence that young adolescents are suffering from a range of health problems associated with the country’s rapidly changing culture. The pervasiveness of social networking means that entire schools can witness someone’s shame, instead of a gaggle of girls on a school bus. And with continual access to such networks, those pressures do not end when a child comes home in the afternoon.

“It’s clear to me that the question of suicidal thoughts and behavior in this age group has certainly come up far more frequently in the last decade than it had in the previous decade,” said Dr. Maxine L. Home, a clinical...
National Center for Health Statistics: April 2016

Adolescent Suicides
Among children aged 10 to 14, death by suicide is now more common than death from traffic accidents.

- Traffic accidents
- Suicide
- Homicide

- 4 deaths per 100,000
- 3
- 2
- 1

Screening - C-SSRS

- Columbia Suicide Severity Rating Scale
- Can be a useful tool to assess safety
- Free online
## Screening - C-SSRS

### SUICIDAL IDEATION

**Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 1 is "yes", ask questions 3, 4, and 5. If the answer to question 1 and/or 2 is "yes", complete "Intention of Ideation" section below.**

#### Part 1: month

<table>
<thead>
<tr>
<th>Question</th>
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<th>Partial Risk</th>
<th>Suicide Attempt</th>
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<tbody>
<tr>
<td>1. <strong>Wish to be Dead</strong>&lt;br&gt;Subject thoughts about wish to be dead or easy to imagine, or wish to fall asleep and not wake up.&lt;br&gt;How you would express that wish or wish you could die or be dead?&lt;br&gt;How you would end your life or kill yourself?&lt;br&gt;How you ever had such thoughts or wishes?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2. <strong>Non-Specific Active Suicidal Thoughts</strong>&lt;br&gt;General, non-specific thoughts of death or end of life by suicide (e.g., &quot;I’ve thought about killing myself&quot;) without thoughts of ways to kill oneself or specific methods, intent, or plan during the assessment period.&lt;br&gt;How often you think about something or make you yourself or others uncomfortable?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3. <strong>Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</strong>&lt;br&gt;Active thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan that has clear plans and descriptions about specific methods, intent, or plan during the assessment period.&lt;br&gt;How you think about something or make you yourself or others uncomfortable?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4. <strong>Active Suicidal Ideation with Some Intent to Act, without Specific Plan</strong>&lt;br&gt;Active suicidal thoughts of killing oneself and subject reports having some intent to act in each episode, as opposed to &quot;have the thoughts but don’t say or do anything about them.&quot;&lt;br&gt;When you think about making yourself or another person uncomfortable (killing yourself), did you think you were going to succeed?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>5. <strong>Active Suicidal Ideation with Specific Plan and Intent</strong>&lt;br&gt;Thoughts of killing oneself with plans and descriptions, and subject reports having some intent to act in each episode, as opposed to &quot;have the thoughts but don’t say or do anything about them.&quot;&lt;br&gt;How you think about something or make you yourself or others uncomfortable?</td>
<td>Yes</td>
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**Interruption:**<br>This is different from the above being thoughts but knowing you wouldn’t do anything about it.

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<td>8. <strong>Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</strong>&lt;br&gt;Active thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan that has clear plans and descriptions about specific methods, intent, or plan during the assessment period.&lt;br&gt;How often you think about something or make you yourself or others uncomfortable?</td>
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<td>9. <strong>Active Suicidal Ideation with Some Intent to Act, without Specific Plan</strong>&lt;br&gt;Active suicidal thoughts of killing oneself and subject reports having some intent to act in each episode, as opposed to &quot;have the thoughts but don’t say or do anything about them.&quot;&lt;br&gt;When you think about making yourself or another person uncomfortable (killing yourself), did you think you were going to succeed?</td>
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<td>Yes</td>
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<td>10. <strong>Active Suicidal Ideation with Specific Plan and Intent</strong>&lt;br&gt;Thoughts of killing oneself with plans and descriptions, and subject reports having some intent to act in each episode, as opposed to &quot;have the thoughts but don’t say or do anything about them.&quot;&lt;br&gt;How you think about something or make you yourself or others uncomfortable?</td>
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### INTENSITY OF IDEATION

The following behavior should be noted with respect to the most recent type of ideation (i.e., “1” from above, with 2 being the least severe and 3 being the most severe).

<table>
<thead>
<tr>
<th>Type</th>
<th>Description of Ideation</th>
<th>Most Severe</th>
<th>Most %</th>
<th>Most %</th>
<th>Most %</th>
<th>Most %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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</table>

**Frequency**<br>How many times have you had these thoughts?<br>Write response:
- Once a time<br>None of times<br>At a time<br>For all the time<br>Don’t know/Not applicable

---

### SUICIDAL BEHAVIOR

**Check all that apply; as long as these are separate events, must ask about all types.**

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<td>1. <strong>Attempted</strong>&lt;br&gt;A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was past thought or method of die is not required for intent. If there are any thoughts about how to commit suicide, then it can be considered an actual suicide. There do not have to be any injury or harm, just the potential for injury or death. If person plans or deliberately plans to kill self in the near future, but is not immediately acting, it is considered as attempt.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>2. <strong>Partial Risk</strong>&lt;br&gt;A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was past thought or method of die is not required for intent. If there are any thoughts about how to commit suicide, then it can be considered an actual suicide. There do not have to be any injury or harm, just the potential for injury or death. If person plans or deliberately plans to kill self in the near future, but is not immediately acting, it is considered as attempt.</td>
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<td>No</td>
<td>Yes</td>
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<td>3. <strong>Suicide Attempt</strong>&lt;br&gt;A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was past thought or method of die is not required for intent. If there are any thoughts about how to commit suicide, then it can be considered an actual suicide. There do not have to be any injury or harm, just the potential for injury or death. If person plans or deliberately plans to kill self in the near future, but is not immediately acting, it is considered as attempt.</td>
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<tr>
<td>4. <strong>Attempted</strong>&lt;br&gt;A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was past thought or method of die is not required for intent. If there are any thoughts about how to commit suicide, then it can be considered an actual suicide. There do not have to be any injury or harm, just the potential for injury or death. If person plans or deliberately plans to kill self in the near future, but is not immediately acting, it is considered as attempt.</td>
<td>Yes</td>
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<td>Yes</td>
</tr>
<tr>
<td>5. <strong>Partial Risk</strong>&lt;br&gt;A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was past thought or method of die is not required for intent. If there are any thoughts about how to commit suicide, then it can be considered an actual suicide. There do not have to be any injury or harm, just the potential for injury or death. If person plans or deliberately plans to kill self in the near future, but is not immediately acting, it is considered as attempt.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>6. <strong>Suicide Attempt</strong>&lt;br&gt;A potentially self-injurious act committed with at least some wish to die, as a result of an act. Behavior was past thought or method of die is not required for intent. If there are any thoughts about how to commit suicide, then it can be considered an actual suicide. There do not have to be any injury or harm, just the potential for injury or death. If person plans or deliberately plans to kill self in the near future, but is not immediately acting, it is considered as attempt.</td>
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</tr>
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**Interruption:**<br>This is different from the above being thoughts but knowing you wouldn’t do anything about it.
Screening - C-SSRS
Suicidal Ideation

- Active suicidal ideation with specific plan and intent
- Active suicidal ideation with some intent to act, without specific plan
- Active suicidal ideation with any methods (not plan) without intent to act
- Non-specific active suicidal thoughts
- Wish to be dead
Treatment

- Anxiety and Depression are treated essentially identically
- Psychoeducation
- Psychotherapy
- Pharmacotherapy
- Best outcomes with combined CBT and antidepressant
Treatment

- For a patient with
  - Mild depression
  - Mild psychosocial impairment
  - Brief depression
- Begin with education, support, and case management related to possible environmental stressors in the family and school
- If after 4-6 weeks of treatment these patients do not respond, offer more specific types of treatment
Treatment

- If the patient has any of the following conditions, psychotherapy alone may not be sufficient
  - Severe depression/melancholic symptoms
  - Chronic depression
  - Psychosis
  - Seasonal depression
  - Patient, family, and/or therapist factors (e.g. lack of motivation, no expertise)
Treatment

- Best outcomes with combined CBT and antidepressant
Treatment - SSRIs

- Fluoxetine has the most data to support its use in children/adolescents
  - Start at 10 mg for 1 week, then increase to 20 mg
  - Therapeutic dose range 20-80 mg
- Sertraline
  - Start at 25-50 mg for 1 week, then double
  - Therapeutic dose range 50-200 mg
  - Average response dose in one study of 137 mg
- Citalopram
  - Start at 10 mg for 1 week, then increase to 20 mg
  - Therapeutic dose range 20-40 mg
- Escitalopram
  - Start at 5 mg for 1 week, then increase to 10 mg
  - Therapeutic dose range 10-30 mg
Treatment - SNRIs

- Venlafaxine XR
  - Start at 37.5 mg daily for 1 week, then increase to 75 mg daily
  - Therapeutic dose range 75-375 mg daily
- Duloxetine
  - Start at 30 mg daily for 2 weeks, then increase to 60 mg daily
  - Therapeutic dose range 60-120 mg daily
- Desvenlafaxine
  - ?
Treatment - Atypical Antidepressants

Mirtazapine
- More sedating at lower doses
- Adjunct for sleep
- Start at 15 mg QHS
- Therapeutic dose range 15-45 mg QHS
Bupropion

- **Bupropion SR**
  - Start at 3-6 mg/kg/day up to 100 mg daily
  - BID medication
  - Therapeutic dose range 150-400 mg daily

- **Bupropion XL**
  - Start at 150 mg daily
  - Once daily
  - Therapeutic dose range 150-450 mg daily
Treatment

- Atomoxetine: not effective for depression, unimpressive in anxiety + ADHD
  - <70 kg: start 0.5 mg/kg/day (or divide BID), target 1.2 mg/kg/day, max 1.4 mg/kg/day
  - >70 kg: start 40 mg/day (or divide BID), target 80 mg/day, max 100 mg/day
- Buspirone: not effective for depression
  - 15-60 mg daily divided BID
Treatment

- Paroxetine: June 2003 FDA recommended not using in children/adolescents
- Tricyclic antidepressants: not effective
  - In some cases may be helpful as an augmenting agent
  - Still used cautiously in management of migraine, OCD, ADHD, and nocturnal enuresis
  - Serious cardiotoxicity risk in overdose
- Antipsychotics
  - May have a role in treatment resistant depression as an augmenting agent
  - *Probably not within the scope of primary care*
Treatment

- Benzodiazepines
Treatment

- Benzodiazepines
Treatment

Benzodiazepines

HOW ABOUT NO
Treatment

Benzodiazepines
No Benzodiazepines
Treatment:

- Benzodiazepines
Treatment

Benzodiazepines
Treatment

- Benzodiazepines
Black Box Warning

“Tell your doctor right away if your depression worsens, you have unusual changes in behavior, or thoughts of suicide. Antidepressants can increase these in children, teens, and young adults.”
Clinical Worsening and Suicide Risk Patients with Major Depressive Disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and others) showed that these drugs increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with Major Depressive Disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older.

The pooled analyses of placebo-controlled trials in children and adolescents with MDD, Obsessive Compulsive Disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 295 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77,000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug versus placebo), however, were relatively stable within age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in Table 2.

No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide. It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression. All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for Major Depressive Disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient’s presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see Warnings and Precautions (5.13)). Families and caregivers of patients being treated with antidepressants for Major Depressive Disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers. Prescriptions for PROZAC should be written for the smallest quantity of capsules consistent with good patient management, in order to reduce the risk of overdose. It should be noted that PROZAC is approved in the pediatric population only for Major Depressive Disorder and Obsessive Compulsive Disorder. Safety and effectiveness of PROZAC and dlanzepine in combination in patients less than 18 years of age have not been established.
Black Box Warning

Clinical Worsening and Suicide Risk Patients with Major Depressive Disorder (MDD) and other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4400 patients. There was a trend toward an increase in the number of cases of suicidality per 1000 patients treated by age group at 18 to 64 years and age 65 years and older.

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Black Box Warning

- Patients with Major Depressive Disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications.
- Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide.
Black Box Warning

- 2004 FDA issues a black box warning for increasing suicidal thoughts and behaviors for those age 24 and younger
- There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD
- No suicides occurred in any of the pediatric trials
- There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide
- It is unknown whether the suicidality risk extends to longer-term use
- There is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression
Black Box Warning

- In 2003 to 2004, after the ‘black-box’ warning, pediatric antidepressant prescriptions declined and suicide rates increased 11%.
- Pooled adverse event data from 24 pediatric antidepressant trials totaling >4,400 patients showed a higher risk of suicidal ideation or behavior (no suicides occurred) with antidepressants (4%) vs placebo (2%).
- Systematically collected suicide-related item scores from 17 of the trials showed no evidence that antidepressants worsen suicidality or cause it to emerge.
Black Box Warning

- An independent meta-analysis examined the pediatric trial data used in the FDA meta-analysis plus 7 additional studies. Its findings differ in 2 important ways from those of the FDA review:
  - Antidepressants, including others besides Fluoxetine, showed efficacy in treating anxiety disorders and depression in children and adolescents
  - The frequency of suicide-related adverse events (no trial patients committed suicide) was approximately 3% on active medication—25% lower than the FDA estimated rate—and 2% on placebo, similar to the FDA estimate
Black Box Warning

- The number needed to treat (NNT)—number of patients who must be treated to get a therapeutic response that would not have happened with placebo—ranged from 3 to 10
- The number needed to harm (NNH)—number of patients who must be treated for 1 suicidal ideation/non-fatal attempt to occur that would not have happened with placebo—ranged from 112 to 200
Black Box Warning

- Relative risk for suicidality ranged 10-fold among agents, from 0.9 with Fluoxetine to 8.8 with Venlafaxine
- Most suicide-related events occurred in subjects having the highest baseline levels of suicidality
- Hostility and agitation emerged with SSRI use, particularly during the first month of treatment
- Patient age, sex, or history of suicide attempt/ideation did not affect the results
Suicide

- More than 90% of pediatric patients that die by suicide have a mental illness
- Firearms are the most common method of death by suicide
- Ingestions are the most common attempts
- No data to support the use of “no-suicide contracts”
Suicidal Ideation

- If you have concern for imminent risk of self to harm or others, refer for hospitalization
  - King County Crisis and Commitment (206) 421-3222
  - Send to ER by ambulance
- If risk is determined not to be imminent, talk to parents about safety proofing the home. Securing the following:
  - Medications, including OTC, pets’, and daily Rx
  - Firearms should be removed
  - If not removed, should be stored unloaded and locked in a separate location from ammunition, with a biometric lock
When to Consult or Refer

- Patients who are not improving with usual care
- Diagnostic clarification
- Medication evaluation
- Patients whom you envision maintaining long-term care with occasional input from psychiatry
Swedish Behavioral Health

- Psychiatric consultation for Swedish primary care physicians
- Consultations are brief (usually 1-3 visits) and are meant to stabilize to return to primary care for ongoing management
- Referrals to community providers will be necessary if longer-term treatment is needed
- Place referral in EPIC
  - Adult: AMBR0716*SMG Behavioral Health Psychiatry (Benner, Dinsio, Lang-Furr, Karz, Nielsen, Turner, Waghray, Waring)
  - Pediatric: AMBR0756*SMG Behavioral Health Child/Adolescent Psychiatry (Benner, Chiarelli, Waring, Yu)
Who might not be a good fit for behavioral health consultation?

- Acutely suicidal, homicidal, or gravely disabled patients requiring urgent ED evaluation
- Patients currently tiered with community mental health
- Patients currently connected with an outpatient psychiatric treatment team or provider
Resources

- National Suicide Prevention Lifeline
  - (800) 273-TALK
  - Live online chat available
- King County Crisis Line 24/7
  - (866) 427-4747
  - Crisisclinic.org
- Children’s Crisis Outreach Response System
  - (206) 461-3222
- Text Crisis Line 24/7
  - Text “help” to 741-741
- Lok It Up (firearm safe storage information)
  - Lokitup.org
Resources

- Parentsmedguide.org (depression)
- AACAP Practice Parameters & Clinical Practice Guidelines
- AACAP Facts for Families
- SCARED (free) [www.wpic.pitt.edu/research](http://www.wpic.pitt.edu/research) under “tools and assessments”
- PHQ (free)
Resources

- System Adult and Adolescent Depression Pathway
- Swedish Behavioral Health
  - (206) 320-2961
- Partnership Access Line (PAL)
  - (866) 599-PALS
  - PALforkids.org
- American Academy of Child & Adolescent Psychiatry practice parameters
- Children’s Crisis Outreach Response System (CCORS)
  - (206) 461-3222
References

- Available by request (there's a lot) 😊