PPS-PSCAP-PPA Task Force on Mental Health

Child and Adolescent Mental Health within REACH

(Resiliency, Empathy, Acceptance, Connection, Hope)

Jacqueline O. Navarro, MD, FPPS, FPSDBP, MClinEpid

Education and Training

- Doctor of Medicine, UP College of Medicine
- Pediatric Residency, The Medical City
- Fellowship, Developmental Pediatrics, John Hunter Children's Hospital, NSW, Australia
- Observership, Dept of Pediatrics, Subsection of Developmental-Behavioral Pediatrics, Yale University School of Medicine, Connecticut, USA
- Master of Clinical Epidemioloy, University of Newcastle, NSW, Australia

Current Positions/Affiliations

- Vice President, Philippine Society for Developmental and Behavioral Pediatrics
- Assistant Secretary, Philippine Pediatric Society
- Consultant Director, Center for Developmental Pediatrics, The Medical City
- Training Officer, Institute of Pediatrics, The Medical City

Screening for Depression, Anxiety and Suicide

Jacqueline O. Navarro, MD, FPPS, FPSDBP

Developmental and Behavioral Pediatrician

Outline

- Screening Tools: How to administer, score and interpret
  - PHQ-9
  - GAD-7
  - C-SSRS
- Algorithm on what to do after getting a positive result on the screening tools

When do we use Screening Tools

- If you have concerns about a child or adolescent
- If you see red flags, risk factors or warning signs
- Screening tools further refine risks which would help you decide what to do next

Patient Health Questionnaire 9 (PHQ 9)

Patient Health Questionnaire (PHQ-9)

- Self-administered instrument consisting of nine questions that assess the severity of **depression symptoms** (DSM-5)
- For 12 years and older
- A PHQ-9 score of 11 or more had a sensitivity of 89.5% and a specificity of 77.5% for major depression
- Each item asks the individual to rate the severity of his or her symptoms over the past two weeks
- Response options include “not at all”, “several days”, “more than half the days” and “nearly every day”

Kroenke et al. PHQ9. J Gen Intern Med 2001: 16: 606-613
Sun et al. BMC Psychiatry (2020) 20:474

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

SIGNIFICANT SCORE: Answered 1, 2 or 3 on Question 9

Total Score of 11 or higher

TASK FORCE ON MENTAL HEALTH

PPS · PSCAP · PPA

Name: _____ Date: _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Nitong nakaraang 14 na araw, gaano ka kadalas binagabag ng alinman sa mga sumusunod na mga problema?)* *Use "✓" to indicate your answer (Lagyan ng "✓" ang iyong sagot)*	Not at all *(Hindi kailanman)*	Several days *(Maraming Araw)*	More than half the days *(Lagpas sa kalahati ng bilang ng mga araw)*	Nearly every day *(Halos araw-araw)*
1. Little interest or pleasure in doing things *(Di gaanong interesado o nasisiyahan sa paggawa ng mga bagay)*	0	1	2	3
2. Feeling down, depressed, or hopeless *(Pakiramdam na nalulungkot, nadidipress o nawawalan ng pag-asa)*	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much. *(Hirap na makatulog o manatiling tulog, o labis na pagtulog)*	0	1	2	3
4. Feeling tired or having little energy *(Pagkaramdam ng pagod o walang lakas)*	0	1	2	3
5. Poor appetite or overeating *(Kawalan ng ganang kumain o labis na pagkain)*	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down *(Pagkaramdam ng masama tungkol sa iyong sarili — o nabigo ka o nabigo mo ang iyong sarili o ang iyong pamilya)*	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television *(Hirap magtuon ng pansin sa mga bagay, tulad ng pagbabasa ng dyaryo or panonood ng telebisyon)*	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual *(Pagkilos o pagsasalita ng mabagal na maaring napansin ng ibang tao? O ang kabaligtaran — pagiging alumpihit o di mapakali kaya ikot nang ikot nang higit sa karaniwan)*	0	1	2	3
9. Thoughts that you would be better of dead of or hurting yourself in some way *(Nag-iisip na mas mabuting mamatay ka na lang o saktan mo ang iyong sarili sa ilang paraan)*	0	1	2	3
FOR OFFICE CODING	Total Score: _____			

PHILIPPINE PEDIATRIC SOCIETY 1947

TASK FORCE ON MENTAL HEALTH
PPS · PSCAP · PPA

Management

SCORE	DEPRESSION SEVERITY	COMMENTS
0-4	Minimal or None	Monitor, may not require treatment
5-9	Mild	Use clinical judgement (symptom duration, functional impairment) to determine necessity of treatment
10-14	Moderate	
15-19	Moderately Severe	Warrants active treatment with psychotherapy, medications or combinations
20-27	Severe	

ADVICE

Final diagnosis should be made with clinical interview and mental status examination including assessment of patient's level of distress and functional impairment

https://www.mdcalc.com/phq-9-patient-health-questionnaire-9#next-steps

Critical Actions

- Perform suicide risk assessment in patients who respond positively to item 9 “thoughts that you would be better off dead or of hurting yourself in some way.”
- Rule out bipolar disorder, normal bereavement and medical disorders causing depression

https://www.mdcalc.com/phq-9-patient-health-questionnaire-9#next-steps

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + 3 + 8 + 6 =Total Score: 17

SIGNIFICANT

Management

SCORE	DEPRESSION SEVERITY	COMMENTS
0-4	Minimal or None	Monitor, may not require treatment
5-9	Mild	Use clinical judgement (symptom duration, functional impairment) to determine necessity of treatment
10-14	Moderate	
15-19	Moderately Severe	Warrants active treatment with psychotherapy, medications or combinations
20-27	Severe	

https://www.mdcalc.com/phq-9-patient-health-questionnaire-9#next-steps

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + 6 + 2 + 0

=Total Score: 8

SIGNIFICANT

General Anxiety Disorder 7-item Anxiety Scale (GAD-7)

General Anxiety Disorder
7-item Anxiety Scale (GAD-7)

- Used to measure or assess the severity of generalized anxiety disorder
- For 12 years and older
- Sensitivity of 89% and Specificity of 82%
- Each item asks the individual to rate the severity of his or her symptoms over the past two weeks
- Response options include “not at all”, “several days”, “more than half the days” and “nearly every day”

Spitzer RL et al. ArchInternMed.2006; 166:1092-1097

GAD-7 Scoring

- The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively, and then adding together the scores for the seven questions.
- GAD-7 total score for the seven items ranges from 0 to 21

Spitzer RL et al. ArchInternMed.2006; 166:1092-1097

GAD-7

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

Spitzer RL et al. ArchInternMed.2006; 166:1092-1097

Management

SCORE	SYMPTOM SEVERITY	COMMENTS
5-9	Mild	Monitor
10*-14	Moderate	Possible clinically significant condition
> 15	Severe	Active treatment probably warranted

*** For Panic Disorder, Social Phobia and PTSD, cutoff score of 8 may be used for optimal sensitivity/specificity**

https://www.mdcalc.com/gad-7-general-anxiety-disorder-7#next-steps

Management

SCORE	SYMPTOM SEVERITY	COMMENTS
5-9	Mild	Monitor
10*-14	Moderate	Possible clinically significant condition
> 15	Severe	Active treatment probably warranted

MANAGEMENT

Scores ≥ 10: Further assessment (including diagnostic interview and mental status examination) and/or referral to a mental health professional recommended

https://www.mdcalc.com/gad-7-general-anxiety-disorder-7#next-steps

GAD-7

MANAGEMENT

Scores ≥ 10: Further assessment (including diagnostic interview and mental status examination) and/or referral to a mental health professional recommended

3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

otals 0 + 3 + 6 + 3 =

Total score 12

SIGNIFICANT

Spitzer RL et al. ArchInternMed.2006; 166:1092-1097

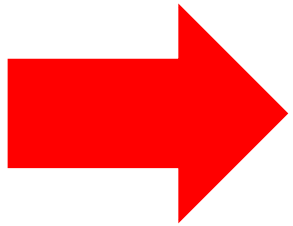
Critical Actions

- This tool should be used for screening and monitoring symptom severity and should not replace a clinical assessment and diagnosis
- Do not forget to rule out medical causes of an anxiety disorder (e.g. ECG for arrhythmias, TSH for thyroid disease)

https://www.mdcalc.com/gad-7-general-anxiety-disorder-7#next-steps

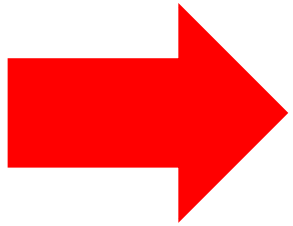
For Significant Scores

Significant scores for GAD-7



Refer

Significant scores for PHQ-9



Screen for suicidality (C-SSRS)
Refer

Screening for Suicidality (C-SSRS)

- **Columbia Suicide Severity Rating Scale**
- Gold standard in suicide assessment
- Is clinician administered and rated; questions have already been phrased for use in an interview format
- Designed for use by health care professionals, including pediatricians and primary care providers without specialized mental health training
- Makes distinction between suicidal ideation and behavior, allowing for stratification of risk and treatment planning

Screening for Suicidality (C-SSRS)

- Remember that Suicidal Ideation falls along a spectrum of severity, and this severity determines the best course of action:

1. Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up

2 Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan."

Screening for Suicidality (C-SSRS)

3. Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period.

- This is different than a specific plan with time, place or method details worked out. “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.”

Screening for Suicidality (C-SSRS)

4. Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “I have the thoughts but I definitely will not do anything about them.”

5. Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

Screening for Suicidality (C-SSRS)

- 6. **Suicidal Behavior** is distinct and can occur apart from Suicidal Ideation

  - 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.

  - ***Non Suicidal Self-Injury - harm to self without intent to die; can still result in morbidity and mortality

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.*" ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** 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. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Screening for Suicidality and Self Harm

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan."* ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		

Screening for Suicidality and Self Harm

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** 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. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Answers to C-SSRS
"YES" to Questions **4,5 or 6**
"YES" to Question 3
"YES" OR “No” to Questions 1 or 2 AND "NO" to Question 6
"NO" to Questions 1 and 2 AND "YES" to Question 6

Answers to C-SSRS	Risk Assessment
"YES" to Questions 4 **4,5 or 6**	High Risk
"YES" to Question 3	Medium Risk
"YES" OR "No" to Questions 1 or 2 AND "NO" to Question 6	Low Risk
"NO" to Questions 1 and 2 AND "YES" to Question 6	*Possible Non-Suicidal Self-Injurious Behavior Medium or High Risk (depending on clinical judgment)

Answers to C-SSRS	Risk Assessment	Recommended Course of Action
"YES" to Ques[redacted]or 6 **4,5 or 6**	High Risk	Counseling / Psychoeducation and Inpatient Safety Planning with Pediatrician and Admission to Hospital with referral to a Psychiatrist OR Same day outpatient consult with a Child and Adolescent Psychiatrist (facilitated by the Pediatrician)
"YES" to Question 3	Medium Risk	Counseling / Psychoeducation and Outpatient Safety Planning with Pediatrician with Outpatient referral to a Psychiatrist
"YES" OR "No" to Questions 1 or 2 AND "NO" to Question 6	Low Risk	Counseling/Psychoeducation and Outpatient Safety Planning with Pediatrician with possible Referral to a Psychologist, School Counselor, Adolescent Medicine Specialist or a Psychiatrist
"NO" to Questions 1 and 2 AND "YES" to Question 6	*Possible Non-Suicidal Self-Injurious Behavior Medium or High Risk (depending on clinical judgment)	Depending on clinical judgment, follow recommendations for high risk or medium risk

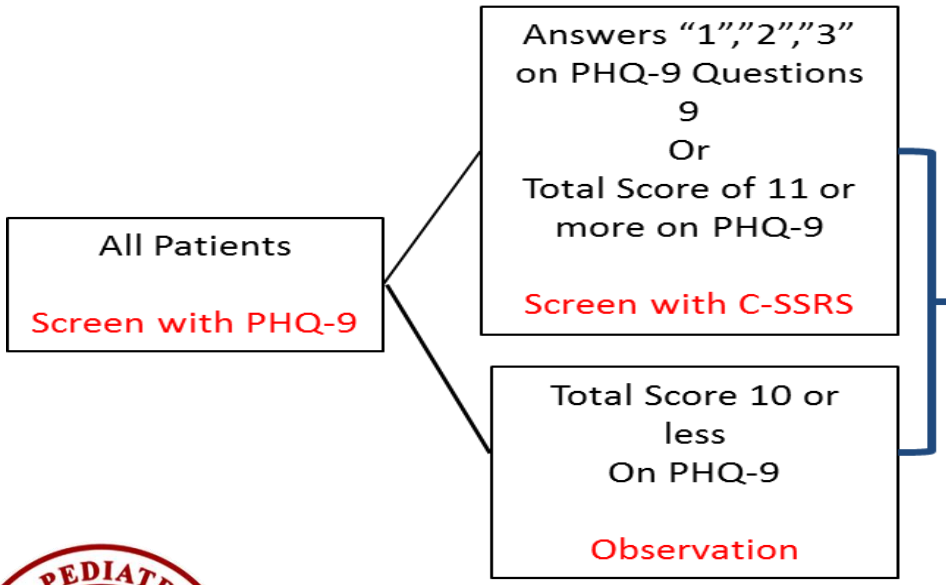
Self-Report Screening

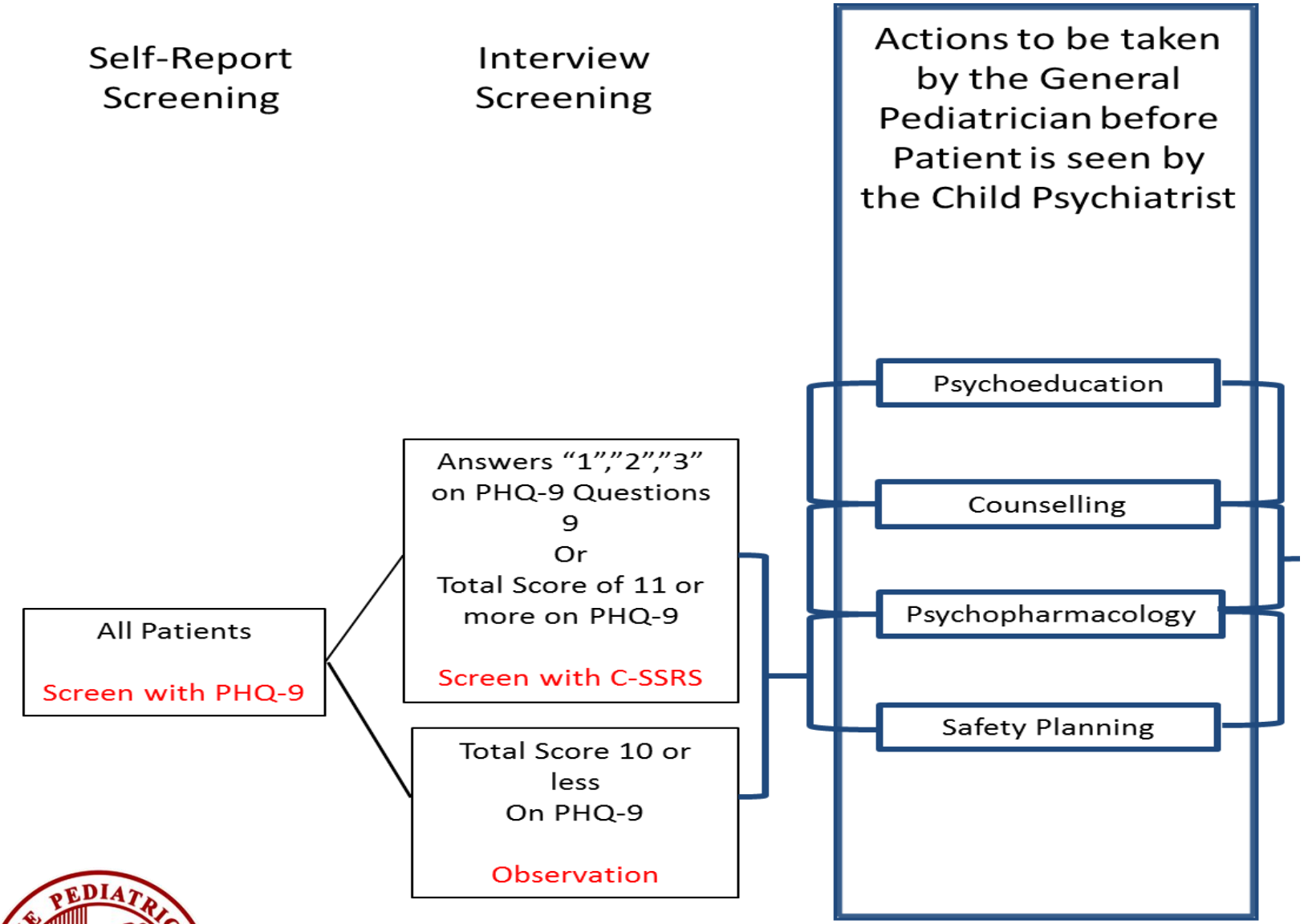
All Patients

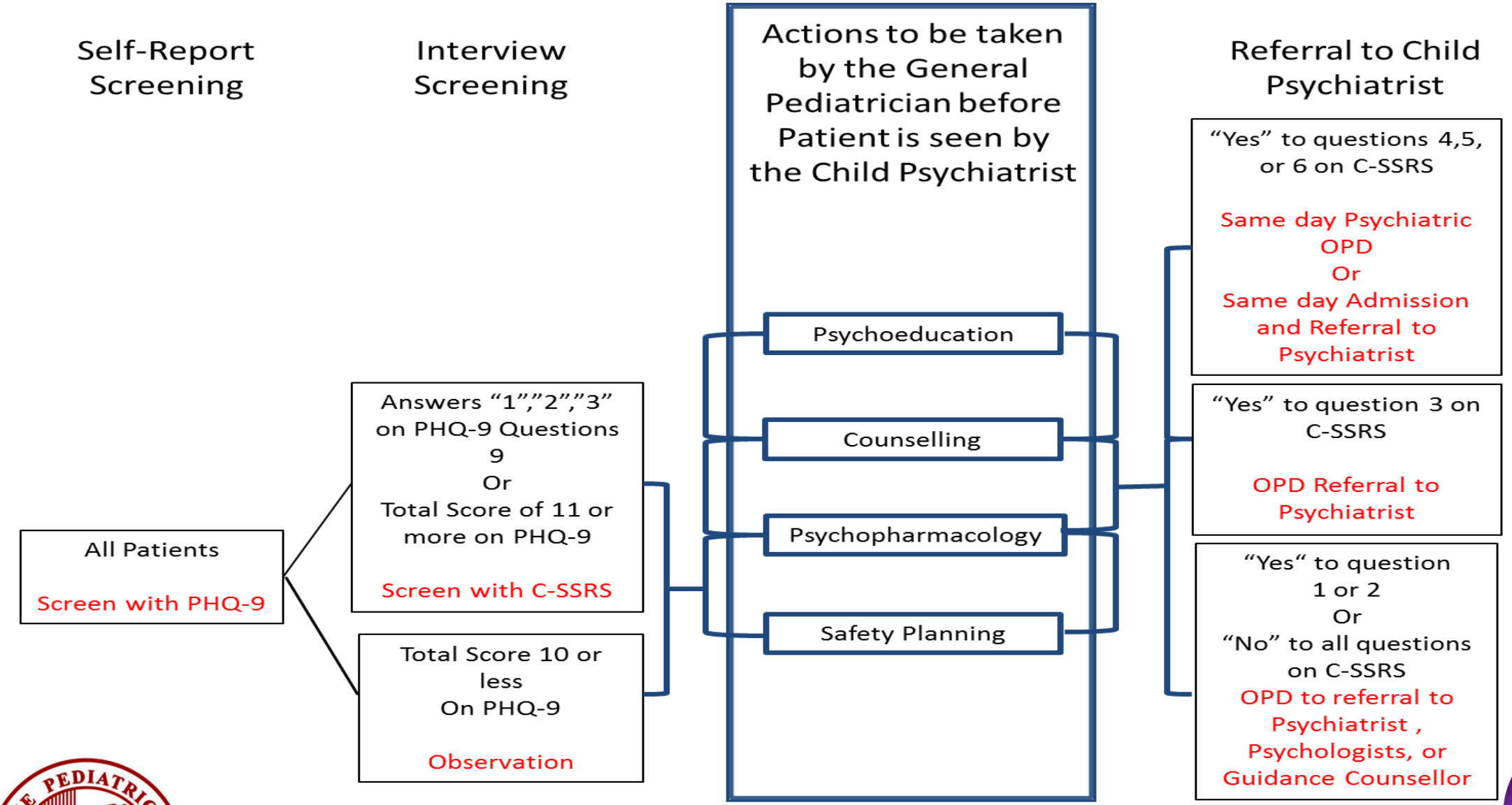
Screen with PHQ-9

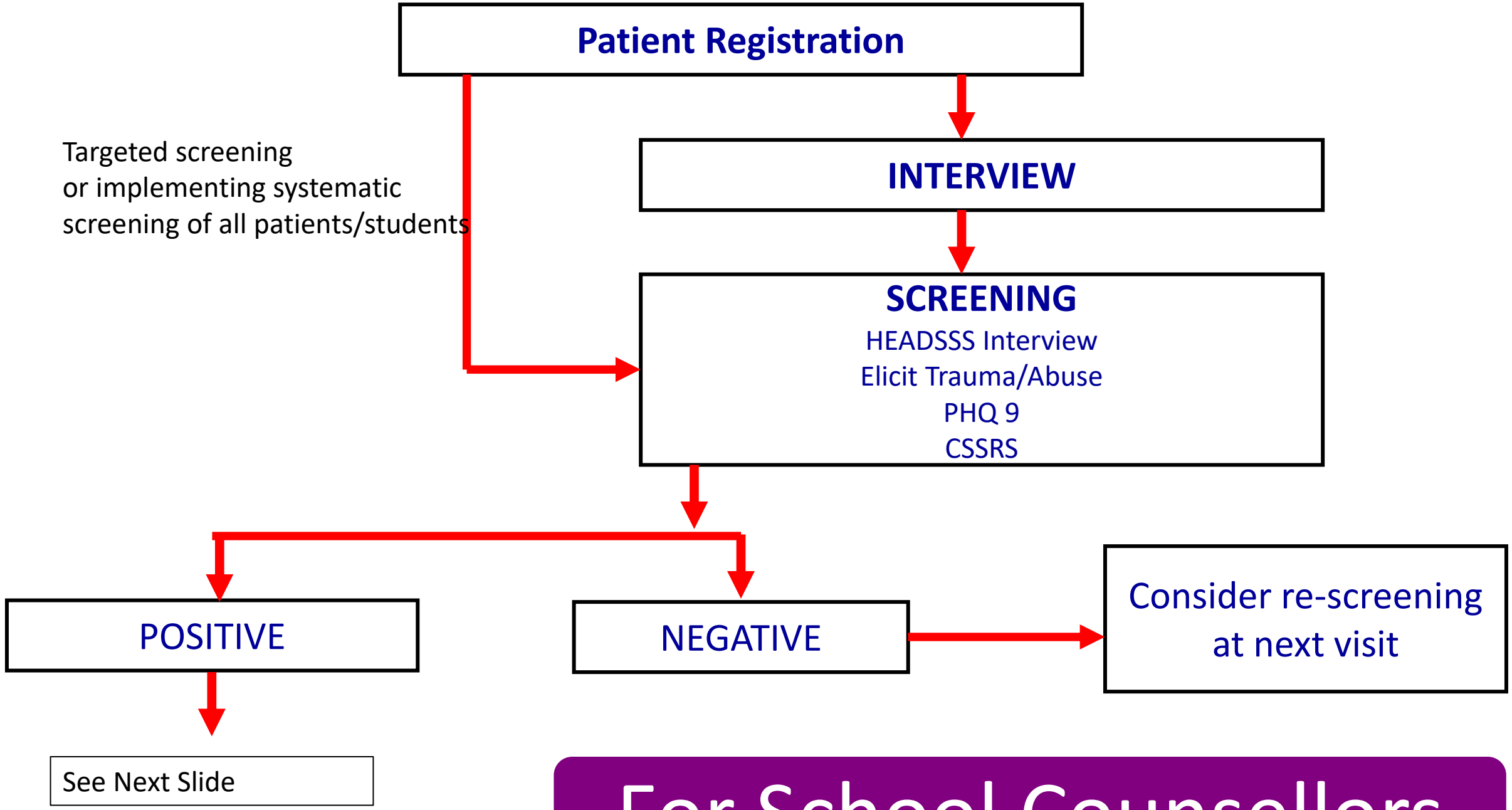
Self-Report Screening

Interview Screening

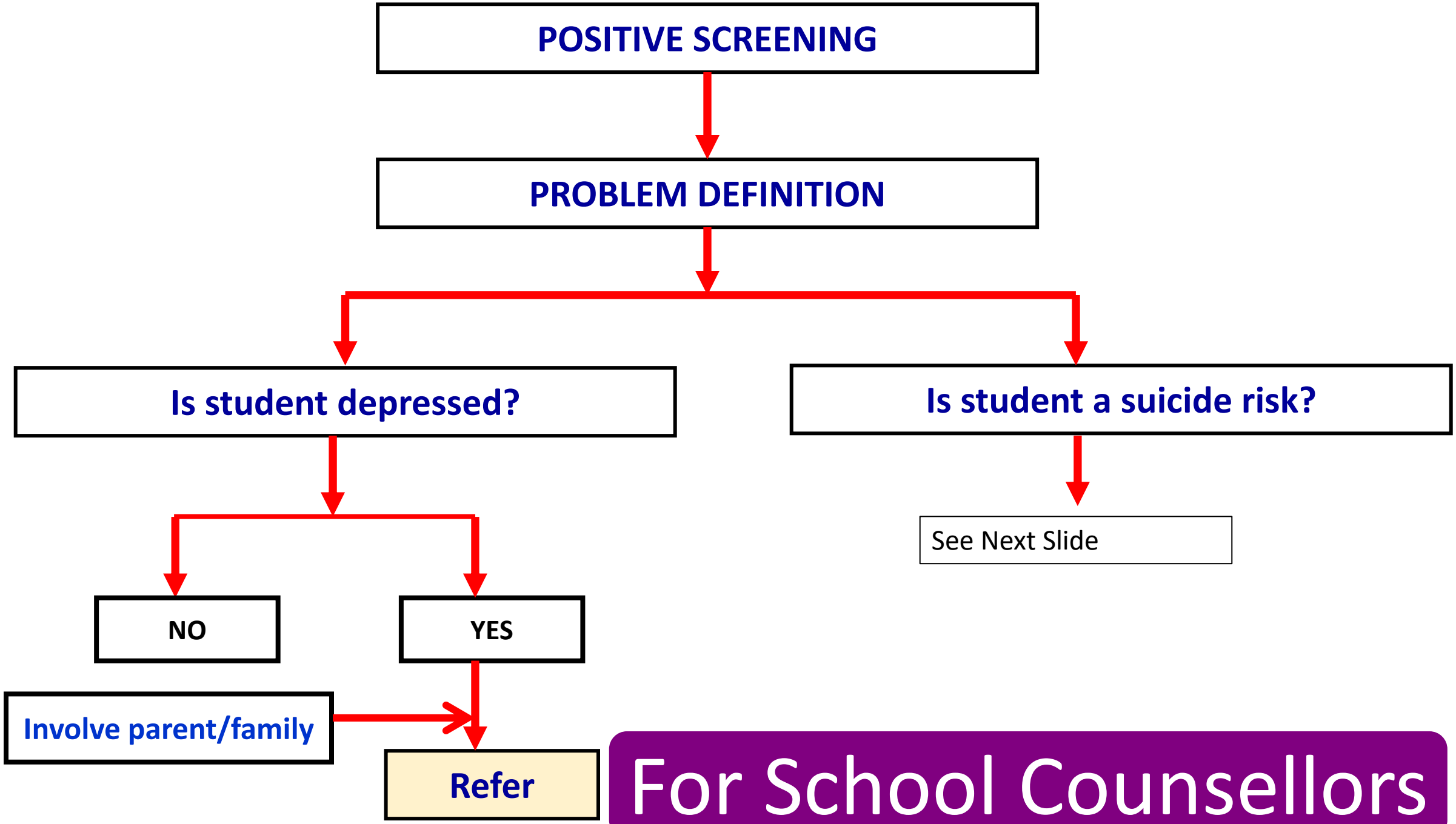



Self-Report Screening
Interview Screening
Actions to be taken by the General Pediatrician before Patient is seen by the Child Psychiatrist
All Patients
Screen with PHQ-9
Answers "1","2","3" on PHQ-9 Questions 9
Or
Total Score of 11 or more on PHQ-9
Screen with C-SSRS
Total Score 10 or less
On PHQ-9
Observation
Psychoeducation
Counselling
Psychopharmacology
Safety Planning

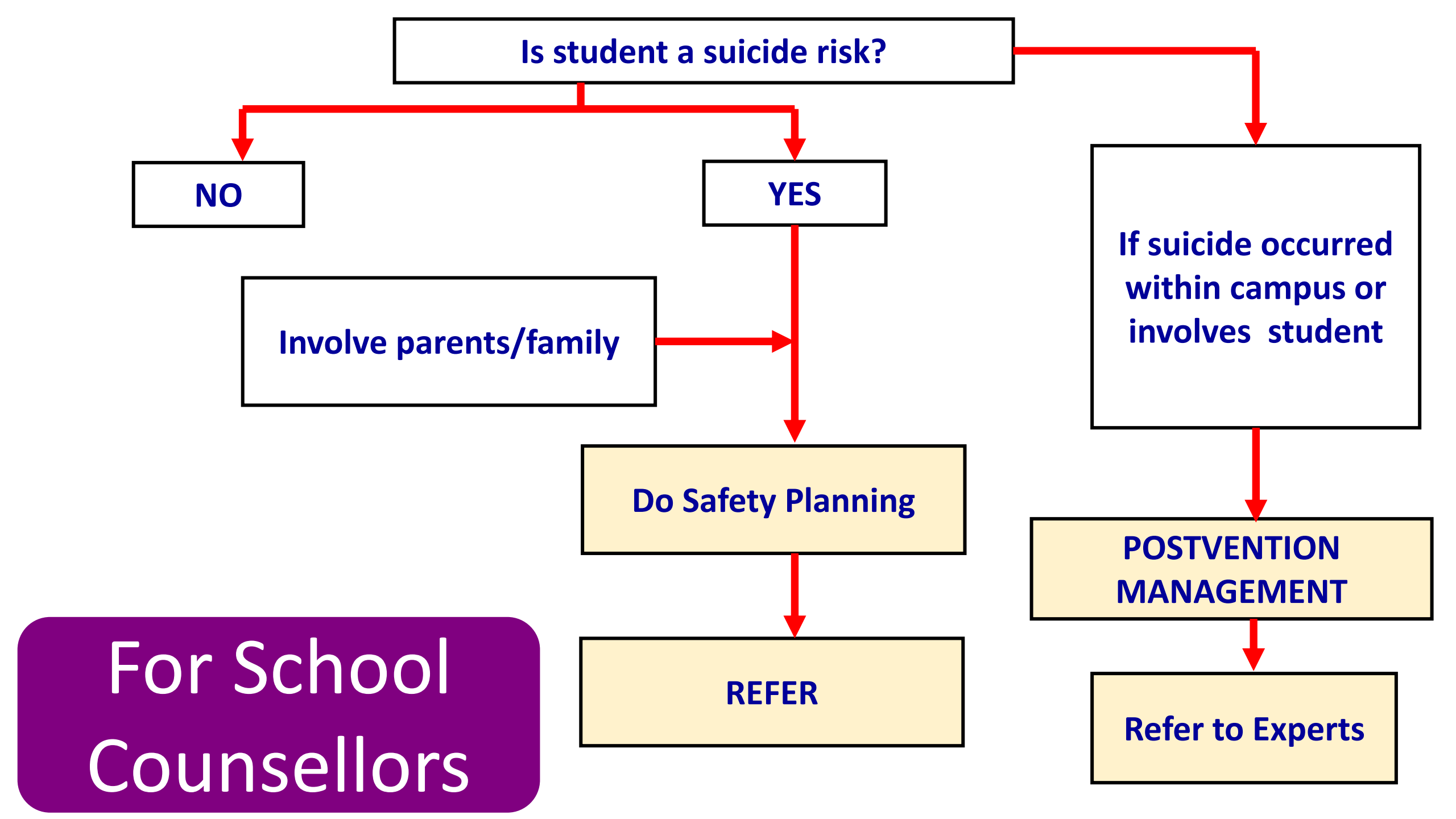

Self-Report Screening
Interview Screening
Actions to be taken by the General Pediatrician before Patient is seen by the Child Psychiatrist
Referral to Child Psychiatrist
All Patients
Screen with PHQ-9
Answers "1","2","3" on PHQ-9 Questions 9
Or
Total Score of 11 or more on PHQ-9
Screen with C-SSRS
Total Score 10 or less
On PHQ-9
Observation
Psychoeducation
Counselling
Psychopharmacology
Safety Planning
"Yes" to questions 4,5, or 6 on C-SSRS
Same day Psychiatric OPD
Or
Same day Admission and Referral to Psychiatrist
"Yes" to question 3 on C-SSRS
OPD Referral to Psychiatrist
"Yes" to question 1 or 2
Or
"No" to all questions on C-SSRS
OPD to referral to Psychiatrist , Psychologists, or Guidance Counsellor



For School Counsellors



For School Counsellors


Is student a suicide risk?
NO
YES
Involve parents/family
Do Safety Planning
REFER
If suicide occurred within campus or involves student
POSTVENTION MANAGEMENT
Refer to Experts
For School Counsellors

Important Reminder

- The above recommendations **do not replace** the importance of clinical judgment and decision making, taking into account individual considerations

Referral

Eastern Visayas Medical Center (EVMC)

Department of Psychiatry

Psychiatry Ward: 09273233556

Psychiatry OPD: 09058850766

Other Psychiatrists

- **Divine Word Hospital Psychiatrists**

- Dr.Violeta Perez
- Rm.66 2nd floor
- Mon-Sat 9am-2pm
- 09367355383

- Dr.Benjamin Go
- Rm.74 2nd floor
- By Appointment
- 09178696369

- **RTR Hospital Psychiatrists**

- Dr. Teresita Cajano
- Tuesday & Saturday 12nn-4pm
- By appointment
- 09464887580

- Dr.Germilina Cerro-Go
- Thursday 9am to 12 noon
- By appointment
- 09178228253

- **United Shalom Medical Center**
- Dr. Prisillana Lee Gilboy
- Room 16, Saturday 8:30-11 AM
- 09568693939

Referral to Specialists

- Directories of the following will be provided:
  - Philippine Society for Child and Adolescent Psychiatry
  - Philippine Society of Adolescent Medicine Specialists
  - Philippine Society for Developmental and Behavioral Pediatrics

Mental Health Support: For teachers and students

- https://www.deped.gov.ph/2021/11/08/deped-launches-mental-health-helpline-system-for-learners-teachers/

Mental Health Support

DOH Regional Helplines

REGION	CENTER	SERVICES	HOTLINE
NATIONWIDE	National Center for Mental Health	24/7 Crisis Hotline Telemental Health Psychological/Psychiatric Referrals & Management	1553 0917-899-8727 0966-351-4518 0908-639-2672 bit.ly/mhusaptayo

Mental Health Support

National Center for Mental Health

Mental Health Support

Philippine Mental Health Association
Online Mental Health Support
Viber: 0995-093-2679
pmha.cisd@gmail.com

Important Points

- Use of screening tools will further refine the concerns
- Presence of risk factors, red flags or warning signs and significant scores on the screening tool warrant professional help.
- Screening tools do not replace clinical judgement
- If you are concerned and even if the child passes the screening tool, then do not hesitate to consult