Children's National

Depression Screening & Follow-Up: Overview and Trends

April 28, 2023

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A few notes about today's webinar:

- All lines are muted throughout the presentation.
- Please use the Q&A function to ask questions or make comments during the presentation
- We will be recording the session.
- Today's recording and materials will be posted to the project's Teams page following the presentation.

PHN QI Team

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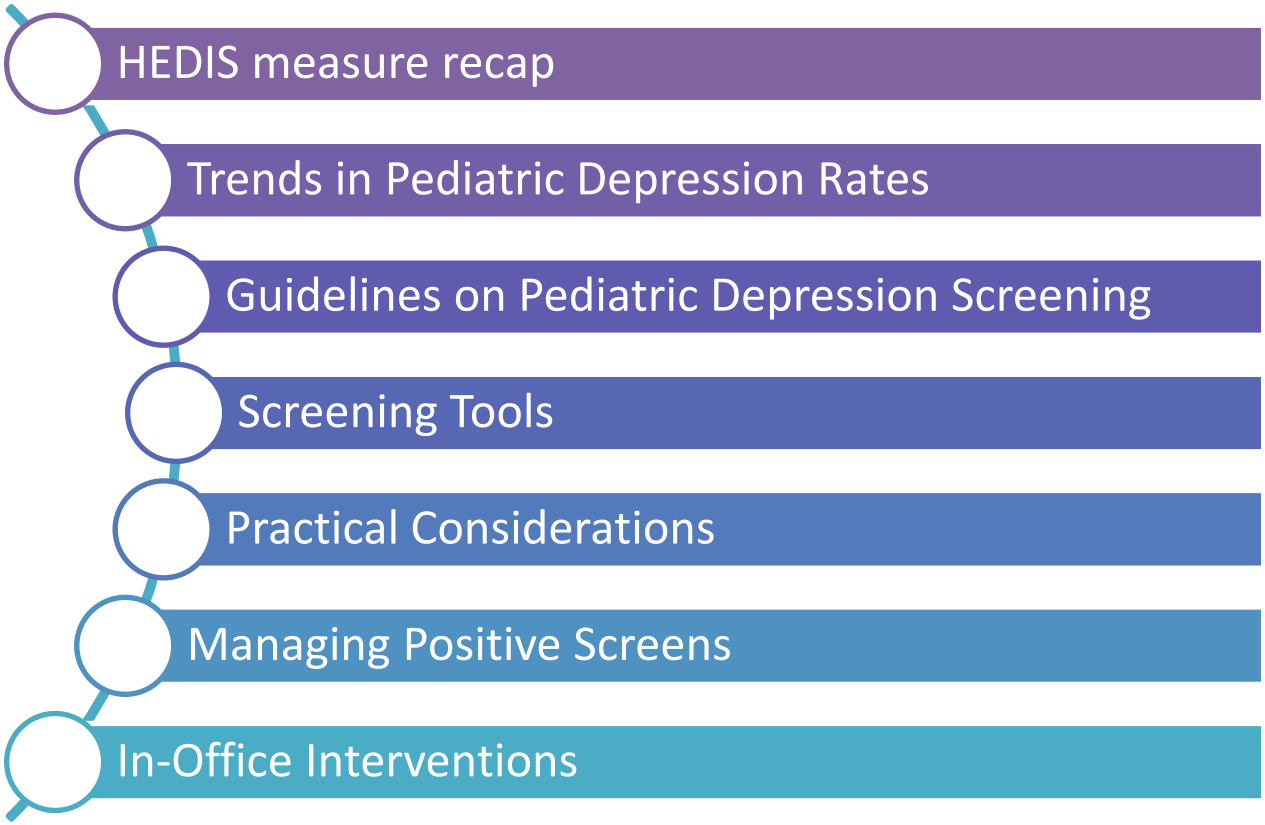
Disclosures

None

Outline


HEDIS measure recap
Trends in Pediatric Depression Rates
Guidelines on Pediatric Depression Screening
Screening Tools
Practical Considerations
Managing Positive Screens
In-Office Interventions

Recap: Depression Screening and Follow-Up for Adolescents and Adults (DSF)

HEDIS Measure Definition: The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

Codes to capture screening:
96127 (CPT code) + LOINC codes and score input into structured field
96127 (CPT code) + G codes

Follow-Up for Positive Scores

Any of the following on or up to 30 days after the first positive screen:

1. An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition.
2. A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
3. A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
4. A dispensed antidepressant medication.
5. Receipt of an assessment on the same day and subsequent to the positive screen.

Recap: DSM-5 MDD Criteria

1 for 2 weeks:

- Depressed mood (or irritable mood in kids)
- Anhedonia

4 for 2 weeks:

- Change in sleep
- Change in appetite
- Worthlessness
- Decreased energy
- Poor concentration
- Psychomotor agitation or retardation
- Suicidality

Exclusion criteria

- Causes significant distress or impairment in functioning
- Not due to substance use, bipolar disorder, another condition

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Recap: DSM-5 Persistent Depressive Disorder Criteria

1 for most days in a year:

- Depressed mood (or irritable mood in kids)
- Anhedonia

2 or more when depressed:

- Change in sleep
- Change in appetite
- Worthlessness
- Decreased energy
- Poor concentration

Exclusion criteria

- No more than 2 months out of past year without depression
- Causes significant distress or impairment in functioning
- Not due to substance use, bipolar disorder, another condition

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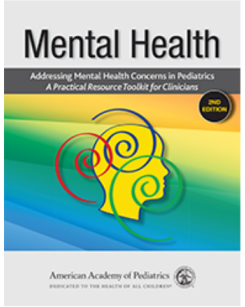
AAP Key Resources

Addressing Mental Health Concerns in Pediatrics: A Practical Resource Toolkit for Clinicians, 2nd edition



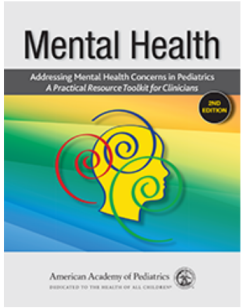
Marian F. Earls, MD, FAAP; Jane Meschan Foy, MD, FAAP; Cori M. Green, MD, MSc, FAAP

All clinicians working with children and adolescents must be prepared to be a first-line advocate when mental health concerns arise.

The tools in this collection align with the current AAP Mental Health Competencies for Pediatric Practice, giving you convenient access to core content, forms, screening and assessment resources, plus videos demonstrating conversation techniques firsthand.

AAP Key Resources

Addressing Mental Health Concerns in Pediatrics: A Practical Resource Toolkit for Clinicians, 2nd edition



Marian F. Earls, MD, FAAP; Jane Meschan Foy, MD, FAAP; Cori M. Green, MD, MSc, FAAP

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FROM THE AMERICAN ACADEMY OF PEDIATRICS | POLICY STATEMENT | NOVEMBER 01 2019

Mental Health Competencies for Pediatric Practice FREE

Jane Meschan Foy, MD, FAAP ✉; Cori M. Green, MD, MS, FAAP; Marian F. Earls, MD, MTS, FAAP; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP; Arthur Lavin, MD, FAAP; George LaMonte Askew, MD, FAAP; Rebecca Baum, MD, FAAP; Evelyn Berger-Jenkins, MD, FAAP; Thresia B. Gambon, MD, FAAP; Arwa Abdulhaq Nasir, MBBS, MSc, MPH, FAAP; Lawrence Sagin Wissow, MD, MPH, FAAP; Alain Joffe, MD, MPH, FAAP

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POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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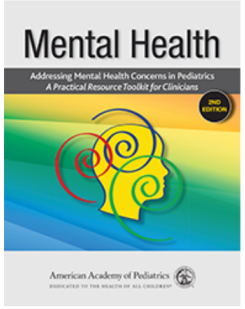

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POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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March 2018

FROM THE AMERICAN ACADEMY OF PEDIATRICS | STATEMENT OF ENDORSEMENT | MARCH 01 2018

Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management

Rachel A. Zuckerbrot, MD ✉; Amy Cheung, MD; Peter S. Jensen, MD; Ruth E.K. Stein, MD; Danielle Laraque, MD; GLAD-PC STEERING GROUP; Anthony Levitt; Boris Birmaher; John Campo; Greg Clarke, PhD; Graham Emslie; Miriam Kaufman; Kelly J. Kelleher; Stanley Kutcher; Michael Malus; Diane Sacks; Bruce Waslick; Barry Sarvet

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POTENTIAL CONFLICT OF INTEREST: Dr Zuckerbrot works for CAP PC, child and adolescent psychiatry for primary care, now a regional provider for Project TEACH in New York State. Dr Zuckerbrot is also on the steering committee as well as faculty for the REACH Institute. Both of these institutions are described in this publication. Drs Cheung and Zuckerbrot receive book royalties from Research Civic Institute.

Trends in Pediatric Depression Rates and Screening

US Trends in Pediatric Depression

Number of children ages 3-17 whose parents reported their child is currently diagnosed with depression grew by 27% from 2016-2020 (Lebrun-Harris et al. 2022).

US Trends in Pediatric Depression

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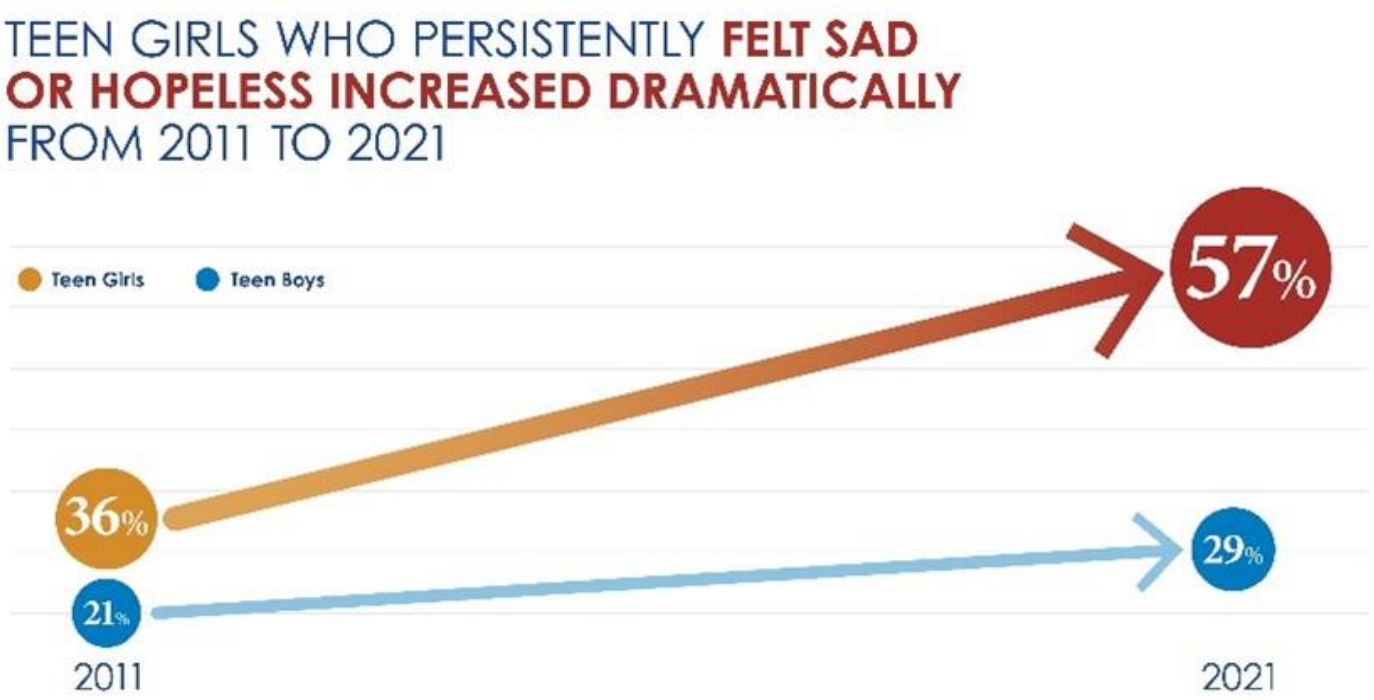

[Youth Risk Behavior Survey Data Summary & Trends Report: 2011-2021 (cdc.gov)]

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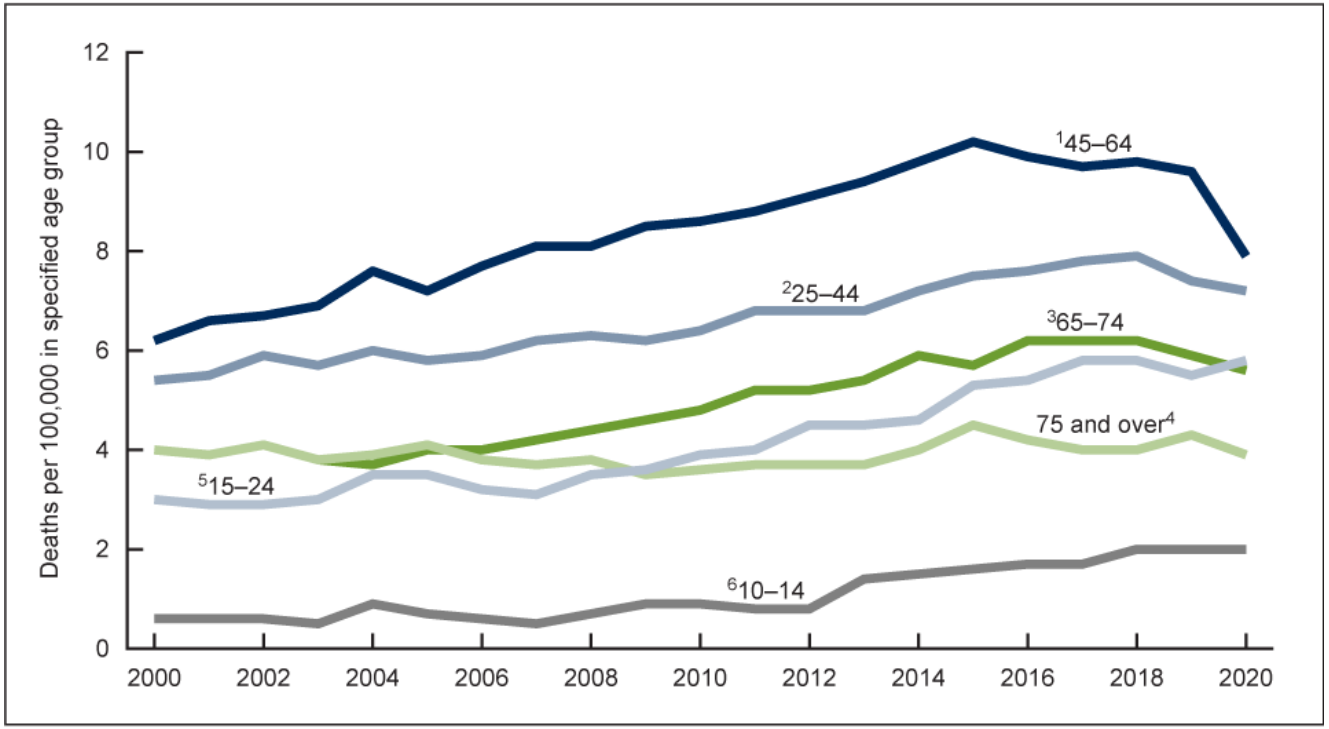
US Trends in Suicide Mortality

Figure 2. Suicide rates for females, by age group: United States, 2000–2020



[1]Significant increasing trend from 2000 through 2016, significant decreasing trend from 2016 through 2020, $p < 0.05$.
[2]Significant increasing trend from 2000 through 2018, with different rates of change over time; significant decreasing trend from 2018 through 2020, $p < 0.05$.
[3]Stable trend from 2000 through 2004, significant increasing trend from 2004 through 2017, significant decreasing trend from 2017 through 2020, $p < 0.05$.
[4]Significant decreasing trend from 2000 through 2009, significant increasing trend from 2009 through 2020, $p < 0.05$. The rate in 2020 was significantly lower than the rate in 2019, $p < 0.05$.
[5]Stable trend from 2000 through 2007, significant increasing trend from 2007 through 2020, $p < 0.05$.
[6]Significant increasing trend from 2000 through 2020, $p < 0.05$.
NOTES: Suicide deaths are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0.
Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db433-tables.pdf#2.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

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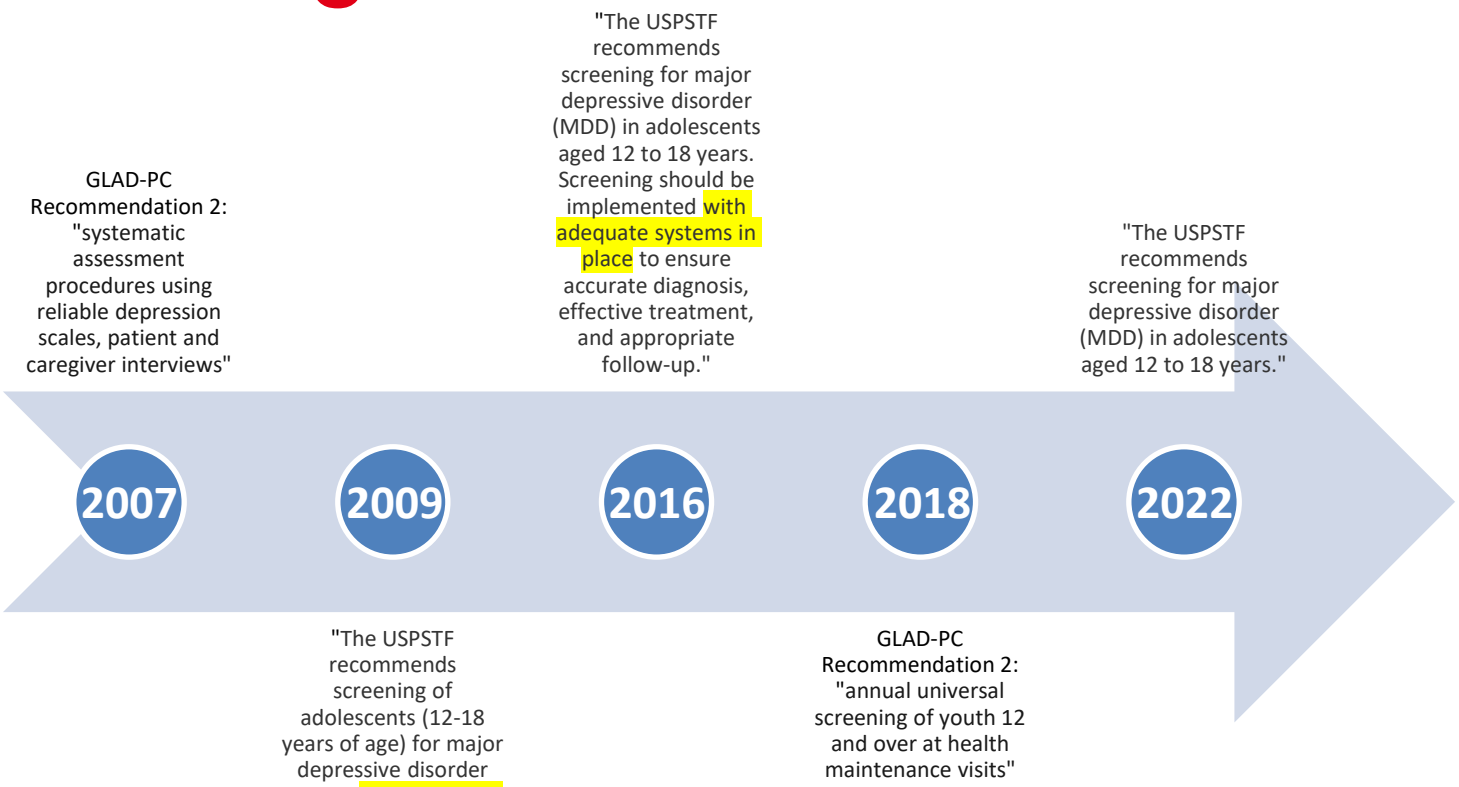
[Products - Data Briefs - Number 433 - March 2022 (cdc.gov)]

Guidelines on Pediatric Depression Screening

AAP and USPTF Adolescent Depression Screening Recommendations



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Final Recommendation Statement

Depression and Suicide Risk in Children and Adolescents: Screening

October 11, 2022

What does the USPSTF recommend?	**Adolescents aged 12 to 18 years:** Screen for major depressive disorder (MDD). **Grade: B**
	Children 11 years or younger: The evidence is insufficient to assess the balance of benefits and harms of screening for depression. **I statement**
	Children and adolescents: The evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk. **I statement**
To whom does this recommendation apply?	This recommendation applies to children and adolescents 18 years or younger who do not have a diagnosed depression disorder and who are not showing recognized signs or symptoms of depression.
What's new?	This recommendation is consistent with the 2014 USPSTF recommendation statement on screening for suicide risk in adolescents and the 2016 recommendation statement on screening for MDD in children and adolescents.
How to implement this recommendation?	• Treatment options for MDD in children and adolescents include pharmacotherapy, psychotherapy, and collaborative care. • Clinicians should be aware of the risk factors, signs, and symptoms of depression and suicide, listen to any patient concerns, and make sure that persons who need help get it. Youth diagnosed with depression and their health care professional should decide together with the parents or guardians what treatment is right for them.
What additional information should clinicians know about this recommendation?	• All children aged 12 to 18 years are at risk of depression and should be screened. However, there are some factors that increase the risk. These include family history of depression, prior episodes of depression, childhood abuse or neglect, exposure to traumatic events or stress, bullying, maltreatment, adverse life events, and a difficult relationship with parents. Some gender identities and sexual orientations may increase risk of depression. • If antidepressants are used, the USPSTF recommends that health care professionals follow US Food and Drug Administration guidance and observe patients closely. • In the absence of evidence, health care professionals should use their judgment based on individual patient circumstances when determining whether to screen for MDD in children 7 years or younger or screen for suicide risk in youth not showing recognized signs or symptoms.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
Hearing		●[8]	●[9]	→	★	★	★		★	★	★	★	★	★	●	●	●	★	●	★	●	●	←	●[10]	→	←	●	→	←		●	→	
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	●	→	★	★	★	★	★	←		●	→	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	●	→					
Hepatitis B Virus Infection[31]		★	→																													→
Hepatitis C Virus Infection[32]																													●	→		→
Sudden Cardiac Arrest/Death[33]																						★	→									→
Cervical Dysplasia[34]																																●
ORAL HEALTH[35]							●[36]	●[36]	★			★	★	★	★	★	★															
Fluoride Varnish[37]							←	→			●	→																				
Fluoride Supplementation[38]							★	★	★			★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←★ or ●→ = range during which a service may be provided

BFNC.2023.PSFEB
3-365/0223

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in December 2022 and published in April 2023. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See 'Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management' (https://doi.org/10.1542/peds.2017-4081), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

Screening Tools

Common Depression Screening Measures

From AAP's **Addressing Mental Health Concerns in Pediatrics: A Practical Resource Toolkit for Clinicians, 2nd edition** and **GLAD-PC Toolkit**

- Beck Depression Inventory-II (BDI-II)
- Beck Depression Inventory-FastScreen (BDI-FS) for Medical Patients
- Center for Epidemiological Studies Depression Scale for Children (CES-DC)
- Children's Depression Inventory 2 (CDI-2)
- Children's Global Assessment Scale (C-GAS)
- Columbia Depression Scale (Teen and Parent Versions)
- Kutcher Adolescent Depression Scale (KADS)
- PHQ-2, **PHQ-9, and PHQ-9 Modified for Teens**
- Preschool Feelings Checklist
- Short Mood and Feelings Questionnaire (SMFQ)

PEDIATRICS Volume 141, number 3, March 2018

SUPPLEMENTAL TABLE 3 Pros and Cons of Depression Screening and/or Assessment Tools

Tool	Pros	Cons
PHQ-9	Well validated in multiple adult PC populations Validated in 1 adolescent study Already widely available in many PC settings and EMRs Maps neatly onto DSM-5 MDD criteria Can be used serially to follow treatment progress May be used without cost	Does not have DSM-5 wording for adolescent depression, specifically the word "irritability" Does not have any questions asking specifically about suicide attempts Given less research in adolescent PC, cutoffs may need to be adjusted in different adolescent populations.
PHQ-2	Validated in many adult PC studies Validated in 1 adolescent PC study Already widely available in many PC settings and EMRs Short screen that is easily administered May be used without cost	Given its brevity, may miss less impaired youth Does not have DSM-5 wording for adolescent depression, specifically the word "irritability" No questions about thoughts of suicide No questions about suicide attempts Given less research in adolescent PC, cutoffs may need to be adjusted in different adolescent populations
PHQ-9: Modified for Teens (often mislabeled as the PHQ-A; also previously marketed as part of the TeenScreen Primary Care)	Same format as PHQ-9, which is widely accepted Same scoring as PHQ-9 Modified to fit adolescent criteria with the word "irritability" Has 2 specific suicide questions (1 was validated as part of the CDS, and 1 was validated as part of the PHQ-A) Can be used serially to follow treatment progress May be used without cost	Although composed of all validated questions and although additional questions are not part of scoring, the screen in this exact format was never research validated
PHQ-A	Validated in 1 study with a semistructured mental health telephone interview with a population recruited from PC Original PHQ-A included questions about anxiety and eating disorders as well	Original PHQ-A used in this validation study required a computerized algorithm to score Never evaluated within the PC clinic or practice Updated, streamlined versions get confused with PHQ-9: modified for teens and are often mislabeled as the PHQ-A

peds_20174081supplementarydata.pdf (silverchair-cdn.com)

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**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

For office coding: _____0_____+_____+_____+_____

= Total Score _____

PHQ-2 Scores and Proposed Treatment Actions

The PHQ-2 consists of the first 2 questions of the PHQ-9. Scores range from 0 to 6. The recommended cut point is a score of 3 or greater. Recommended actions for persons scoring 3 or higher are one of the following:

- Administer the full PHQ-9
- Conduct a clinical interview to assess for Major Depressive Disorder

1. Korenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. *Med Care*. 2003, Nov;41(11):1284-92.
2. Kroenke K(1), Spitzer RL, Williams JB, Löwe B. The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. *Gen Hosp Psychiatry*. 2010 Jul-Aug;32(4):345-59.

	Recommendation from Healthy Kids Preventive Health Schedule	Examples of Acceptable Standardized Tools	Billing Guidelines	Limitations
Depression screening	Screening recommended annually beginning at 11 years of age. If providers choose, they can "pre-screen" with PHQ-2 to determine if a longer standardized screening tool is needed.	• PHQ-9 Modified for Teens • Pediatric Symptom Checklist (PSC-Y) • Center for Epidemiological Studies Depression Scale for Children (CES-DC) • Beck Depression Inventory (BDI)	**96127:** Brief emotional/ behavioral assessment **may be billed only when a standardized screening tool is used and results documented. PHQ-2 may not be billed.**	A maximum of 2 units of 96127 will be reimbursed per visit; OR 96127 may be combined with other screening codes (ex. W7000) for a maximum of 2 units of screening per visit

https://health.maryland.gov/mmcp/epsdt/healthykids/AppendixSection6/Coding-Guidelines-for-Screening-Tools-Primary-Care-final.pdf

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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: _____

If you checked off any problems, 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

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

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Scoring the PHQ-9 Modified for Teens

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

To use the PHQ-9 as a diagnostic aid for major depressive disorder:

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

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

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

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

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

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

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

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

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

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

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Sensitivity and Specificity: GLAD-PC

Updates since prior review: 2 publications by Richardson et al (2010)

"Validated the Patient Health Questionnaire-2 (PHQ-2) and the Patient Health Questionnaire-9 (PHQ-9) in a PC sample against a gold standard diagnostic interview (the Diagnostic Interview Schedule for Children-IV [DISC-IV])

The PHQ-9, with a cut-point of 11, had a sensitivity and specificity of 89.5% and 77.5%, respectively, to DISC-IV MDD with a PPV of 15.2% and NPV of 99.4%.

A PHQ-2 cut score of 3 had a sensitivity and specificity of 73.7% and 75.2%, respectively, to DISC-IV MDD."

Experiences of Other Systems: Rady Children's Hospital

- Universal screening of 95,613 patients aged 12-17 years given PHQ-2->PHQ-9->CSSRS
- 2.4% of patients had moderate-severe depression without suicide risk and another 4.1% with suicide risk.
- 51% of patients with a primary psychiatric concern and 2% of patients with a primary medical concern screened positive for suicide.
- Overall, 88% of patients with depression and half of patients with elevated suicide risk screenings presented with a primary medical concern (Crandal et al. 2022).

Experiences of Other Systems: Nationwide Children's

- 12 urban primary care clinics, >120,000 mostly Medicaid patients
- PHQ-9A and ASQ screening rates >90% of routine preventative care adolescent visits
- On PHQ-9A and/or ASQ, 56.4% of patients screened positive for any type of depression (score of 2 or 3 on any ?), 24.7% screened positive for MDD (PHQ-9A >=10), and 21.1% screened positive for suicide risk.
- ASQ identified additional subjects (eg, 2.2% additional cases compared with screening for any type of depression or other mental illness and 8.3% additional cases compared with screening positive for MDD).
- Initial management documentation declined after adopting tablets in clinic flow (88 to 68%), then increased to 87.3% after EHR redesign (Kemper et al. 2021; Beck et al. 2022)

Experiences of Other Systems: CHOP

Adolescents aged 12-21 at a routine preventative health visit (N=91,188 visits), June-December 2019 (prepandemic) versus June-December 2020 (pandemic) using PHQ-9M plus 2 extra SI questions

- Screening rate declined 77.6% to 75.8%
- Positive depression screens (PHQ-9M>11) increased 5.0% to 6.2%
- Positive suicide risk screens increased 6.1% to 7.1% (Mayne et al. 2021)

Practical Considerations

Most Common Screening Barriers Encountered by PHN Practices

Endorsed by more than one respondent:

- Patient reluctance to complete screen (20+ respondents)
- Lack of privacy for adolescent to complete screen (15+)
- Inconsistent screening workflow (10+)
- Lack of automated documentation of results (10)
- Lack of automated coding/documentation charge (5+)
- Inconsistent coding/documentation workflow (5+)

Sample Language for Introducing Screens

Because so many teens are under so much stress these days, new national guidelines have all pediatricians check in with all teens about mental health issues at their well visits.

As we take your blood pressure and temperature, we also want to assess your mental well-being because it can impact your overall health.*

* PHQ-9-Screening-Guidance-PDF (ks.gov)

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Sample Language for Reluctance/Privacy

Filling out these forms can seem stressful for a lot of different reasons. What is hard about it for you?

These forms are more accurate when teens fill them out in private. This is good practice for adulthood, when you will be responsible working with your doctor on your own.

Mental health is a key part of human health. Mental health is not just about responding to problems. Even if you are doing fine, it is important for us to talk about ways to build positive mental health and resilience, like through self-care and healthy habits. These questions help us get that conversation started.*

*Teen Mental Health: How to Know When Your Child Needs Help - HealthyChildren.org

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Sample Language: Positive Screen

I have reviewed your forms, and I want to talk about how you have been feeling lately. On this form, you indicated that you are feeling hopeless. Can you tell me more about that?

When people feel down, have low energy, have trouble sleeping, and no longer enjoy activities, they may have depression. Does that sound like it could apply to you?

What do you think is going on? Is there something you are worried about?

Slide excerpted from PHN webinar by Dr. Laura Willing: https://pediatrichealthnetwork.org/behavioral-health-initiative/#toggle-id-3

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Assessing Suicidal Risk

- The validation study of the PHQ-2 found that 19% of teenagers who did endorse suicidality did not screen positive on the PHQ-2 (Zuckerbrot et al. 2018)

- ASQ suicide screen identified 8.3% additional cases compared with screening positive for MDD on the PHQ-9A (Kemper et al. 2021; Beck et al. 2022)

- See PHN webinar for additional information: https://pediatrichealthnetwork.org/behavioral-health-initiative/#toggle-id-4

Screening Modality

- Options include pencil and paper measures, Internet-based measures, and electronic measures accessed via device
- No current evidence comparing methods to each other
- All appear generally equally successful and problematic (e.g., universally well accepted but also universal implementation problems) (Zuckerbrot et al. 2018)

Managing Positive Screens

From: **Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management**

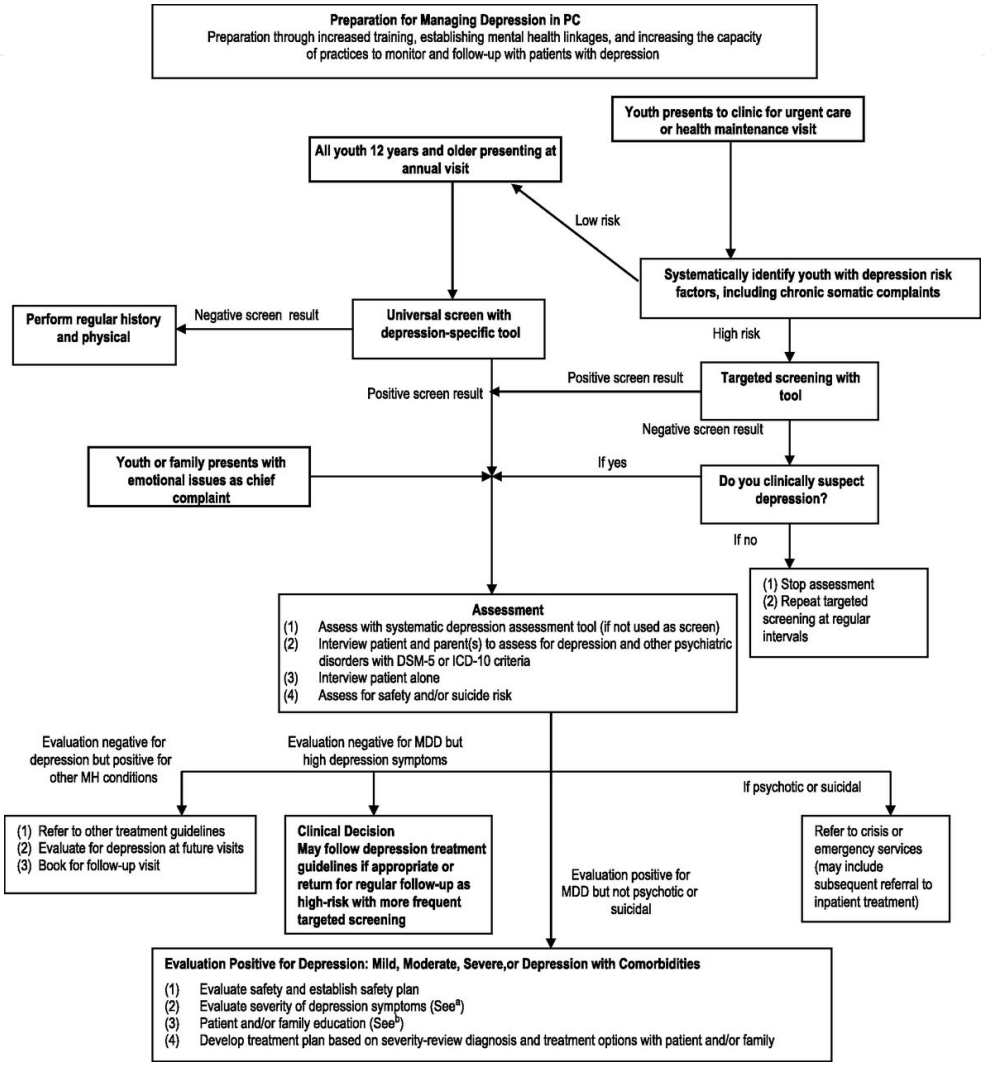
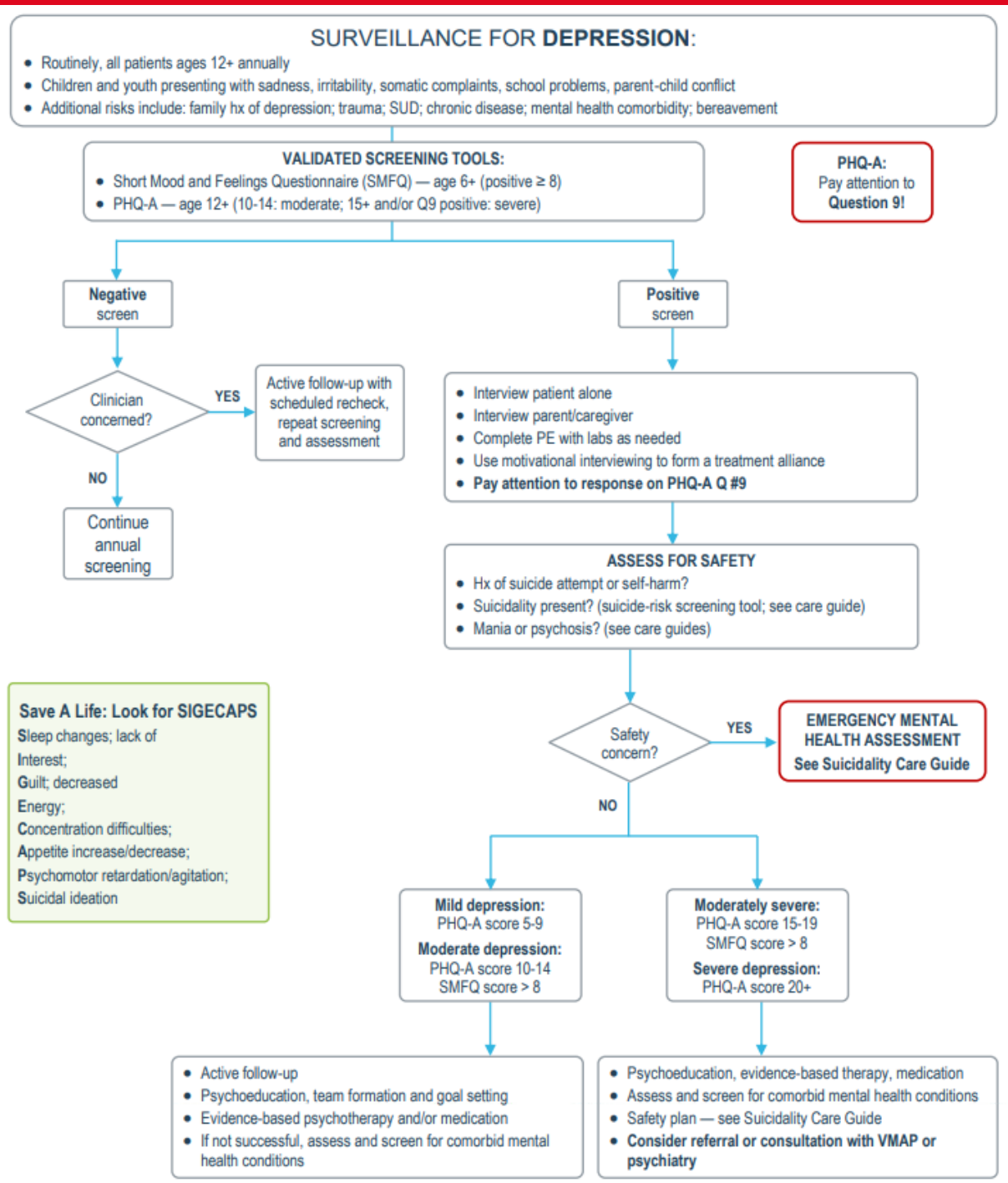


Figure Legend:

Clinical assessment flowchart. ICD-10, International Classification of Diseases, 10th Revision; MH, mental health. [a] See part I of the guidelines for definitions of mild, moderate, and severe depression. Please consult the tool kit for methods that are available to aid dinicians in distinguishing among mild, moderate, and severe depression. [b] Psychoeducation, supportive counseling, facilitation of parental and patient self-management, referring for peer support, and regular monitoring of depressive symptoms and suicidality.

Pediatrics. 2018;141(3). doi:10.1542/peds.2017-4081

VMAP



https://vmap.org/guidebook/

In-Office Interventions

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Pediatric Health Network
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About Us News Our Members Events

Behavioral Health Initiative

The Behavioral Health Initiative is a collaborative partnership between Children's National Hospital and the Pediatric Health Network that aims to develop a comprehensive strategy to address mental and behavioral health needs in our regional primary care practice network, recognizing there is not a one-size-fits-all solution.

The Behavioral Health Initiative: Three Key Focus Areas

We focus our efforts on three key areas that we believe will make a major impact on the mental and behavioral health of children and families in the Pediatric Health Network. These focus areas are: 1) behavioral health education and training, 2) care management or coordination, and 3) integrated business models for mental health support in primary care.

This initiative will be integrated with other ongoing efforts within the PHN and will leverage expertise across our network. We plan to create sustainable solutions with measurable impacts to improve the pediatric behavioral health of our population.

If you have questions about the initiative or suggestions for content to include, please contact us at PHN@childrensnational.com.

Resources for Providers

As part of the Behavioral Health Initiative, experts have created a comprehensive list of useful online mental and behavioral health tools that are available for primary care providers in Washington, D.C., Maryland, and Virginia. See below for a collection of free resources covering a range of behavioral health topics.

We also offered a pilot educational initiative that ran from May through August 2022, pairing clinical behavioral health education webinars with discussion-based office hours staffed by Children's National psychiatrists. We offered lectures tailored for experienced pediatricians to build on their existing skill sets and help them meet the mental health needs of their patients. You may view those recordings below.

Search topics ... Find

State and Local Resources

Pediatric mental health resources in Washington, D.C., Maryland, and Virginia.

Professional Development and Practice Toolkits

Online collections of mental health resources for mental health providers.

Anxiety

Resources for supporting youth with anxiety problems including Generalized Anxiety Disorder, Social Anxiety Disorder, and Separation Anxiety Disorder.

Autism and Intellectual Disability

Resources for supporting youth with autism and/or intellectual disability.

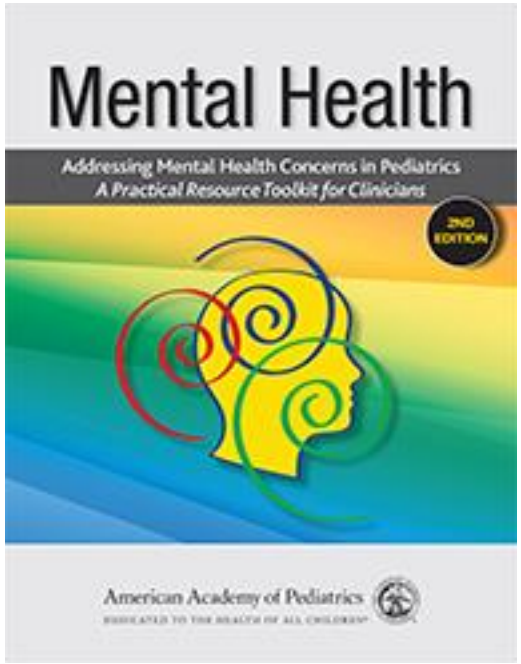
Depression

Tools, including screening instruments and treatment guides, for pediatric depression.

Early Childhood Mental Health

Early childhood mental health resources for children ages birth to five.

AAP Toolkit



"Common-elements" approaches can be used as brief interventions. They differ from common-factors in that instead of applying to a range of diagnoses that are not causally related, common-elements are semi-specific components of psychosocial therapies that apply to a group of related conditions.

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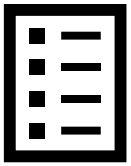
Brief Interventions

- Psychoeducation
- Reduce Stressors
- Sleep Hygiene
- Safety Plan
- Behavioral Activation
- Coping Skills
- Exercise



Slide excerpted from PHN webinar by Dr. Laura Willing: https://pediatrichealthnetwork.org/behavioral-health-initiative/#toggle-id-3

REACH GLAD-PC Toolkit

Antidepressant Medication and YOU

How do the medications work?

The brain uses chemical messengers, called neurotransmitters, to send signals to different parts of the brain and the body. In young people with depression certain neurotransmitters may not be working the right way. The antidepressant medications help these neurotransmitters work better. Different antidepressant medications work on different neurotransmitters. That is why sometimes one medication will work better than another, and sometimes more than one medication will need to be tried before finding the one that works best for you. Also new medications and treatments are being developed and tested all the time.

How will medication help me?

Antidepressant medications may help you have:

- Improved mood
- Better concentration
- More normal appetite
- More normal sleeping
- Greater interest in activities
- More energy
- Improved self-esteem

Will taking medication change who I am?

You may be concerned about taking medication. You may think that it will make you different from other young people or that it will change who you are. These things aren't true. Medication will help you get back to the way you were before you became depressed, so you feel like yourself again. Taking medication is really no different than using glasses or wearing braces – it's only a tool to help you.

What are the problems with taking medications?

Like all medical treatments, there can be side effects with these medications. Side effects are usually very mild and tend to disappear as you continue to take the medication or as the dose is changed. Sometimes the side effects may continue, and this usually means that the doctor will change the medication. Some common side effects are:

difficulty sleeping	headaches	irritability
upset stomach	dry mouth	blurry vision

Specific side effects can be found in the individual medication information sheets. Make sure you tell your doctor if you experience any side effects. Your doctor may change the dose or switch to another medication.

How long will I have to take medication?

If the medication is helpful and you have no problems with it, you will probably continue to take the medication for a number of months, even after you feel better, to make sure the depression is gone. If your doctor decides to stop the medication, it will be slowly decreased over a number of weeks. Antidepressant medication should never be stopped without first talking to your doctor. Sometimes young people who have been depressed will become depressed again, so it is important to notice if your symptoms return. If you do become depressed again, you will probably be restarted on medication.

What is my role in taking medication for depression?

It is your responsibility to take your medication in the right amount at the right time. You should not take any other medication (even over-the-counter) without talking to your doctor first. And you should never use alcohol or drugs while taking medication; it is very dangerous and can be deadly. It is also your responsibility to never share your medication with anyone else. It can be harmful, and it is illegal. Most importantly, you should talk openly with your doctor about any problems and work together as a team in making decisions about medications.

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
A-DEP

[Guidelines for Adolescent Depression in Primary Care (thereachinstitute.org)]

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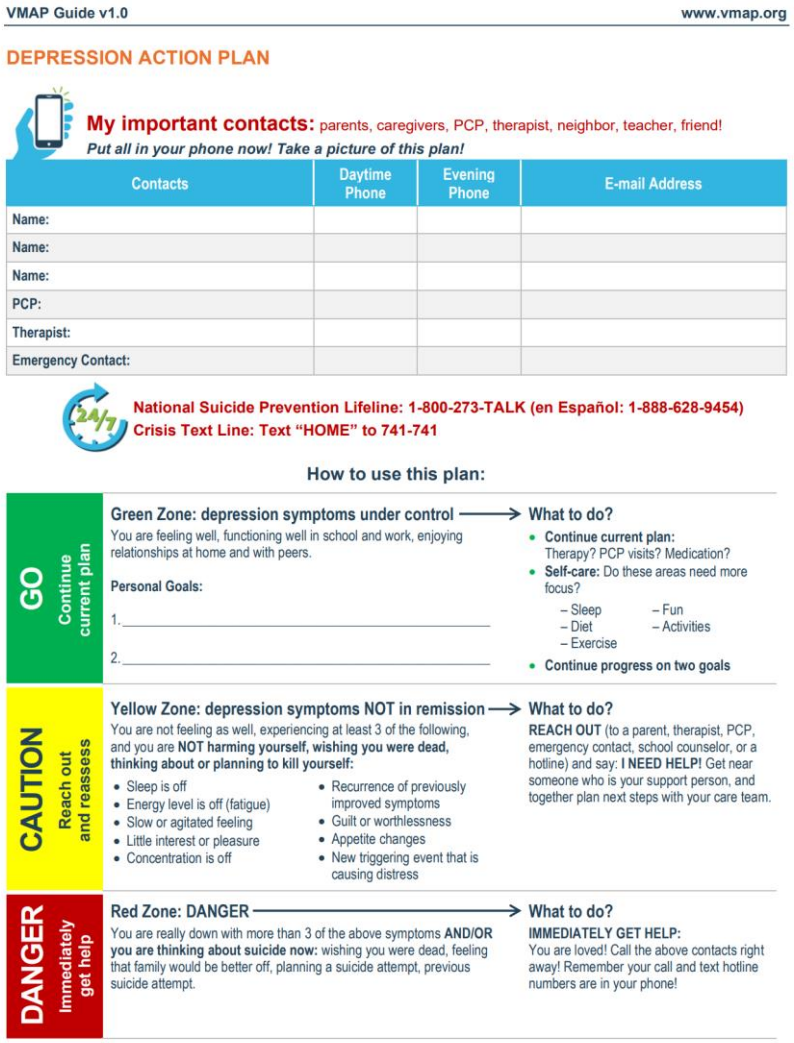
VMAP Guidebook



VMAP Guide v1.0 www.vmap.org

DEPRESSION ACTION PLAN

My important contacts: parents, caregivers, PCP, therapist, neighbor, teacher, friend!

Put all in your phone now! Take a picture of this plan!

Contacts	Daytime Phone	Evening Phone	E-mail Address
Name:			
Name:			
Name:			
PCP:			
Therapist:			
Emergency Contact:			

National Suicide Prevention Lifeline: 1-800-273-TALK (en Español: 1-888-628-9454)
Crisis Text Line: Text "HOME" to 741-741

How to use this plan:

GO Continue current plan

Green Zone: depression symptoms under control → **What to do?**

You are feeling well, functioning well in school and work, enjoying relationships at home and with peers.

Personal Goals:

1. _____

2. _____

- **Continue current plan:** Therapy? PCP visits? Medication?
- **Self-care:** Do these areas need more focus?
  - Sleep
  - Diet
  - Exercise
  - Fun
  - Activities
- **Continue progress on two goals**

CAUTION Reach out and reassess

Yellow Zone: depression symptoms NOT in remission → **What to do?**

You are not feeling as well, experiencing at least 3 of the following, and you are **NOT harming yourself, wishing you were dead, thinking about or planning to kill yourself:**

- Sleep is off
- Energy level is off (fatigue)
- Slow or agitated feeling
- Little interest or pleasure
- Concentration is off
- Recurrence of previously improved symptoms
- Guilt or worthlessness
- Appetite changes
- New triggering event that is causing distress

REACH OUT (to a parent, therapist, PCP, emergency contact, school counselor, or a hotline) and say: **I NEED HELP!** Get near someone who is your support person, and together plan next steps with your care team.

DANGER Immediately get help

Red Zone: DANGER → **What to do?**

You are really down with more than 3 of the above symptoms **AND/OR you are thinking about suicide now:** wishing you were dead, feeling that family would be better off, planning a suicide attempt, previous suicide attempt.

IMMEDIATELY GET HELP:
You are loved! Call the above contacts right away! Remember your call and text hotline numbers are in your phone!

[VMAP Guidebook – Virginia Mental Health VMAP.org]

Washington State CBT+ Handouts

Depression (Client Handouts)

- Small Talk and Friend Making Tips
- Take Action to Feel Better
- Taking Charge of Negative Emotions
- What Gets in Your Way
- Actions I Took to Feel Better
- Activity Scheduling – At Home Practice Sheet
- Activity Scheduling – At Home Practice Sheet – Spanish Version
- CBT+ Getting Active Homework Sheet
- CBT+ Getting Active Homework Sheet – Spanish
- CBT+ Goal Setting Worksheet
- CBT+ Triangle
- Depression Relapse Prevention Worksheet
- Depression Common Unhelpful Helpful Thoughts Tool
- Depression Information
- Depression Information – Spanish version
- Depression Information and Treatment Roadmap
- Depression Information and Treatment Roadmap – Spanish
- Depression Pattern Exercise
- Depression Steps
- FAST D Activity Scheduling
- Getting Active
- Goal Setting Bricks Handout
- Goal Setting Bricks Handout – Spanish
- List of Things I Can Do to Feel Good
- Mood Monitoring Homework Sheet
- Mood Monitoring Homework Sheet – Spanish version
- Problem Solving Worksheet Advanced
- Problem Solving Worksheet Advanced – Spanish
- Problem Solving Skills Worksheet – Basic
- Problem Solving Skills Worksheet – Basic – Spanish
- Replacing Negative Thoughts Exercise
- So You Have a Problem

CBT + Notebook – Harborview Abuse & Trauma Center (washington.edu)

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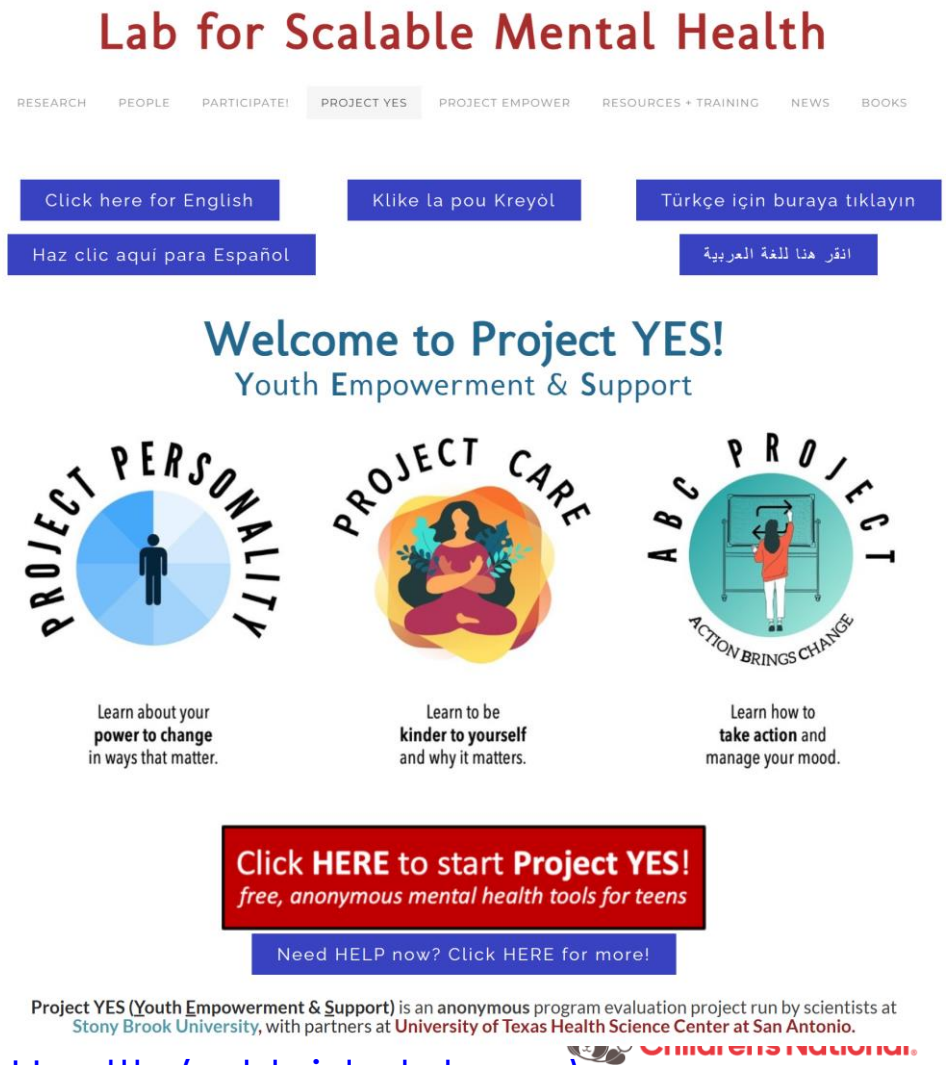
Free Online Single Session Interventions



[Project YES - Lab for Scalable Mental Health (schleiderlab.org)](schleiderlab.org)

Thank You!