Guidelines for Adolescent Depression in Primary Care

GLAD – PC

Toolkit

Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit

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Preface to the Updated Toolkit

Dear Colleagues:

Welcome back to the GLAD-PC toolkit. We are so excited to present this updated toolkit as a companion to the GLAD-PC guidelines published in the March 2018 volume of *Pediatrics*. This toolkit aims to assist primary care providers in putting the GLAD-PC recommendations into practice. Given that over a decade has passed since our first set of guidelines, we have updated some of the tools and materials in this kit. Fortunately, many others have withstood the test of time. As before, whenever possible, we have adapted or borrowed generously (and with permission) from those pioneers who had already developed such materials for their own populations and settings. We especially want to thank our current partners in depression care improvement from the American Academy of Pediatrics, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the National Alliance of Mental Illness, and the New York City Health + Hospitals Office of Population Health and Office of Diversity and Inclusion, as well as the many others, too numerous to mention, who have shared time, expertise, and toolkit content. We are still indebted to all of our partners who collaborated on the first edition in 2007.

We want to thank you for your continued dedication to helping the whole child, mind and body. Because of your dedication and hard work, despite the obstacles, we know that today's adolescents will have a brighter future.

Amy Cheung, M.D., Rachel A. Zuckerbrot, M.D., and Peter S. Jensen, M.D. (2018)

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Preface to the First Edition

Dear Colleagues:

Welcome to the GLAD-PC toolkit. This kit has been assembled to assist primary care providers in putting the GLAD-PC guidelines into effect. This toolkit has been assembled with the input of experts from the areas of adolescent depression, primary care behavioral medicine, parent and family advocacy, guideline development, and quality improvement. Whenever possible, we have adapted or borrowed generously (and with permission) from those pioneers who had already developed such materials for their own populations and settings. We especially want to thank our partners in depression care improvement from the Texas State Department of Health Services, Columbia University's Treatment Guidelines Project, Intermountain Health Care, American Medical Association, Western Psychiatric Institute and Clinic, the National Alliance for the Mentally Ill, and the Depression & Bipolar Support Alliance, as well as many others too numerous to mention who have shared time, expertise, and toolkit content.

On behalf of the GLAD-PC Steering Committee, organization liaison representatives, and the many expert clinicians who contributed to this process to improve adolescent depression management in primary care, we thank you for your service and efforts for depressed teens.

Peter S. Jensen, MD (2007)

Table of Contents

Guide to Using This Toolkit

This toolkit was created to help primary care providers decide whether and how to implement the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) into their practice. It was designed to be user-friendly and applicable to real-world primary care practices.

As we know the specific needs of providers' practices both differ and change, we have included topics ranging from diagnosis to treatment and follow-up. We have designed each section so that it could be referenced in sequence or on its own. Simply refer to the Table of Contents to find the sections that your practice needs most and is ready to implement. In every section, you'll find each of the following:

- A title page, which lists the contents of the section
- A "guide" which briefly describes the tools contained in the section
- The tools themselves

In the first section, "GLAD-PC Guidelines," you'll find the guideline recommendations and a flow chart, which depicts how best to manage adolescent depression in the primary care setting.

The following two sections, "General Psychosocial Screens," and "Screening and Diagnostic Aids" contain tools for identifying and diagnosing cases of depression. The "Guide to" sections will help you choose the right types of tools for your particular practice.

The subsequent sections "Treatment Information for Providers," and "Treatment Referrals and Follow-up" contain tools to help clinicians initiate treatment as well as provide referrals and follow up care. Different tools are available to accommodate individual or large group practices.

The "Speaking with Patients and Parents" section provides primary care clinicians with information and guidance for the crucial task of communicating with adolescents and their caretakers. The sections "Educational Materials for Adolescents" and "Educational Materials for Parents" contain helpful tools to complement and reinforce verbal communication.

The final sections, "Billing" and "Organizational Change," address administrative issues often crucial to creating an environment in which to deliver optimal clinical care.

In this toolkit, we've included tools that we believe are broadly relevant, as well as both easy to use and free. However, in selecting these tools we do not intend to formally exclude other materials that are also widely available and satisfactory for use. Our selections should not be considered exhaustive.

Chapter I.
GLAD-PC Guidelines

Guide to the "GLAD-PC Guidelines" Section

GLAD-PC Recommendations

GLAD-PC Flowchart

Guide to the GLAD-PC Guidelines Section

The Guidelines for Adolescent Depression in Primary Care are not meant to be a cookbook for pediatric providers but rather to provide some much-needed information, recommendations, educational resources, and tools to aid in the management of adolescent depression in primary care. As usual, providers should use their clinical judgment at all times.

GLAD-PC Recommendations

These recommendations are derived from the full updated Guidelines for Adolescent Depression in Primary Care paper. They are listed in the order of clinical care when a patient presents at a practice.

Please refer to the Guidelines papers for a more comprehensive description of each recommendation and to understand the evidence behind these recommendations (Zuckerbrot et al., *Pediatrics*, 2018, & Cheung et al., *Pediatrics*, 2018).

GLAD-PC Flowchart

This two-page flowchart, also derived from the updated papers, depicts the natural flow of patient care in a primary care practice.

As not all providers may be ready to implement all the recommendations at once, use this toolkit to help yourself identify and implement those recommendations that your practice is prepared to apply.

GLAD-PC Recommendations

Practice Preparation

Recommendation I: PC clinicians are encouraged to seek training in depression assessment, identification, diagnosis, and treatment if they are not previously trained (grade of evidence: 5; strength of recommendation: very strong).

Recommendation II: PC clinicians should establish relevant referral and collaborations with mental health resources in the community, which may include patients and families who have dealt with adolescent depression and are willing to serve as a resource for other affected adolescents and their family members. Consultations should be pursued whenever available in initial cases until the PC clinician acquires confidence and skills and when challenging cases arise. In addition, whenever available, these resources may also include state-wide or regional child and adolescent psychiatry consultation programs (grade of evidence: 5; strength of recommendation: very strong).

Identification

Recommendation I: Adolescent patients ages 12 years and older should be screened annually for depression (major depressive disorder or depressive disorders) with a formal self-report screening tool either on paper or electronically (universal screening) (grade of evidence: 2; strength of recommendation: very strong).

Recommendation II: Patients with depression risk factors (eg, a history of previous depressive episodes, a family history, other psychiatric disorders, substance use, trauma, psychosocial adversity, frequent somatic complaints, previous high-scoring screens without a depression diagnosis, etc) should be identified (grade of evidence: 2; strength of recommendation: very strong) and systematically monitored over time for the development of a depressive disorder by using a formal depression instrument or tool (targeted screening) (grade of evidence: 2; strength of recommendation: very strong).

Assessment/Diagnosis

Recommendation I: PC clinicians should evaluate for depression in those who screen positive on the formal screening tool (whether it is used as part of universal or targeted screening), in those who present with any emotional problem as the chief complaint, and in those in whom depression is highly suspected despite a negative screen result. Clinicians should assess for depressive symptoms on the basis of the diagnostic criteria established in the DSM-5 or the International Classification of Diseases, 10th Revision (grade of evidence: 3; strength of recommendation: very strong) and should use standardized depression tools to aid in the assessment (if they are not already used as part of the screening process) (grade of evidence: 1; strength of recommendation: very strong).

Recommendation II: Assessment for depression should include direct interviews with the patients and families and/or caregivers (grade of evidence: 2; strength of recommendation:

very strong) and should include the assessment of functional impairment in different domains (grade of evidence: 1; strength of recommendation: very strong) and other existing psychiatric conditions (grade of evidence: 1; strength of recommendation: very strong). Clinicians should remember to interview an adolescent alone.

Initial Management of Depression

Recommendation I: Clinicians should educate and counsel families and patients about depression and options for the management of the disorder (grade of evidence: 5; strength of recommendation: very strong). Clinicians should also discuss the limits of confidentiality with the adolescent and family (grade of evidence: 5; strength of recommendation: very strong).

Recommendation II: After appropriate training, PC clinicians should develop a treatment plan with patients and families (grade of evidence: 5; strength of recommendation: very strong) and set specific treatment goals in key areas of functioning, including home, peer, and school settings (grade of evidence: 5; strength of recommendation: very strong).

Recommendation III: All management should include the establishment of a safety plan, which includes restricting lethal means, engaging a concerned third party, and developing an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute crisis associated with psychosocial stressors, especially during the period of initial treatment, when safety concerns are the highest (grade of evidence: 3; strength of recommendation: very strong). The establishment and development of a safety plan within the home environment is another important management step.

Treatment

Recommendation I: PC clinicians should work with administration to organize their clinical settings to reflect best practices in integrated and/or collaborative care models (eg, facilitating contact with psychiatrists, case managers, embedded therapists) (grade of evidence: 4; strength of recommendation: very strong).

Recommendation II: After initial diagnosis, in cases of mild depression, clinicians should consider a period of active support and monitoring before starting evidence-based treatment (grade of evidence: 3; strength of recommendation: very strong).

Recommendation III: If a PC clinician identifies an adolescent with moderate or severe depression or complicating factors and/or conditions such as coexisting substance abuse or psychosis, consultation with a mental health specialist should be considered (grade of evidence: 5; strength of recommendation: strong). Appropriate roles and responsibilities for ongoing comanagement by the PC clinician and mental health clinician(s) should be communicated and agreed on (grade of evidence: 5; strength of recommendation: strong). The patient and family should be active team members and approve the roles of the PC and mental health clinicians (grade of evidence: 5; strength of recommendation: strong).

Recommendation IV: PC clinicians should recommend scientifically tested and proven treatments (ie, psychotherapies, such as CBT or IPT-A, and/or antidepressant treatment, such as SSRIs) whenever possible and appropriate to achieve the goals of the treatment plan (grade of evidence: 1; strength of recommendation: very strong).

Recommendation V: PC clinicians should monitor for the emergence of adverse events during antidepressant treatment (SSRIs) (grade of evidence: 3; strength of recommendation: very strong).

Ongoing Management

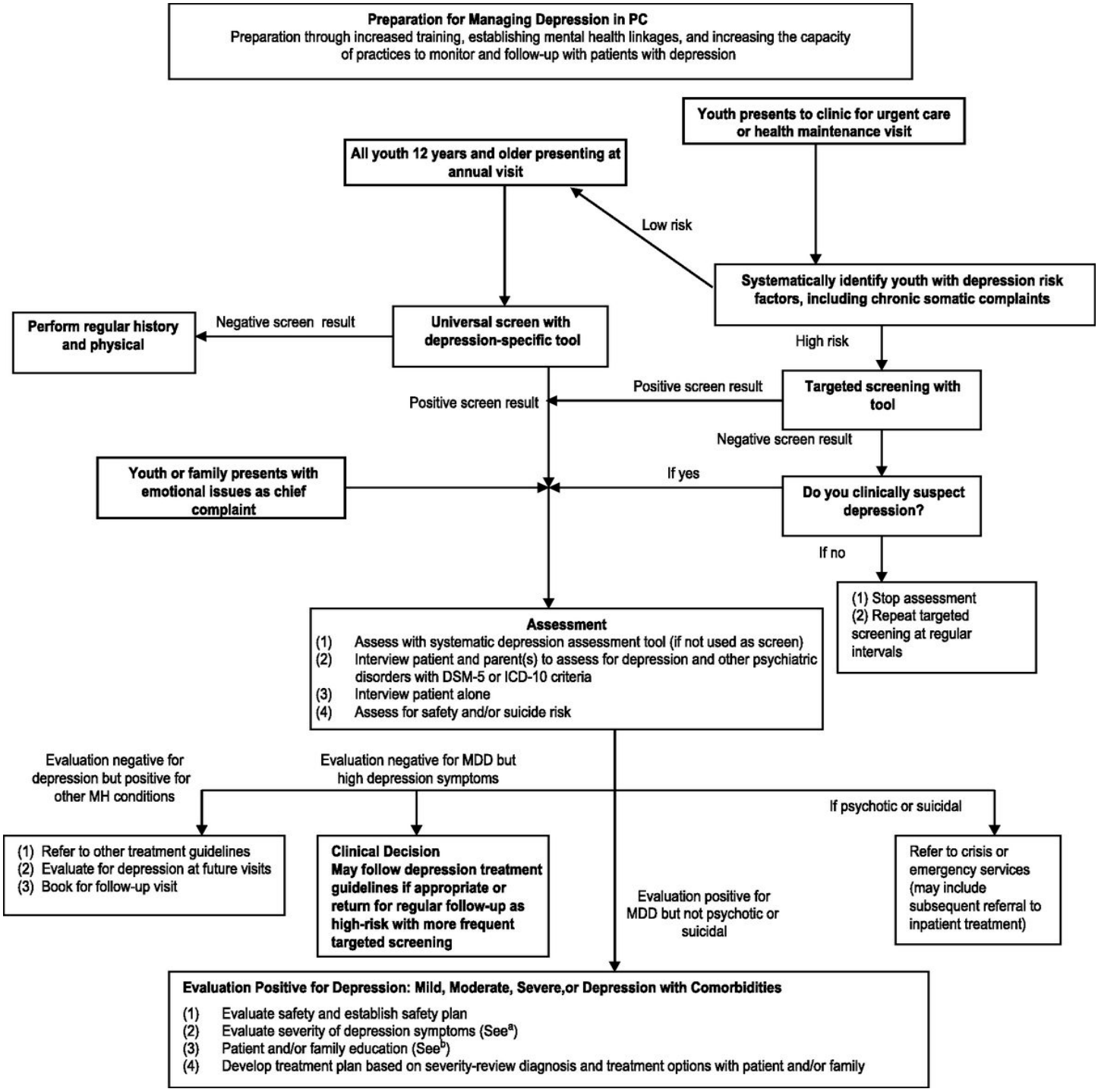
Recommendation I: Systematic and regular tracking of goals and outcomes from treatment should be performed, including assessment of depressive symptoms and functioning in several key domains. These include home, school, and peer settings (grade of evidence: 4; strength of recommendation: very strong).

Recommendation II: Diagnosis and initial treatment should be reassessed if no improvement is noted after 6 to 8 weeks of treatment (grade of evidence: 4; strength of recommendation: very strong). Mental health consultation should be considered (grade of evidence: 4; strength of recommendation: very strong).

Recommendation III: For patients achieving only partial improvement after PC diagnostic and therapeutic approaches have been exhausted (including exploration of poor adherence, comorbid disorders, and ongoing conflicts or abuse), a mental health consultation should be considered (grade of evidence: 4; strength of recommendation: very strong).

Recommendation IV: PC clinicians should actively support depressed adolescents referred to mental health services to ensure adequate management (grade of evidence: 5; strength of recommendation: very strong). PC clinicians may also consider sharing care with mental health agencies and/or professionals where possible (grade of evidence: 1; strength of recommendation: very strong). Appropriate roles and responsibilities regarding the provision and comanagement of care should be communicated and agreed on by the PC clinician and the mental health clinician(s) (grade of evidence: 4; strength of recommendation: very strong).

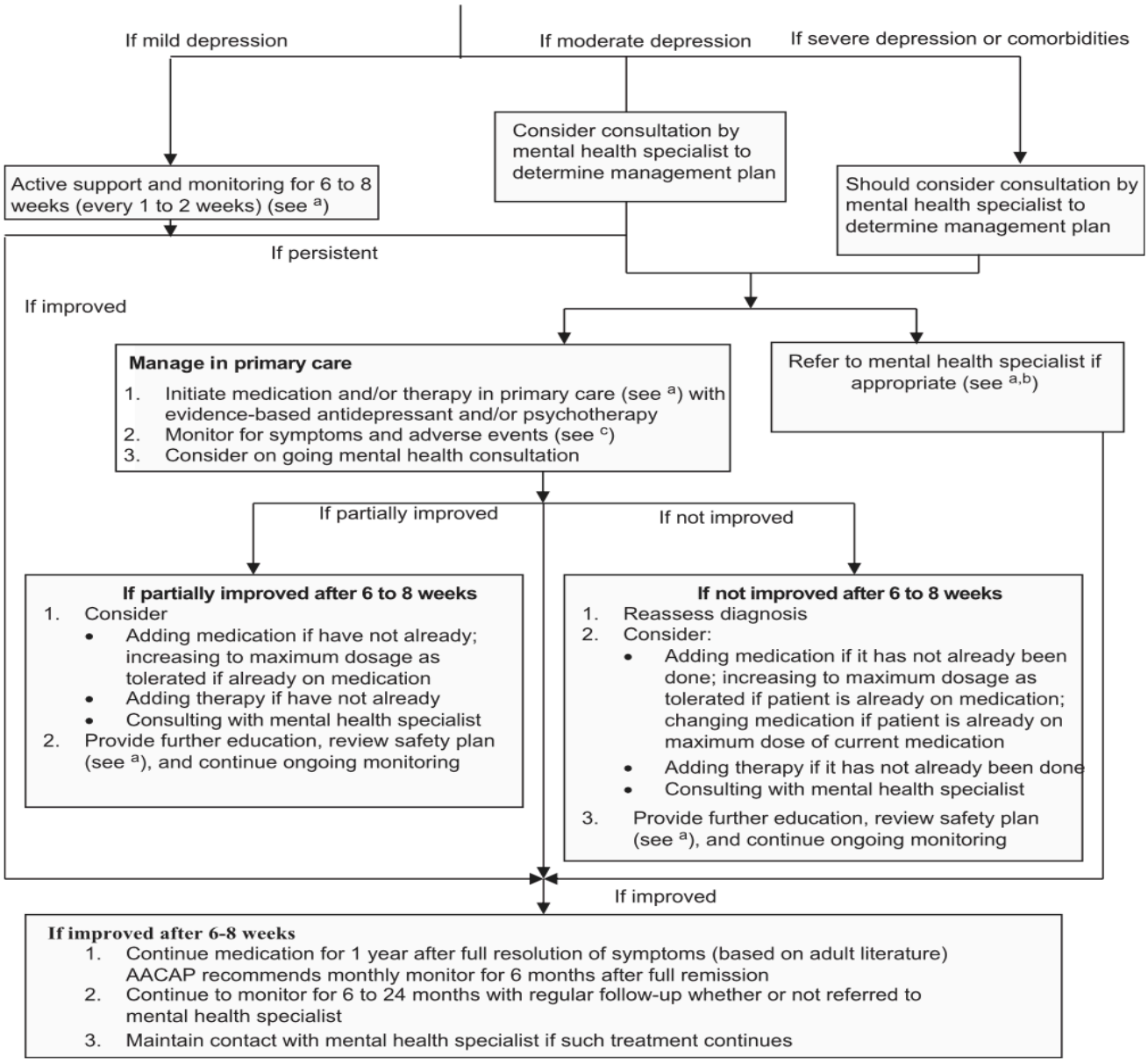
Clinical Assessment Flowchart



[a] See Chapter 3 in the Toolkit for definition of mild, moderate, and severe depression. Please consult toolkit for methods available to aid clinicians to distinguish between mild, moderate, and severe depression.

[b] Provide psychoeducation, provide supportive counseling, facilitate parental & patient self-management, refer for peer support and regular monitoring of depressive symptoms and suicidality.

Clinical Management Flowchart



[a]Psychoeducation, supportive counseling, facilitate parental and patient self-management, refer for peer support, and regular monitoring of depressive symptoms and suicidality.
[b]Negotiate roles and/or responsibilities between PC and mental health and designate case coordination responsibilities. Continue to monitor in PC after referral and maintain contact with mental health.
[c]Clinicians should monitor for changes in symptoms and emergence of adverse events, such as increased suicidal ideation, agitation, or induction of mania. For monitoring guidelines, please refer to the guidelines and/or toolkit.

Chapter II.
General Psychosocial Screens

Guide to the "General Psychosocial Screens" Section

Whole Child Assessment (12–17 years)

Strengths and Difficulties Questionnaire (SDQ, adolescent self-report)

Pediatric Symptom Checklist (PSC)35, Y-PSC-35

PSC-17, PSC-17-Y

Guide to the "General Psychosocial Screens" Section

This section of the toolkit is designed to help you use general psychosocial screens in your practice. One way to identify adolescent depression as early as possible is to establish a systematic universal protocol to screen adolescents for risk factors for depression as well as symptoms of depression. While many providers rely on their clinical interview to identify these risk factors and symptoms, providers often do not have enough time to review all risk factors with all patients. As discussed in the guidelines, screening for depression using a formal self-report depression screening tool is recommended; however, some practices may choose to use a general psychosocial screen either in addition to a depression self-report tool to gain more information, or alone as a gate to a second stage self-report tool. Some general psychosocial screens can help identify those with risk factors for depression; others may ask about specific depression symptoms as well. Using both a general psychosocial screen and a depression-specific self-report tool provides a lot more information and can also capture the parental view of the adolescent. However, sometimes gathering too much information may overwhelm the clinician. Practices should decide which kind of protocol works best for them.

We have provided three questionnaires: the Whole Child Assessment (WCA), the Strengths and Difficulties Questionnaire (SDQ), and the Pediatric Symptom Checklist-17 (PSC-17, parent and youth versions). These questionnaires cover many different psychosocial and health-related risk factors. (Information on accessing the longer PSC-35 is also included.) These can be completed either at home before the visit, in the waiting room in a confidential area, or in the room before the PCP arrives. If these forms are used as a gate, those teens who answer or whose parents answer positively either to depression-specific questions or to questions about depression risk factors should then be given a formal depression self-report tool.

There are information sheets describing these questionnaires in front of the forms.

The Whole Child Assessment (WCA)

Strengths and Difficulties Questionnaire (SDQ)

Pediatric Symptom Checklist-35 (PSC-35)

Youth Pediatric Symptom Checklist (Y-PSC-35)

Pediatric Symptom Checklist-17 (PSC-17)

Pediatric Symptom Checklist-17, Youth (PSC 17-Y)

Whole Child Assessment (WCA)

The Whole Child Assessment (WCA) for teens 12–17 is available in both English and Spanish. This assessment was developed by a California pediatrician, Dr. Ariane Marie-Mitchell. It incorporates questions about adverse childhood experiences (ACEs) in a user-friendly manner, along with general psychosocial and mental health questions. This questionnaire has been field-tested in the Loma Linda Residency Clinic. California MediCal has approved this questionnaire for use.

Dr. Marie-Mitchell describes this questionnaire as a lifestyle assessment. As opposed to other questionnaires that ask about ACEs, the WCA normalizes the questions by asking about domestic violence and seatbelts at the same time.

For more information about how the WCA was developed and how the WCA and the identification of ACEs can help children, go to this link: https://www.acesconnection.com/blog/ca-pediatrician-develops-tests-gets-state-ok-for-whole-child-assessment-tool-that-includes-aces

Selected References

Marie-Mitchell A. O'Connor TG. Adverse childhood experiences: translating knowledge into identification of children at risk for poor outcomes. *Acad Pediatr*. *13(1):14-9, 2013.*

Marie-Mitchell A. Studer KR. O'Connor TG. How knowledge of adverse childhood experiences can help pediatricians prevent mental health problems. *Fam Syst Health. 34(2):128-135, 2016.*

Burke NJ. Hellman JL. Scott BG. Weems CF. Carrion VG. The impact of adverse childhood experiences on an urban pediatric population. *Child Abuse Negl. 35(6):408-13, 2011.*

PLACE PATIENT STICKER HERE

Whole Child Assessment- Version 2 for 12 – 17 Years

Please answer all the questions on this form as best you can. It will help us know how we can help you be healthy. ***You may skip any question if you do not know an answer or do not want to answer.*** *You may add comments to explain your answers. We will keep this information confidential, unless there is concern that you are being hurt.*

1	Person completing form	□ Self	If patient unable to complete, who helped fill out forms? □ Parent □ Friend □ Other *(specify)*									
	Do you live with…?	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*										
2	What grade are you in school?		7		8		9	10	11	12		Interval History
	Are you in special ed or are your grades below average?		No			Unsure				Yes		
3	Since the last visit, have you											
	• Been seen in another clinic?		No			Unsure				Yes		
	• Developed a new illness?		No			Unsure				Yes		
	• Been seen in the Emergency Room?		No			Unsure				Yes		
	• Been hospitalized?		No			Unsure				Yes		
	• Had an operation?		No			Unsure				Yes		
4	Since the last visit, have there been any changes or events that were stressful, scary, or upsetting to you?		No			Unsure				Yes		
5	Do you have any questions or concerns about your health or development? Girls, do you have any questions or concerns about your periods? *If yes, please describe:*		No			Unsure				Yes		
6	Has a family member or close contact had tuberculosis disease during your lifetime?		No			Unsure				Yes		10 Tuberculosis
7	Were you born in the United States?		Yes			Unsure				No		
8	Have you lived or traveled outside of the United States for at least a **month**?		No			Unsure				Yes		
9	Do you brush **and** floss your teeth twice daily?		Often			Sometimes				Never		9 Dental
10	Have you been seen twice by a dentist this year?		Yes			Unsure				No		
11	How many servings of fruit (about the size of your fist) do you eat each **day**?		3+			2				0-1		8 Nutrition
12	How many servings of vegetables (about the size of your fist) do you eat each **day**?		4+			2-3				0-1		
13	How many servings a **day** do you drink or eat of calcium-rich foods, such as milk, cheese, yogurt, soy milk, **OR** tofu?		3+			2				0-1		
14	How many times a **day** do you drink a cup (about 8 oz) of juice, soda, sports drinks, energy drinks, **OR** other sweetened drinks?		0-1			2				3+		
15	How many times a **week** do you eat breakfast?		6-7			3-5				0-2		
16	How many times a **week** do you eat high-fat foods, such as fried foods, pizza, **OR** other fast food?		0-1			2-3				4+		
17	How many times a **week** do you snack on chips, pretzels, **OR** crackers?		0-1			2-3				4+		
18	How many times a **week** do you eat ice cream, cookies, **OR** other desserts?		0-1			2-3				4+		

Whole Child Assessment- Version 2 for 12 – 17 Years

19	How many times a **week** do you engage in moderate to strenuous exercise (causes you to breathe hard or sweat)?	6-7	3-5	0-2	7 Physical Activity
20	On those days that you engage in moderate to strenuous exercise, how many **minutes** to you exercise?	60+	30-59	0-29	
21	Outside of schoolwork, how many **hours a day** do you spend on screen time (TV, phone, computer, tablet, video games, etc.)?	0-1	2+ Sometimes	2+ Often	
22	Do you have trouble falling asleep or staying asleep?	Never	Sometimes	Often	6 Sleep
23	Did you **ever** live with anyone who **often** shouted or yelled at you?	No	Unsure	Yes	5 Relationships
24	Did you **ever** live with anyone who acted in a way that made you feel afraid?	No	Unsure	Yes	
25	Are your parents separated, divorced, or not living together?	No	Deceased parent / Unsure	Yes	
26	Does your family look out for each other, feel close to each other, and support each other?	Often	Sometimes	Never	
27	Do you feel that your family loves you or thinks that you are important or special?	Often	Sometimes	Never	
28	Do you have someone you can count on to listen to you when you need to talk?	Yes	Unsure	No	
29	Has your parent or anyone you **ever** lived with been arrested, deported, gone to prison, jail, or another correctional facility?	No	Unsure	Yes	
30	Have you ever been arrested or gone to jail or juvenile hall?	No	Unsure	Yes	
31	Do you have any questions about sex, preventing pregnancy, or preventing infections from oral, vaginal, or anal sex?	No	Unsure	Yes	
32	Has anyone ever touched you in a way that was unwanted, or forced you to touch that person in a sexual way?	No	Unsure	Yes	
33	Over the past **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	4 Mental Health
	A1. Little interest or pleasure in doing things	0	1 / 2	3	
	A2. Feeling down, depressed, or hopeless	0	1 / 2	3	A:
	B1. Feeling nervous, anxious, or on edge	0	1 / 2	3	
	B2. Not being able to stop or control worrying	0	1 / 2	3	B:
34	During the past **few months**, have you had thoughts that you would be better off dead, or of hurting yourself?	No	Unsure	Yes	
35	Was your parent or anyone you **ever** lived with depressed, mentally ill, **OR** suicidal?	No	Unsure	Yes	
36	Do you smoke, vape, use e-cigarettes, chew tobacco, **OR** spend time with anyone who does?	No	Unsure	Yes	3 Substances
37	Do you have any friends who drank beer, wine, or any drink containing alcohol in the **past year**?	No	Unsure	Yes	
38	How about you—in the **past year** have you had more than a few sips of beer, wine, or any drinking containing alcohol?	No	Unsure	Yes	
39	In the past year, how many times have you had an illegal drug or used a prescription medication for non-medical reasons?	0	1	2+	
40	Did your parent or anyone you **ever** lived with have a problem with drugs **OR** alcohol?	No	Unsure	Yes	Substances

Whole Child Assessment- Version 2 for 12 – 17 Years

41	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure	No	2 Safety
42	Do you ever forget to wear a seat belt?	No	Unsure	Yes	
43	Do you ever forget to wear a helmet when on roller blades, a bike, skateboard, scooter, or motorcycle?	No	Do not ride	Yes	
44	Do you spend time near a swimming pool, river, lake, or hot tub?	No	Unsure	Yes	
45	Do you spend time with anyone who carries a weapon, or spend time in a home where a gun is kept?	No	Unsure	Yes	
46	Have you **ever** seen or heard adults in the home pushing, hitting, kicking, **OR** physically threatening each other?	No	Unsure	Yes	
47	Did you **ever** live with anyone who physically hurt you in anger?	No	Unsure	Yes	
48	Have you **ever** been bullied or cyber bullied, or felt unsafe at school or in your neighborhood?	No	Unsure	Yes	
49	In the **past year**, have you been afraid of someone you were dating or had sex with?	No	Unsure	Yes	
50	On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the **last year**?	Not at all	Somewhat	Very	

If you have additional concerns, comments, or questions, please describe here:

Clinic Use Only		
23 or 24 = 47 = 1 or 32 = 26 or 27 = 50 = 25 = 46 = 40 = 35 = 29 = ∑ = Child-ACE		
PCP's Signature	Print Name	Date

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief, free-of-charge questionnaire consisting of 25 items assessing positive and negative attributes on five scales (emotional, conduct, hyperactivity, peer problems, and prosocial behavior). It takes 5-15 minutes to administer.

An Impact Supplement is also available to assess chronicity, distress and social impairment.

The SDQ can be administered as a self-report for adolescents, age 11-17, and teacher and parent versions are available for children 4-10 and 11-17.

Follow-up questionnaires are also available. All versions of the SDQ are available in 46 languages.

The SDQ can be scored easily by hand or with the use of transparent scoring keys. A total score can be obtained by summing four of the five subscales (excluding the prosocial scale). Scoring of the SDQ takes less than 5 minutes.

The emotional symptoms scale consists of 5 questions that address both depressive and anxiety symptoms and may flag a child who needs further depression assessment.

Included in this toolkit are the self-report version and transparency scoring sheets with directions.

For other methods of scoring, parent and teacher versions, other language formats, or more references/information, please go to the website: www.sdqinfo.com.

Selected References:

Glazebrook C. Hollis C. Heussler H. Goodman R. Coates L. Detecting emotional and behavioural problems in paediatric clinics. *Child: Care, Health & Development. 29(2):141-9, 2003.*

Strengths and Difficulties Questionnaire S[11-17]

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain . Please give your answers on the basis of how things have been for you over the last six months.

Your name ..... Male/Female

Date of birth .....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get along with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	A little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	A little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	A little	A medium amount	A great deal
☐	☐	☐	☐

Your Signature .....

Today's Date .....

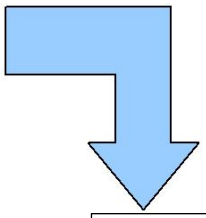
Thank you very much for your help

Scoring the SDQ in 4 Simple Steps

STEP 1

Ask a parent, teacher or adolescent to complete the SDQ.

The age range for each version of the SDQ is noted in the upper right hand corner.



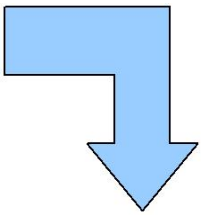
STEP 2

Use the 5 transparent overlays (print the SDQ Scoring pages on transparencies) to score each subscale of the SDQ (i.e., emotional, conduct, hyperactivity, peer and prosocial). Make sure each overlay is lined up properly!

After you've calculated the score for a subscale, write that number down in the appropriate location.

STEP 3

Calculate the TOTAL DIFFICULTIES Score by adding the emotional, conduct, hyperactivity and peer subscale scores. Calculate the PROSOCIAL SCORE separately. Calculate the IMPACT SUPPLEMENT Score using the *Scoring the Impact Supplement* handout as a guide.



STEP 4

Review the SDQ Record Sheet to determine if scores fall in the Normal, Borderline or Abnormal range.

Scoring the Impact Supplement (generating and interpreting impact scores)

When using a version of the SDQ that includes an "Impact Supplement," the items on overall distress and social impairment can be summed to generate an impact score that ranges from 0 to 10 for the self-rated and parent-completed version and from 0 to 6 for the teacher-completed version.

SELF-REPORT IMPACT SUPPLEMENT

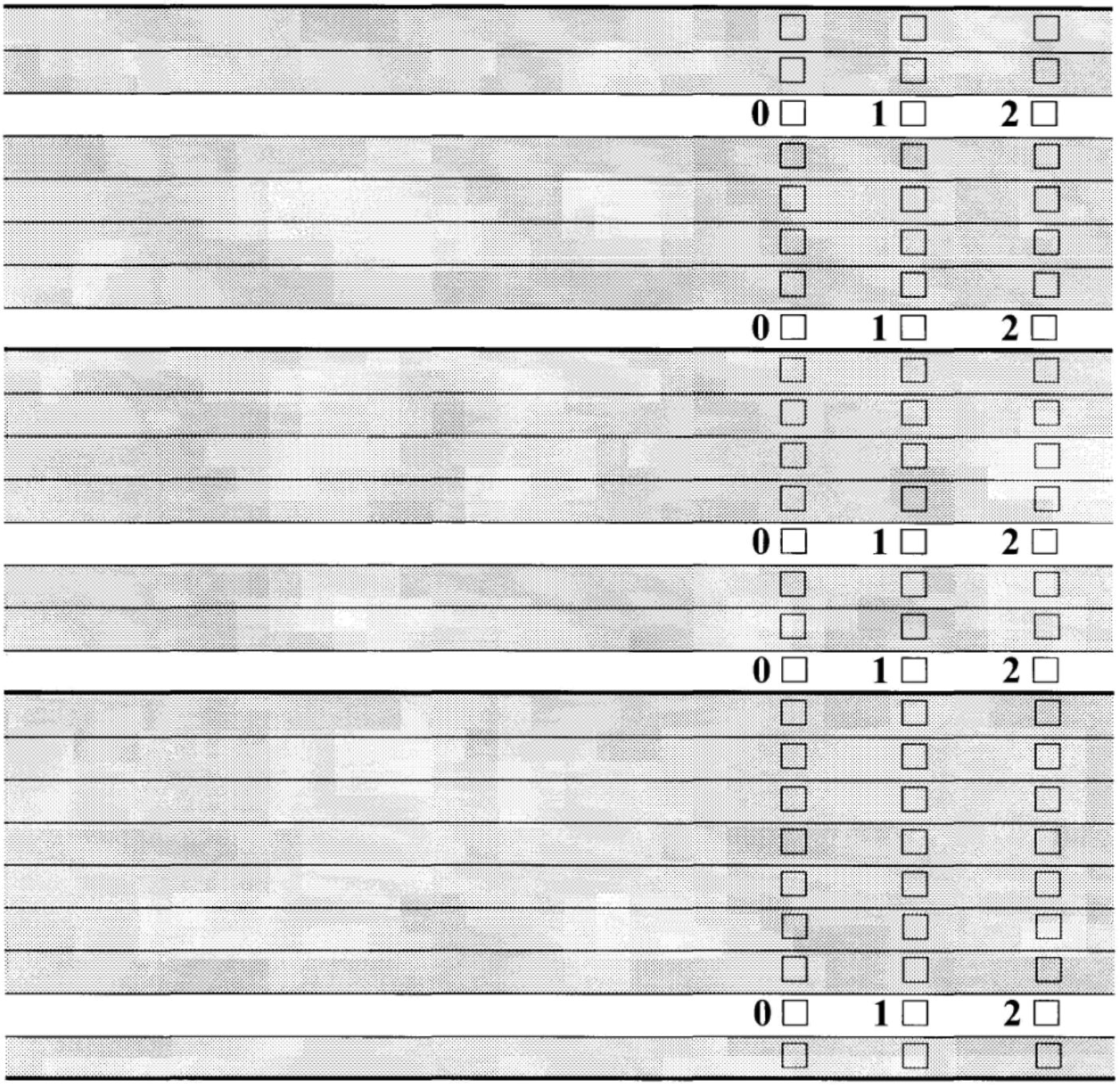
	Not at all	A little	A medium amount	A great deal
Difficulties upset or distress me	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered "no" to the first question on the impact supplement (i.e. when they do not perceive the child, or themselves if self-rated, as having any emotional or behavioral difficulties), they are not asked to complete the questions on resultant distress or impairment; the impact score is automatically scored zero in these circumstances.

Although the impact scores can be used as continuous variables, it is sometimes convenient to classify them as normal, borderline or abnormal: a total impact score of 2 or more is abnormal; a score of 1 is borderline; and a score of 0 is normal.

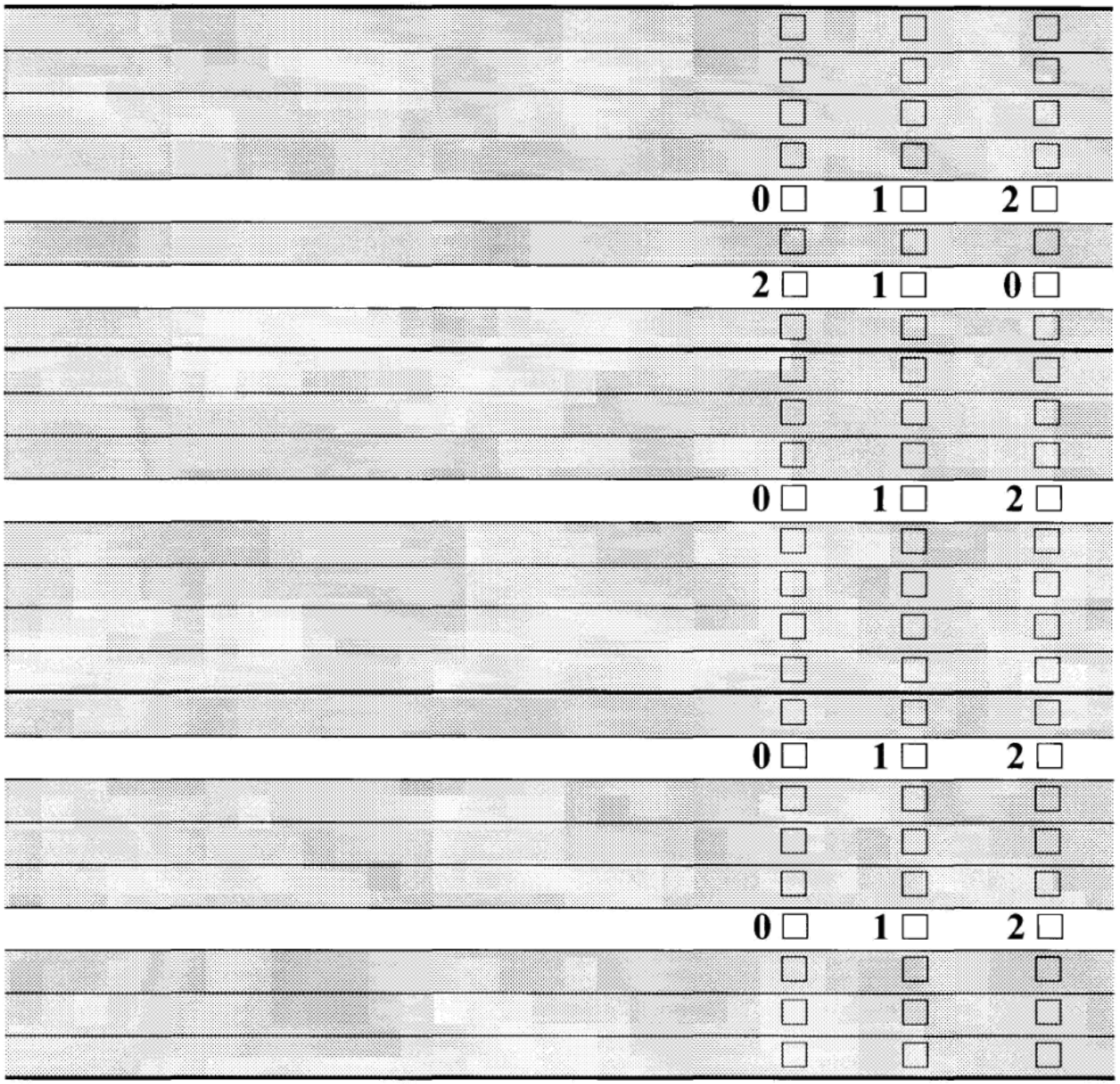
SDQ SCORING 1

SCORING EMOTIONAL SYMPTOMS



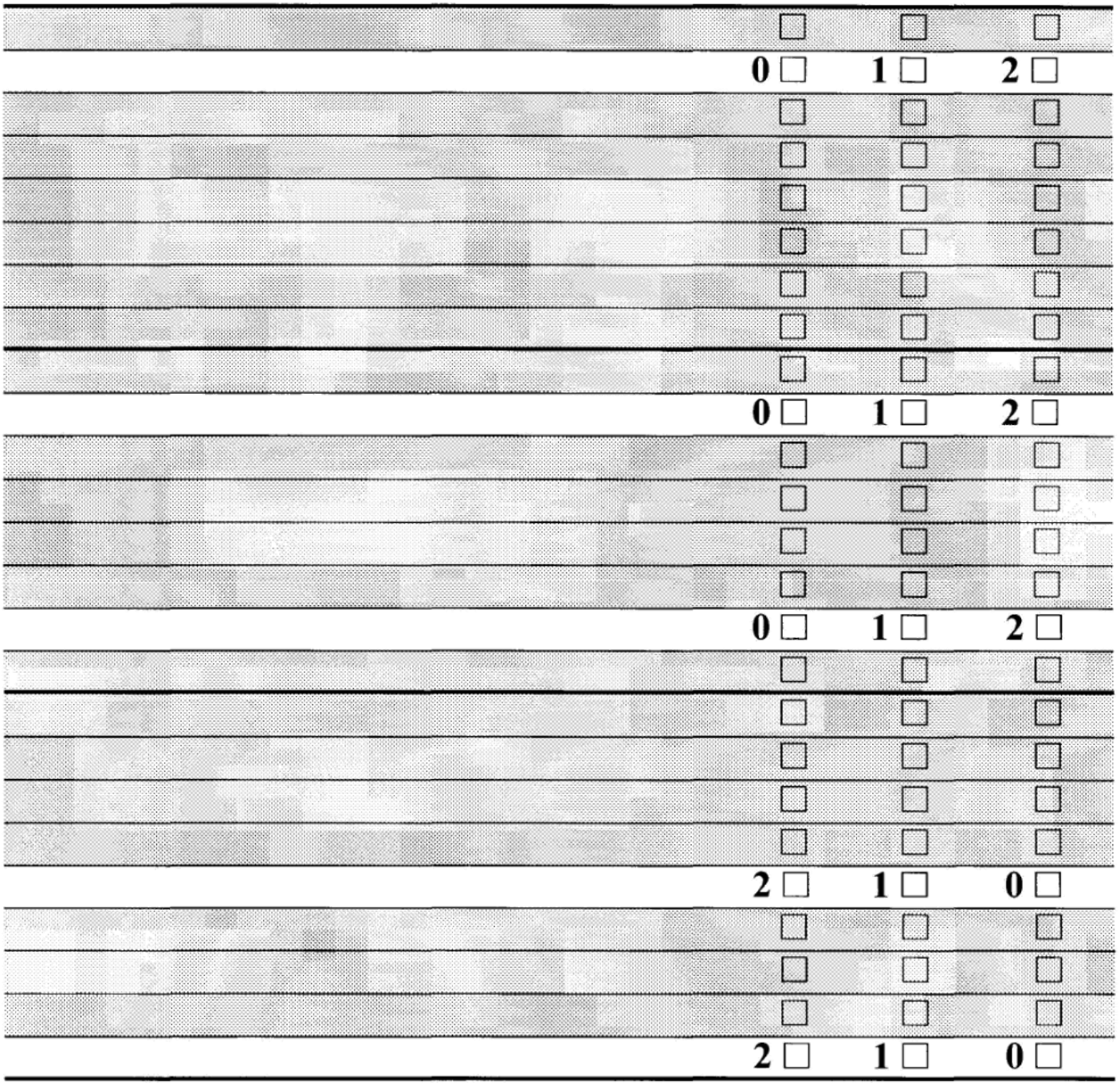
SDQ SCORING 2

SCORING CONDUCT PROBLEMS



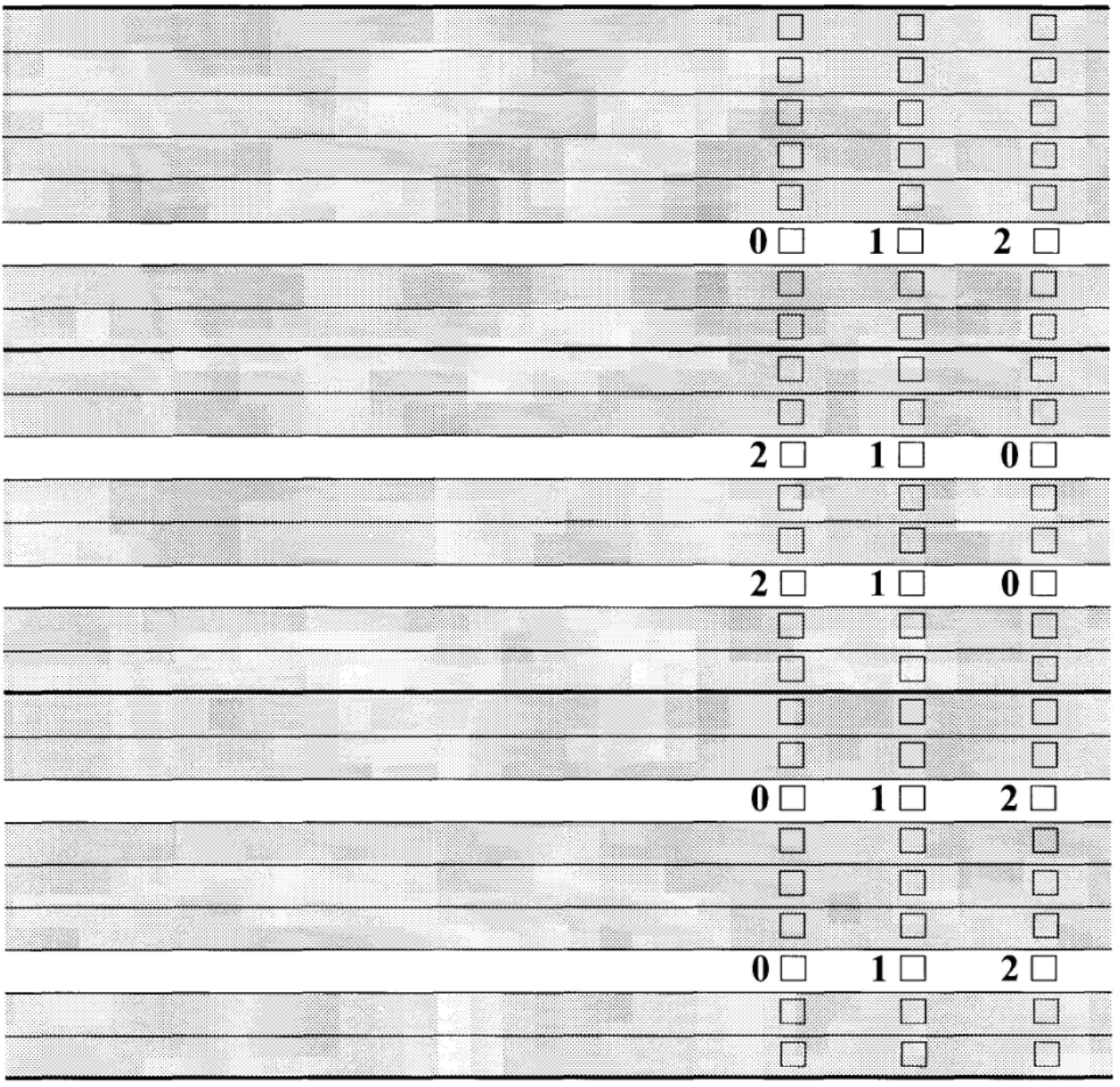
SDQ SCORING 3

SCORING HYPERACTIVITY



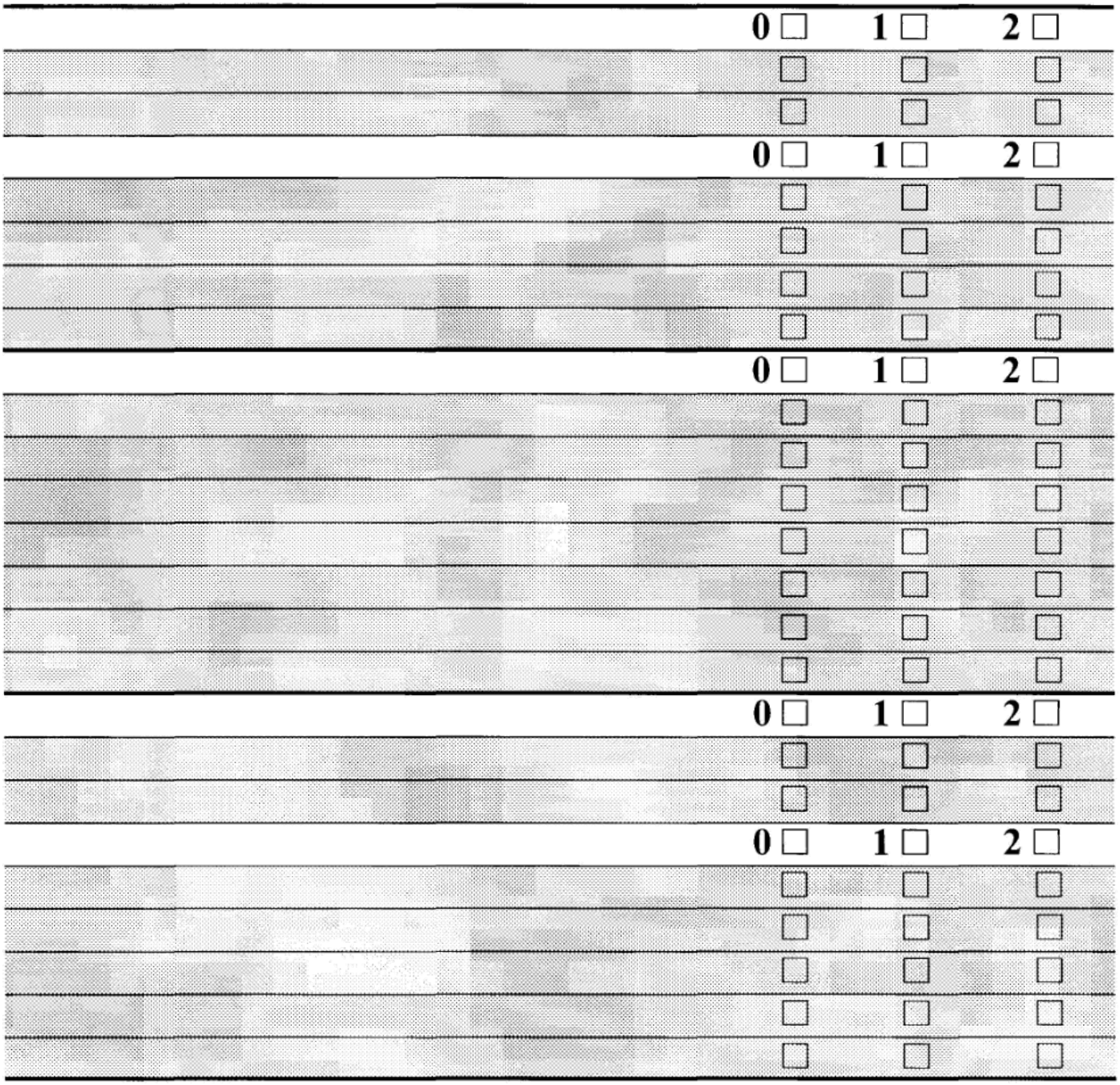
SDQ SCORING 4

SCORING PEER PROBLEMS



SDQ SCORING 5

SCORING PROSOCIAL BEHAVIOUR



SDQ Record Sheet

Name ..... **Age** ..... **Male/Female** **Clinic/Study Number** .....

SDQ completed by: PARENT **on** .....

TEACHER on .....

SELF **on** .....

Scale		Normal														Borderline				Abnormal																
	P	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14		15		16	17	18	19	20	21	22	23	24	25	....	40					
Total difficulties	**T**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**			**12**	**13**	**14**	**15**		**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	.....	**40**					
	S	*0*	*2*	*4*	*6*	*8*	*10*	*11*	*12*	*13*	*14*	*15*				*16*	*17*	*18*	*19*		*20*	*21*	*22*	*23*	*24*	*25*	*26*	...	*40*						
	P	0			1				2				3			4					5	6		7			8			9			10		
Emotional sympt.	**T**	**0**			**1**				**2**				**3**			**4**					**5**	**6**			**7**			**8**			**9**			**10**	
	S	*0*			*1*				*2*				*3*			*4*					*5*	*6*			*7*			*8*			*9*			*10*	
	P	0						1							2						3	4	5	6	7	8	9	10							
Conduct problems	**T**	**0**						**1**							**2**						**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**							
	S	*0*				*1*				*2*					*3*						*4*	*5*		*6*		*7*		*8*			*9*			*10*	
	P	0		1		2		3		4		5				6					7		8			9				10					
Hyperactivity	**T**	**0**		**1**		**2**		**3**		**4**		**5**				**6**					**7**		**8**			**9**				**10**					
	S	*0*		*1*		*2*		*3*		*4*		*5*				*6*					*7*		*8*			*9*				*10*					
	P	0						1							2						3	4	5	6	7	8	9	10							
Peer problems	**T**	**0**				**1**				**2**					**3**						**4**	**5**		**6**		**7**		**8**			**9**			**10**	
	S	*0*				*1*				*2*					*3*			*4*		*5*		*6*			*7*			*8*			*9*			*10*	
	P	10		9		8		7		6						5					4	3		2			1			0					
Prosocial behav.	**T**	**10**		**9**		**8**		**7**		**6**						**5**					**4**	**3**		**2**			**1**			**0**					
	S	*10*		*9*		*8*		*7*		*6*						*5*					*4*	*3*		*2*			*1*			*0*					

Pediatric Symptom Checklist-35 (PSC-35), Parent and Youth

The Pediatric Symptom Checklist-35 (PSC-35) for parents of children 4-16 is a parent-completed general psychosocial screen that looks to flag cognitive, emotional, and behavioral issues. The PSC has been very well-studied and comes in several languages. For children ages 6-16, a cutoff score of 28 suggests the need for follow-up assessment. For ages 4-5, the cut-off is 24. No diagnosis or assumptions should be made on the basis of the PSC-35 alone. Several questions in the PSC-35 address depression symptoms, and these may be used by some to flag the need to do a more intensive depression assessment with a depression specific tool. However, for depression and other internalizing disorders, the teens themselves may be better reporters. To access the tool in English and other languages, go to https://www.massgeneral.org/psychiatry/services/psc_forms.aspx

The Youth Pediatric Symptom Checklist-35 (Y-PSC-35) is intended for adolescents 11 and up. The cut-off score is 30. No diagnosis or assumptions should be made on the basis of the Y-PSC-35 alone. Several questions in the Y-PSC-35 address depression symptoms, and these may be used by some to flag the need to do a more intensive depression assessment with a depression specific tool. To access the tool in English and other languages, go to https://www.massgeneral.org/psychiatry/services/psc_forms.aspx

Selected References

Jellinek MS, Murphy JM, Little M, et al. 1999. Use of the Pediatric Symptom Checklist (PSC) to screen for psychosocial problems in pediatric primary care: A national feasibility study. *Archives of Pediatric and Adolescent Medicine* 153(3):254–260.

Jellinek MS, Murphy JM, Robinson J, et al. 1988. Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics* 112(2):201–209. Web site: http://psc.partners.org.

Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191–197.

Pagano M, Murphy JM, Pedersen M, et al. 1996. Screening for psychosocial problems in 4–5 year olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics* 35(3):139–146.

Pediatric Symptom Checklist-17 (PSC-17), Parent and Youth

The Pediatric Symptom Checklist-17 (PSC-17) for parents of youth was designed as a shorter version of the PSC-35, as it contains only 17 of the original 35 questions. It is divided into three subscales: the internalizing subscale, the externalizing subscale, and the attention subscale. As mentioned with the PSC-35, the PSC-17 is not designed to make a diagnosis but to flag those patients who need further assessment. A total score of 15 or greater is considered positive. A score of 7 or greater on the attention scale, a score of 7 or greater on the externalizing scale (conduct or oppositional behavior problems), or a score of 5 or greater on the internalizing scale (anxiety and/or depression) is considered positive for that specific scale. The different scales are identified by symbols. A positive score on the internalizing scale is sometimes used as a gate to administer more specific depression and anxiety scales. Once again, it is important to note that often teens are better reporters of their internal moods.

To access the tool in more languages, go to
https://www.massgeneral.org/psychiatry/services/psc_forms.aspx

The Pediatric Symptom Checklist-17-Y (PSC-17-Y) is the youth version of the PSC-17 described above. While many PCPs across the country are using this screen in youth ages 11 and older, it should be noted that this specific version of the PSC (the 17-question youth version) was never officially validated; the cut-off scores are extrapolated from the parent version. The PSC-17-Y is divided into three subscales: the internalizing subscale (anxiety and/or depression), the externalizing subscale (conduct or oppositional behavior problems), and the attention subscale. As mentioned with the PSC-35, the PSC-17 is not designed to make a diagnosis but to flag those patients who need further assessment. A total score of 15 or greater is considered positive. A score of 7 or greater on the attention scale, a score of 7 or greater on the externalizing scale, or a score of 5 or greater on the internalizing scale is considered positive for that specific scale. The different scales are identified by symbols. Many use the internalizing subscale as a gate before administering depression-specific screens. To access the tool in more languages, go to https://www.massgeneral.org/psychiatry/services/psc_forms.aspx

Selected Reference

Gardner W, Lucas A, Kolko DJ, Campo JV. 2007 May. Comparison of the PSC-17 and alternative mental health screens in an at-risk primary care sample. *Am Acad Child Adolesc Psychiatry*. 46(5):611-8.

Child's Name: _____ Date of Birth: _____

Filled out by: _____ Today's Date: _____

Pediatric Symptom Checklist 17 (PSC-17)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

	Please mark under the heading that best describes your child:	**Never**	**Sometimes**	**Often**
◆	**Fidgety, unable to sit still**	**0**	**1**	**2**
■	**Feels sad, unhappy**	**0**	**1**	**2**
◆	**Daydreams too much**	**0**	**1**	**2**
●	**Refuses to share**	**0**	**1**	**2**
●	**Does not understand other people's feelings**	**0**	**1**	**2**
■	**Feels hopeless**	**0**	**1**	**2**
◆	**Has trouble concentrating**	**0**	**1**	**2**
●	**Fights with other children**	**0**	**1**	**2**
■	**Is down on him or her self**	**0**	**1**	**2**
●	**Blames others for his or her troubles**	**0**	**1**	**2**
■	**Seems to have less fun**	**0**	**1**	**2**
●	**Does not listen to rules**	**0**	**1**	**2**
◆	**Acts as if driven by a motor**	**0**	**1**	**2**
●	**Teases others**	**0**	**1**	**2**
■	**Worries a lot**	**0**	**1**	**2**
●	**Takes things that do not belong to him or her**	**0**	**1**	**2**
◆	**Distracted easily**	**0**	**1**	**2**

Total ◆ _____ Total ● _____ Total ■ _____ ◆ + ● + ■ _____

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still ◆	0	1	2
❊	Feel sad, unhappy ❊	0	1	2
◆	Daydream too much ◆	0	1	2
❑	Refuse to share ❑	0	1	2
❑	Do not understand other people's feelings ❑	0	1	2
❊	Feel hopeless ❊	0	1	2
◆	Have trouble concentrating ◆	0	1	2
❑	Fight with other children ❑	0	1	2
❊	Down on yourself ❊	0	1	2
❑	Blame others for your troubles ❑	0	1	2
❊	Seem to be having less fun ❊	0	1	2
❑	Do not listen to rules ❑	0	1	2
◆	Act as if driven by a motor ◆	0	1	2
❑	Tease others ❑	0	1	2
❊	Worry a lot ❊	0	1	2
❑	Take things that do not belong to you ❑	0	1	2
◆	Distract easily ◆	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ❊ _____ Grand Total ◆+❑+❊ _____

Form adapted with permission for *Feelings Need Check Ups Too*, 2004
©1988, M. Jellinek & J.M. Murphy, Massachusetts General Hospital (PSC-17 created by W. Gardner & K. Kelleher)
and Bright Futures in Practice: Mental Health, 2002

Pediatric Symptom Checklist 17 Scoring

Instructions for Scoring

The *Pediatric Symptom Checklist-17* (PSC-17) is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

The PSC-17 consists of 17 items that are rated as "Never," "Sometimes, " or "Often" present. A value of **0** is assigned to "Never", **1** to "Sometimes," and **2** to "Often". The total score is calculated by adding together the score for each of the 17 items. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

A PSC-17 score of 15 or higher suggests the presence of significant behavioral or emotional problems.

To determine what kinds of mental health problems are present, determine the 3 factor scores on the PSC:

- **The PSC-17 Internalizing Subscale (Cutoff 5 or more items):**

  Feels sad, unhappy
  Feels hopeless
  Is down on self
  Seems to be having less fun
  Worries a lot

- **The PSC-17 Attention Subscale (Cutoff 7 or more items):**

  Fidgety, unable to sit still
  Daydreams too much
  Has trouble concentrating
  Acts as if driven by a motor
  Distracted easily

- **The PSC-17 Externalizing Subscale (Cutoff 7 or more items):**

  Refuses to share
  Does not understand other people's feelings
  Fights with other children
  Blames others for his/her troubles
  Does not listen to rules
  Teases others
  Takes things that do not belong to him/her

Gardner W, Murphy M, Childs G, et al. The PSC-17: a brief pediatric symptom checklist including psychosocial problem subscales: a report from PROS and ASPN. *Ambulatory Child Health.* 1999;5:225–236.

03/19/08

Chapter III.
Screening and Diagnostic Aids

Guide to "Screening & Diagnostic Aids" Section

The tools in this section can be used for universal screening of adolescents in primary care as recommended by the 2018 GLAD-PC guidelines as well as by the USPSTF's 2015 recommendation: "The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up." For more information see the following website: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening1#Pod8

Diagnosing adolescent depression is an important but challenging process that depends on gathering reliable information. We recommend that you read Part 1 of the GLAD-PC guidelines available at http://pediatrics.aappublications.org/content/141/3/e20174081.long to learn more about diagnosing depression. In order to facilitate and systematize this process, several screens and diagnostic aids have been created, many of which can be found here. Ultimately, however, accurate diagnosis is dependent on a culturally informed, person-to-person interview investigating criteria found in DSM-5.

This section contains listings of **DSM-5 criteria for MDD** and a **framework for grading the severity of depressive episodes**. As discussed in the guidelines, Part 1, referenced above, not all depression is major depressive disorder. Other types of depression exist, including but not limited to dysthymia, subthreshold forms that do not meet the diagnostic standard, substance-induced depressive disorders, and depressive episodes that occur as part of bipolar disorder or other mental illness (anxiety, etc.). Although the evidence in the psychopharmacology recommendations in GLAD-PC focus extensively on MDD, the recommendations around identification, assessment, and initial management can be applied to other forms of depression as well. Suggestions for a **differential diagnosis** are also provided.

This section also discusses developmental considerations and culturally sensitive diagnostic approaches. References to more comprehensive cultural resources are provided.

The following free, depression-specific screens and diagnostic aids, including adolescent-report, parent-report, and provider-assessment scales, are also both described and provided in this section:

Adolescent Reports

Columbia Depression Scale (Teen Version), formerly known as Columbia DISC Depression Scale

Kutcher Adolescent Depression Scale – 6-item

PHQ-9: Modified for Teens

PHQ-9: Modified for Teens in Spanish

PHQ-9: Modified for Teens in Albanian, Arabic, Bengali, Chinese, French, Haitian Creole, Hindi, Korean, Polish, Russian, Urdu (Translated by the New York City Health + Hospitals Office of Population Health and Office of Diversity and Inclusion)

Parent Report

Columbia Depression Scale (Parent Version)

Clinician Assessment of Functioning

Children's Global Assessment Scale (C-GAS)

Some scales, such as the PHQ-9 and the C-GAS, have demonstrated effectiveness not only in diagnosing depression but also tracking response to treatment. (In the "Treatment Information for Providers" section, you will find a form that will allow you to record the results of each assessment, along with other clinical data.) Use the included descriptions to guide you, and choose whichever measures meet your needs in a manner you find user-friendly.

There are other tools in the public domain as well. In addition, some of the more widely used and tested instruments require payment, and thus they are not included here. We have included a sample of instruments and do not intend to reject tools that are not included. It is important to realize that these are screens and aids; they are not sufficient to make a diagnosis or treatment recommendation. A direct interview with the adolescent and, whenever possible, collateral information from parents are necessary to make the most accurate diagnosis as described in Part 1 of the Guidelines at http://pediatrics.aappublications.org/content/141/3/e20174081.long.

DSM-5 Criteria for Major Depressive Disorder

A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

Note: Do not include symptoms that are clearly attributable to another medical condition

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gain.
4) Insomnia or hypersomnia nearly every day
5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6) Fatigue or loss of energy nearly every day
7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C) The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of a clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D) The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
E) There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Coding and Recording Procedures

The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are indicated only if the full criteria are not currently met for a major depressive episode. Codes are as follows.

Severity/course specifier	Single episode	Recurrent episode*
Mild	F32.0	F33.0
Moderate	F32.1	F33.1
Severe	F32.2	F33.2
With psychotic features**	F32.3	F33.3
In partial remission	F32.4	F33.41
In full remission	F32.5	F33.42
Unspecified	F32.9	F33.9

*For an episode to be considered recurrent, there must be an interval of at least 2 consecutive months between separate episodes in which criteria are met for a major depressive episode.

** If psychotic features are present, code the "with psychotic features" specifier irrespective of episode severity.

In recording the name of a diagnosis, terms should be listed in the following order: major depressive disorder, single or recurrent episode, severity/psychotic/remission specifiers, followed by as many of the following specifiers without codes that apply to the current episode.

Specify:

With anxious distress

With mixed features

With melancholic features

With mood-congruent psychotic features

With mood-incongruent psychotic features

With catatonia

With peripartum onset

With seasonal pattern

Framework for Grading Severity of Depressive Episodes

In both the DSM-5 and the ICD-10, severity of depressive episodes is based on the number, type, and severity of symptoms, as well as the degree of functional impairment. The DSM-5 guidelines are summarized in the table below.

DSM-5 Guidelines for Grading Severity Depression

Category	Mild	Moderate	Severe
Number of symptoms	Closer to 5	*	Closer to 9
Severity of symptoms	Distressing but manageable	*	Seriously distressing and unmanageable
Degree of functional impairment	Minor impairment	*	Symptoms markedly interfere

* According to the DSM-5, in "moderate" episodes of depression, "the number of symptoms, the intensity of symptoms, and/or the functional impairment are between those specified for 'mild' and 'severe.'"

In addition to the above framework, individual rating scales are associated with their own indicators of severity, as indicated elsewhere in this section.

DSM-5 Symptom Criteria for Other Depressive Disorders

Adjustment Disorder DSM-5 Criteria

A) The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B) These symptoms or behaviors are clinically significant as evidenced by one or both of the following:
    1) Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation
    2) Significant impairment in social or occupational, or other important areas of functioning.
C) The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
D) The symptoms do not represent normal bereavement.
E) Once the stressor or its consequences have been terminated, the symptoms do not persist for more than an additional 6 months.

Specify whether:

F43.21 With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.
F43.22 With anxiety: Nervousness, worry, jitteriness, or separation anxiety are predominant.
F43.23 With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.
F43.24 With mixed disturbance of conduct: Disturbance of conduct is predominant.
F43.25 With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.
F43.20 Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

Persistent Depressive Disorder (Dysthymia) DSM 5 Criteria F34.1

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A) Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.

   Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B) Presence, while depressed, of two (or more) of the following:
   1) Poor appetite or overeating.
   2) Insomnia or hypersomnia.
   3) Low energy or fatigue.
   4) Low self-esteem.
   5) Poor concentration or difficulty making decisions.
   6) Feelings of hopelessness.

C) During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D) Criteria for a major depressive disorder may be continuously present for 2 years.

E) There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F) The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G) The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medication condition (e.g., hypothyroidism).

H) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Specify if:

With anxious distress
With mixed features
With melancholic features
With atypical features
With mood-congruent psychotic features
With mood-incongruent psychotic features
With peripartum onset

Specify if:

In partial remission
In full remission

Specify if:

Early onset: If onset is before age 21 years
Late onset: If onset is age 21 years or older

Specify if (for most recent 2 years of persistent depressive disorder):

With pure dysthymic syndrome: Full criteria for a major depressive episode have not been met in at least the preceding 2 years.

With persistent major depressive episode: Full criteria for a major depressive episode have been met throughout the preceding 2-year period.

With intermittent major depressive episodes, with current episodes: Full criteria for a major depressive episode are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full major depressive episode.

With intermittent major depressive episodes, without current episode: Full criteria for a major depressive episode are not currently met, but there has been one or more major depressive episodes in at least the preceding 2 years.

Specify current severity:

Mild

Moderate

Severe

Other Specified Depressive Disorder DSM-5 Criteria F32.8

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The other specified depressive disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific depressive disorder. This is done by recording "other depressive disorder" followed by the specific reason (e.g., "short-duration depressive episode").

For examples of more presentations that fit this designation, please see the DSM-5.

Unspecified Depressive Disorder DSM-5 Criteria F32.9

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The unspecified depressive disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific depressive disorder and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

DSM-5 Criteria for Manic and Hypomanic Episodes

Manic Episode DSM-5 Criteria

A) A distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B) During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) have been present to a significant degree and represent a noticeable change from usual behavior:

1) Inflated self-esteem or grandiosity
2) Decreased need for sleep (eg feel rested after only 3 hours of sleep)
3) More talkative than usual or pressure to keep talking
4) Flight of ideas or subjective experience that thoughts are racing
5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed
6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
7) Excessive involvement in pleasurable activates that have a high potential for painful consequences (eg engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C) The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D) The episode is not attributable to the physiological effects of a substance (e.g,. a drug of abuse, a medication, other treatment) or to another medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and therefore, a bipolar I diagnosis.

Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Hypomanic Episode DSM-5 Criteria

A) A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B) During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:
    1) Inflated self-esteem or grandiosity
    2) Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
    3) More talkative than usual or pressure to keep talking
    4) Flight of ideas or subjective experience that thoughts are racing
    5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
    6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
    7) Excessive involvement in pleasure activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C) The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
D) The disturbance in mood and the change in functioning are observable by others.
E) The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
F) The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A-F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Differential Diagnosis of Depressive Symptoms in Adolescents

On the next page is a comprehensive list of disorders that can either be comorbid or mimic the symptoms of depression.

Some patients may have a medical etiology for their symptoms; therefore, ruling out medical causes of depressive symptoms should be done prior to any mental health treatment or referral. However, no lab tests or imaging is routinely required. The medical work-up should be guided by the history and physical examination.

Along with ruling out normal mood changes of adolescence, which are generally not associated with changes in functioning (e.g., drop in grades), clinicians should assess for any symptoms of bipolar disorder. Bipolar disorder is less common in teens than adults. In addition, many teens who may go on to have bipolar disorder will be presenting first with a depressive episode in adolescence, and thus diagnosing bipolar disorder at this point will not be possible. However, since teens with bipolar disorder can have significant adverse effects when treated with antidepressants, obtaining any history of past or current bipolar symptoms is critical. See the DSM-5 criteria for manic and hypomanic episodes on the previous pages. The symptoms of bipolar disorder include an extended period of elevated mood (either happy or irritable or both), decreased need for sleep, an increase in goal-directed activity, increased or pressured speech, racing thoughts or flight of ideas, acting silly or inappropriate with poor judgment that can lead to painful consequences, distractibility, and grandiosity. Others around the teen will often comment on this behavior – noting it as unusual. In addition, teens with a first-degree relative with bipolar disorder are at increased risk of bipolar disorder (although they are at even a greater increased risk for unipolar depression). If clinicians suspect bipolar disorder, a referral should be made to mental health services before initiating treatment.

Differential Diagnosis

Normal moodiness of teens

Major depressive disorder

Persistent depressive disorder (dysthymia)

Premenstrual dysphoric disorder

Substance/medication-induced depressive disorder

Adjustment disorder

Other specified or unspecified depressive disorder

Subthreshold depression

Anxiety disorders

PTSD or other trauma-related disorder

Depressive episode of bipolar disorder

Eating disorders

ADHD

Conduct disorder

Depressive disorder due to another medical condition

- Anemia
- Mononucleosis
- Thyroid disorders
- Other medical disorders

Medication adverse effects

Developmental Considerations for Identifying and Treating Depressed Youth

Just as depression presents differently in youth as compared to adults, identifying and treating pre-pubertal children can be different from treating late adolescents. For example, as younger children often lack the ability to label and verbalize their emotions, they may present with more somatic symptoms compared to more verbal teens. Differences tend to manifest around the time of puberty, but they also depend upon individual's cognitive function. The table on the next page shows some developmental considerations for identifying and treating pre-pubertal children and post-pubertal adolescents. While this guideline refers to adolescents, some adolescents may present at a younger developmental level.

		Children / Pre-pubertal Youth	Adolescents / Post-pubertal Youth
Prevalence of depressive disorders		1-2%; girls: boys = 1:1	3-8%; girls: boys = 2:1
Identification techniques		Given limited ability of most children to identify and communicate how they are feeling, obtaining history from contacts such as parents and teachers is crucial to obtaining an accurate history and chronology of symptoms.	Adolescents themselves may be able to provide a reliable and detailed history,but speaking with contacts is still important. Remember to inquire about any recent dangerous behaviors or statements which may impl suicidal ideation.
Commonly occurring symptoms		Somatic complaints Psychomotor agitation Mood-congruent hallucinations School refusal Phobias / separation anxiety / increase in worrying	Low self-esteem, apathy, boredom Substance use Change in weight, sleep or grades Psychomotor depression / hypersomnia Aggression / antisocial behavior Social withdrawal
Treatment		Treatment of depression should be individualized. It also needs to reflect the severity of depression and the available resources. As fewer rigorous studies have been conducted with pre-pubertal youth, more evidence exists for the treatment of post-pubertal depression.	
	CBT	Good evidence for effectiveness in pre-pubertal children with depressive symptoms	Good evidence for effectiveness in post-pubertal adolescents with depressive symptoms or mild depression
	IPT	No evidence in pre-pubertal youth	Good evidence for effectiveness in mild to moderate depression
	SSRIs	Some evidence for fluoxetine	Good evidence for fluoxetine (TADS), some evidence for escitalopram, citalopram, and sertraline
Prognosis		May be at increased risk for bipolar disorder	Increased risk for depression in adulthood
Suicide		May not understand lethality of means or permanence of death	Tend to use more lethal methods than pre-pubertal youth

Sources: Textbook of Developmental and Behavioral Pediatrics, 2nd Edition, 2018;
Child and Adolescent Psychiatric Clinics of North America, Oct 2006, V15, N4

Resources to Promote Culturally Competent Diagnosis

The diagnosis of depression is improved by being aware of how depression is experienced and discussed among adolescents and parents of different cultural backgrounds. While a discussion of adolescent depression in various cultural contexts is beyond the scope of this toolkit, listed below are links to several free resources that will allow you to assess and improve your cultural knowledge of patients in your practice.

In order to assess the adequacy of your current approach to culturally competent diagnosis, you may want to complete a "self-test" published in the *Journal of the American Association of Family Practice*:

https://www.aafp.org/fpm/2000/1000/p58.html#fpm20001000p58-bt2

For a good overview of cultural competence in the mental health, read "Cultural Competency, A Practical Guide for Mental Health Service Providers," published by the Hogg Foundation for Mental Health at the University of Texas:

https://www.psyrehab.ca/files/documents/Hogg_Foundation_for_MentalHealth.pdf

Another resource is published by the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues:

"Practice parameter for cultural competence in child and adolescent psychiatric practice." https://www.ncbi.nlm.nih.gov/pubmed/24074479#

Finally, the following website, maintained by Georgetown University's National Center for Cultural Competence, provides links to a number of cultural competence resources, self-assessments, and other learning opportunities:

https://nccc.georgetown.edu/index.php

Adolescent Reports

Columbia Depression Scale - Teen Version

(formerly known as the Columbia DISC Depression Scale)

This scale's 22 yes/no questions are the depression stem questions from the Diagnostic Interview Schedule for Children (DISC), which is a structured clinical interview of children that covers all major mental health diagnoses. Question 22 is not scored.

This scale includes questions about suicidal ideation and attempts.

Free with permission: Please contact prudence.fisher@nyspi.columbia.edu

Selected Reference

Shaffer D. Fisher P. Lucas CP. Dulcan MK. Schwab-Stone ME. 2000. NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child & Adolescent Psychiatry. 39(1):28-38.*

Kutcher Adolescent Depression Scale – 6-item

Several versions of the KADS are available and have been tested. The 6-item version is recommended for screening. Longer versions are available for other purposes.

Free with permission.

Selected Reference

LeBlanc JC. Almudevar A. Brooks SJ. Kutcher S. 2002. Screening for adolescent depression: Comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory. *Journal of Child & Adolescent Psychopharmacology. 12(2):113-26.*

PHQ-9: Modified for Teens (English)

The PHQ-9 is a well-validated and respected tool used to assess adult depression in primary care. It was a validated for adoelscents in one study. For a clinical adolescent depression collaborative, the PHQ-9 was modified with permission to better represent DSM-5 adolescent depression by adding *irritability* and changing *work* to *schoolwork*. In addition, it was modifed to include previously validated questions on suicide attempts and adolescent dysthymia. These modifications have never been validated in a research setting.

The socring sheet appears after the English version; translations follow.

Selected References

Kroenke K. Spitzer RL. Williams JB. The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine. 16(9):606-13, 2001.*

Richardson LP. McCauley E. Grossman DC. McCarty CA. Richards J. Russo JE. Rockhill C. Katon W. Evaluation of the Patient Health Questionnaire-9 Item for detecting major depression among adolescents. Pediatrics. *126(6):1117-23, 2010.*

PHQ-9: Modified for Teens in Translation

Spanish

Albanian

Arabic

Bengali

Chinese

French

Haitian Creole

Hindi

Korean

Polish

Russian

Urdu

We want to thank the Office of Population Health and the Office of Diversity and Inclusion, NYC Health + Hospitals, New York City, NY, for providing the PHQ-9 translations.

CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY TEEN

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions as honestly as possible.

In the last four weeks …	No	Yes
1. Have you often felt sad or depressed?	0	1
2. Have you felt like nothing is fun for you and you just aren't interested in anything?	0	1
3. Have you often felt grouchy or irritable and often in a bad mood, when even little things would make you mad?	0	1
4. Have you lost weight, more than just a few pounds?	0	1
5. Have you lost your appetite or often felt less like eating?	0	1
6. Have you gained a lot of weight, more than just a few pounds?	0	1
7. Have you felt much hungrier than usual or eaten a lot more than usual?	0	1
8. Have you had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Have you slept more during the day than you usually do?	0	1
10. Have you often felt slowed down … like you walked or talked much slower than you usually do?	0	1
11. Have you often felt restless … like you just had to keep walking around?	0	1
12. Have you had less energy than you usually do?	0	1
13. Has doing even little things made you feel really tired?	0	1
14. Have you often blamed yourself for bad things that happened?	0	1
15. Have you felt you couldn't do anything well or that you weren't as good looking or as smart as other people?	0	1
16. Has it seemed like you couldn't think as clearly or as fast as usual?	0	1
17. Have you often had trouble keeping your mind on your [schoolwork/work] or other things?	0	1
18. Has it often been hard for you to make up your mind or to make decisions?	0	1
19. Have you often thought about death or about people who had died or about being dead yourself?	0	1
20. Have you thought seriously about killing yourself?	0	1
21. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?	0	1
22. Have you tried to kill yourself in the last four weeks?	0	1

CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

YOUTH-COMPLETED FORM

Add up "1"s ("yes") on items 1 to 21.

Score	Chance of Depression	How often is this seen?
0–6	Very Unlikely	in 2/3 of teens
7–11	Moderately Likely	in 1/4 of teens
12–15	Likely	in 1/10 of teens
16 and Above	Highly Likely	in 1/50 of teens

October 11, 2007

6-item Kutcher Adolescent Depression Scale (KADS)

Over the last week, how have you been "on average" or "usually" regarding the following items:

1) low mood, sadness, feeling blah or down, depressed, just can't be bothered.
    a) hardly ever
    b) much of the time
    c) most of the time
    d) all of the time
2) feelings of worthlessness, hopelessness, letting people down, not being a good person.
    a) hardly ever
    b) much of the time
    c) most of the time
    d) all of the time
3) feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot.
    a) hardly ever
    b) much of the time
    c) most of the time
    d) all of the time
4) feeling that life is not very much fun, not feeling good when usually (before getting sick) would feel good, not getting as much pleasure from fun things as usual (before getting sick).
    a) hardly ever
    b) much of the time
    c) most of the time
    d) all of the time
5) feeling worried, nervous, panicky, tense, keyed up, anxious.
    a) hardly ever
    b) much of the time
    c) most of the time
    d) all of the time
6) Thoughts, plans or actions about suicide or self-harm.
    a) no thoughts or plans or actions
    b) occasional thoughts, no plans or actions
    c) frequent thoughts, no plans or actions
    d) plans and/or actions that have hurt

Scoring of the 6-item Kutcher Adolescent Depression Scale (KADS)

In every item, score:

a) = 0
b) = 1
c) = 2
d) = 3

Then add all 6 item scores to form a single total score.

Interpretation

Total scores at or above 6 suggest “possible depression” (and a need for more thorough assessment).

Total scores below 6 indicate “probably not depressed.”

PHQ-9: Modified for Teens (ages 11-17)

Name: _____ **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. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless?	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired, or having little energy?	0	1	2	3
5. Poor appetite, weight loss, or overeating?	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV?	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 were 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

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

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

[ ] Yes [ ] No

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:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

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).

Scoring the PHQ-9 Modified for Teens

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

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

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

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

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

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

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

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

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

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

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

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

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).

Cuestionario PHQ-9: modificado para adolescentes (edades 11-17)

Nombre:_____ **Fecha:**_____

Instrucciones: ¿Qué tan a menudo le han molestado cada uno de los siguientes síntomas durante las últimas **dos semanas**? Para cada síntoma, escriba una **"X"** en el cuadro que aparece debajo de la respuesta que mejor describe como se siente.

	(0) **Para nada**	*(1)* **Varios días**	*(2)* **Más de la mitad de los días**	*(3)* **Casi todos los días**
1. ¿Poco interés en o placer al hacer las cosas?	0	1	2	3
2. ¿Se siente triste, deprimido, irritable o desesperanzado?	0	1	2	3
3. ¿Le cuesta trabajo quedarse dormido, permanecer dormido, o duerme demasiado?	0	1	2	3
4. ¿Se siente cansado o tiene poca energía?	0	1	2	3
5. ¿Poco apetito, pérdida de peso o come demasiado?	0	1	2	3
6. ¿Se siente mal consigo mismo, o siente que es un fracaso, o que se ha fallado a sí mismo o a su familia?	0	1	2	3
7. ¿Le cuesta trabajo concentrarse en cosas como tareas escolares, leer o ver la televisión?	0	1	2	3
8. ¿Se mueve o habla tan lentamente que otras personas pueden haberlo notarlo? O, por el contrario, ¿está tan inquieto que se mueve mucho más de lo usual?	0	1	2	3
9. ¿Ha pensado que sería mejor estar muerto, o considerado hacerse daño de alguna forma?	0	1	2	3

Si usted está pasando por cualquiera de los problemas mencionados en este formulario, ¿qué tan **difícil** le han hecho estos realizar su trabajo, hacer las cosas de la casa o relacionarse con los demás?

[ ] Nada difícil [ ] Un poco difícil [ ] Muy difícil [ ] Sumamente difícil

¿Se ha sentido deprimido o triste la mayoría de los días durante el **año pasado**, aun cuando se haya sentido bien algunas veces?

[ ] Sí [ ] No

¿Ha habido algún momento durante el **mes pasado** cuando haya pensado seriamente en suicidarse?

[ ] Sí [ ] No

¿**ALGUNA VEZ**, durante su VIDA ENTERA, ha tratado de quitarse la vida o intentado suicidarse?

[ ] Sí [ ] No

Si ha llegado a pensar que sería mejor estar muerto o ha considerado hacerse daño de alguna forma, por favor hable con su clínico de cuidado de la salud, acuda a la sala de emergencias de un hospital o llame al 911.

ÚNICAMENTE PARA USO DE LA OFICINA/FOR OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_Spanish_Feb2018

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).

Pyetësori PHQ-9: Modifikuar për adoleshentët (mosha 11-17)

Emri: _____ **Data:**_____

Udhëzime: Sa herë jeni shqetësuar nga secila prej simptomave të mëposhtme gjatë **dy javëve** të shkuara? Për secilën simptomë vini një **"X"** në kutinë poshtë përgjigjes që përshkruan më së miri se si jeni ndjerë.

	(0) **Aspak**	*(1)* **Disa ditë**	*(2)* **Më shumë se gjysmën e ditëve**	*(3)* **Pothuaj çdo ditë**
1. Keni pak interes ose kënaqësi kur bëni diçka?	0	1	2	3
2. Ndjeheni të rënë shpirtërisht, të acaruar ose të pa shpresë?	0	1	2	3
3. Keni probleme për t'ju zërë gjumi ose të qëndroni në gjumë apo flini jashtë mase shumë?	0	1	2	3
4. Ndiheni të lodhur ose keni pak energji?	0	1	2	3
5. Keni pak oreks, keni rënë në peshë ose hani tej mase?	0	1	2	3
6. Ndjeheni keq rreth vetvetes – ose ndiheni se jeni dështakë, apo e keni zhgënjyer veten ose familjen tuaj?	0	1	2	3
7. Nuk përqendroheni dot si për shembull në detyrat e shkollës, të lexuarin ose shikimin e televizorit?	0	1	2	3
8. Lëvizni ose flisni kaq ngadalë sa njerëzit e tjerë mund ta kenë vënë re? Ose e kundërta – jeni kaq nervozë ose të shqetësuar sa keni lëvizur shumë më tepër se zakonisht?	0	1	2	3
9. Mendime se mund të jeni më mirë të vdekur, ose të lëndoni veten në ndonjë lloj mënyre?	0	1	2	3

Nëse jeni duke përjetuar ndonjë nga problemet në këtë formë, sa **të vështirë** e kanë bërë këto probleme për ju që të bëni punën tuaj, të kujdeseni për gjërat në shtëpi ose të shkoni mirë me njerëzit e tjerë?

[ ] Aspak të vështirë [ ] Disi të vështirë [ ] Shumë të vështirë [ ] Jashtëzakonisht të vështirë

Gjatë **vitit të kaluar** a jeni ndjerë të depresuar apo të trishtuar shumicën e ditëve, edhe nëse jeni ndjerë mirë nganjëherë?

[ ] Po [ ] Jo

A ka pasur një moment në **muajin e kaluar** kur keni pasur mendime të rëndësishme që t'i jepni fund jetës?

[ ] Po [ ] Jo

GJATË GJITHË jetës tuaj a jeni përpjekur **NDONJËHERË** të vrisni veten ose të bëni një përpjekje për vetëvrasje?

[ ] Po [ ] Jo

Nëse keni pasur mendime se do të jeni më mirë të vdekur ose nëse do ta lëndoni veten në një farë mënyre, diskutoni me mjekun tuaj të kujdesit shëndetësor, shkoni në një pavijon urgjence të spitalit ose telefononi 911

VETËM PËR PËRDORIM ZYRTAR /OFFICE USE ONLY:

SCORE: _____ ***Screener Name :*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_Albanian_Feb2018

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).

استبيان PHQ-9: المعدل للمراهقين (من عمر 11 إلى 17 عامًا)

الاسم: _____ **التاريخ:**_____

التعليمات: كم عدد المرات التي تعرضت فيها إلى الأعراض التالية خلال آخر **أسبوعين؟** أمام كل عرَض، ضع علامة **"X"** في المربع الذي أسفل الإجابة الأنسب لوصف ما شعرت به.

	(0) **لا، على الإطلاق**	*(1)* **عدة أيام**	*(2)* **أكثر من نصف يوم**	*(3)* **تقريبًا كل يوم**
1. هل عانيت من قلة الاهتمام أو قلة السعادة تجاه فعل الأشياء؟	0	1	2	3
2. هل شعرت بالإحباط أو الاكتئاب أو الغضب أو فقدان الأمل؟	0	1	2	3
3. هل عانيت من صعوبة عند النوم أو في مواصلة النوم أو هل نمت كثيرًا جدًا؟	0	1	2	3
4. هل شعرت بالتعب أو ضعفت قواك؟	0	1	2	3
5. هل شعرت بضعف الشهية أو فرط الأكل أو تعرضت إلى فقدان الوزن؟	0	1	2	3
6. هل كانت لديك مشاعر سيئة تجاه نفسك – أو شعور بأنك فاشل أو بأنك السبب في إحباط نفسك أو إحباط أسرتك؟	0	1	2	3
7. هل عانيت من مشكلات في التركيز عند التعامل مع أشياء مثل العمل المدرسي أو القراءة أو مشاهدة التلفزيون؟	0	1	2	3
8. هل عانيت من بطء في النطق أو الحركة لاحظه الآخرون؟ أو في المقابل – هل شعرت بالتململ أو العصبية مما جعلك تكثر من الحركة على غير المعتاد؟	0	1	2	3
9. هل رادودتك أفكار بأنك ستكون أفضل إذا مت أو إذا أذيت نفسك بطريقة ما؟	0	1	2	3

إذا كنت تعاني من أي من المشكلات الواردة في هذا النموذج، فما مدى **الصعوبة** الناتجة عن هذه المشكلات على عملك أو اعتنائك بالأشياء في المنزل أو علاقتك بالآخرين؟

[ ] لا صعوبة على الإطلاق [ ] صعوبة بسيطة [ ] صعوبة كبيرة [ ] صعوبة شديدة

خلال **السنة الماضية** هل شعرت بالاكتئاب أو الحزن في أكثر الأيام، حتى وإن شعرت بالراحة أحيانًا؟
[ ] نعم [ ] لا

هل مر عليك وقت خلال **الشهر الماضي** راودتك فيه أفكار خطيرة بشأن إنهاء حياتك؟
[ ] نعم [ ] لا

هل سبق لك، خلال حياتك كلها، أن حاولت قتل نفسك أو قمت بمحاولة انتحار؟
[ ] نعم [ ] لا

إذا رادودتك أفكار بأنك ستكون أفضل إذا مت أو إذا أذيت نفسك بطريقة ما، فيرجى مناقشة ذلك مع طبيب الرعاية الصحية أو اذهب إلى مستشفى طوارئ أو اتصل بالرقم 911

للاستخدام المكتبي فقط/ OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_Arabic_Feb2018

প্রশ্নাবলী **PHQ-9:** কিশোরবয়স্কদের **(**বয়স **11-17)** জন্য সংশোধিত

নাম: _____ **তারিখ:**_____

নির্দেশাবলী: গত **দুই সপ্তাহে** নিম্নলিখিত উপসর্গগুলির প্রতিটির দ্বারা আপনি কতটা বিব্রত হয়েছেন? প্রতিটি উপসর্গের ক্ষেত্রে, আপনি যেমন অনুভব করছিলেন তা সবচেয়ে সঠিকভাবে বর্ণনা করে যে উত্তরটি সেটির জন্য নিচের বক্সে **"X"** চিহ্ন দিন।

	(0) **একেবারেই না**	*(1)* **কয়েক দিন**	*(2)* **দিনের অর্ধেকের বেশি**	*(3)* **প্রায় প্রতিদিন**
1. কাজ করার অল্প আগ্রহ বা আনন্দ?	0	1	2	3
2. মনমরা, অবসাদগ্রস্ত, খিটখিটে, বা নিরাশ অনুভূতি?	0	1	2	3
3. ঘুমিয়ে পড়তে সমস্যা, ঘুমিয়ে থাকতে সমস্যা হওয়া অথবা খুব বেশি ঘুম?	0	1	2	3
4. ক্লান্ত বোধ করা বা শক্তি কম থাকা?	0	1	2	3
5. খাদ্যে অনীহা, ওজন হানি, বা অতিরিক্ত খাওয়া?	0	1	2	3
6. নিজের সম্পর্কে খারাপ বোধ করা - বা আপনি ব্যর্থ হয়েছেন, বা আপনি নিজের ও পরিবারের অবনতি ঘটিয়েছেন এমন মনে করা?	0	1	2	3
7. স্কুলের কাজ, পড়া, বা টিভি দেখার মতো কাজে মনোসংযোগের সমস্যা?	0	1	2	3
8.এত ধীরে চলাফেরা করছেন বা কথা বলছেন যা অন্য ব্যক্তিদের নজরে এসে থাকবে? বা বিপরীত - এত বেশি অধৈর্য বা অস্থির যে আপনি স্বাভাবিকের তুলনায় অনেক বেশি ঘোরাঘুরি করছিলেন?	0	1	2	3
9.আপনি এর চেয়ে মরে গেলেই ভাল হয় বা নিজেকে কোনোভাবে আঘাত করার চিন্তাভাবনা?	0	1	2	3

আপনি যদি এই ধরনের কোনো সমস্যায় ভুগতে থাকেন, তাহলে এইসকল সমস্যাগুলি আপনার কাজ করা, বাড়ির কাজকর্মের প্রতি যত্ন নেওয়া বা অন্যান্য ব্যক্তিদের সাথে মিলেমিশে থাকা কতটা **কষ্টকর** করে তুলেছে?

[ ] একেবারেই কষ্টকর নয় [ ] কিছুটা কষ্টকর [ ] খুব কষ্টকর [ ] অত্যন্ত কষ্টকর

গত বছরে আপনি কি অধিকাংশ দিন অবসাদগ্রস্ত বা দুঃখিত বোধ করেছিলেন, এমনকি আপনি কখনও কখনও ঠিক বোধ করলেও?

[ ] হ্যাঁ [ ] না

গত মাসে এমন কোনো সময় কি এসেছে যখন আপনার জীবন সমাপ্ত করার গুরুতর চিন্তাভাবনাগুলি আপনার দেখা দিয়েছে? [ ] হ্যাঁ [ ] না

আপনি কি **কখনো**, আপনার সারা জীবনে, নিজেকে মেরে ফেলার বা আত্মহত্যা করার চেষ্টা করেছেন?

[ ] হ্যাঁ [ ] না

আপনি এর চেয়ে মরে গেলেই ভাল হয় বা নিজেকে কোনোভাবে আঘাত করার চিন্তাভাবনা যদি আপনার এসে থাকে, তাহলে অনুগ্রহ করে আপনার হেলথ কেয়ার ক্লিনিসিয়ানের সাথে, বা হাসপাতালের আপৎকালীন কক্ষে গিয়ে বা 911 নম্বরে ফোন করে এটি আলোচনা করুন।

শুধুমাত্র অফিসের ব্যবহারের জন্য /OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

问卷 PHQ-9：针对青少年（11 – 17 岁）的改编

姓名：_____ **日期：**_____

说明：过去**两周**内，您多长时间会受到以下各种症状的困扰？对于每种症状，请在最符合您感受的答案下面方框内打**“X”**。

	(0) **完全没有**	*(1)* **几天**	*(2)* **超过一半日子**	*(3)* **几乎每天**
1. 做事情几乎没有兴趣或乐趣？	0	1	2	3
2. 感觉情绪低落、沮丧、易怒或无望？	0	1	2	3
3. 难以入睡、难以维持睡眠、或者睡眠时间过长？	0	1	2	3
4. 感觉疲倦或者几乎没有精力？	0	1	2	3
5. 食欲不振、体重减轻或者吃得过多？	0	1	2	3
6. 感觉自己差劲，觉得自己是个失败者，或者让自己或家人失望？	0	1	2	3
7. 难以专注于学校课业、阅读或看电视等事情？	0	1	2	3
8. 行动或说话很慢，慢到其他人可能已经注意到？或者相反，您明显坐立不安或焦虑烦躁，比平常更多四处走动？	0	1	2	3
9. 存有不如死去或以某种方式伤害自己的念头？	0	1	2	3

如果您正在经历此表所述任何问题，那么这些问题对您完成本职工作、处理家庭事务或与其他人相处造成了多大**困难**？

[ ] 完全没有困难 [ ] 有些困难 [ ] 非常困难 [ ] 极度困难

在**过去一年**中，虽然您有时感觉还好，但是否在大多数日子感觉沮丧或悲伤？

[ ] 是 [ ] 否

在**过去一个月**中，您是否在某个时候曾认真考虑过要终止自己的生命？

[ ] 是 [ ] 否

在您的一生中，是否**曾经**尝试杀死自己或者作出自杀尝试？

[ ] 是 [ ] 否

如果您存有不如死去或以某种方式伤害自己的念头，请与您的临床保健医生讨论此事，也可到医院急诊室就诊或拨打 911

仅限诊室使用/OFFICE USE ONLY：

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_Simplified Chinese_Feb2018

Questionnaire PHQ-9 : Modifié pour les adolescents (âgés de 11 à 17 ans)

Nom :_____ **Date :**_____

Instructions : Au cours des **deux** dernières **semaines**, à quelle fréquence avez-vous été gêné(e) par chacun des symptômes suivants ? Pour chaque symptôme, inscrivez un **« X »** dans la case placée sous la réponse qui décrit le mieux ce que vous avez ressenti.

	(0) **Jamais**	*(1)* **Plusieurs jours**	*(2)* **Plus de la moitié du temps**	*(3)* **Presque tous les jours**
1. Avoir peu d'intérêt ou de plaisir à faire les choses	0	1	2	3
2. Vous sentir triste, déprimé(e), irritable ou désespéré(e)	0	1	2	3
3. Avoir des difficultés à vous endormir, à rester endormi(e) ou trop dormir	0	1	2	3
4. Vous sentir fatigué(e) ou avoir peu d'énergie	0	1	2	3
5. Avoir peu d'appétit, perdre du poids ou trop manger	0	1	2	3
6. Avoir une mauvaise image de vous-même, ou penser que vous êtes un(e) perdant(e) ou que vous n'avez pas satisfait vos propres attentes ou celles de votre famille	0	1	2	3
7. Avoir des difficultés à vous concentrer sur des choses telles que le travail scolaire, lire ou regarder la télévision	0	1	2	3
8. Bouger ou parler si lentement que d'autres personnes ont pu le remarquer Ou au contraire, être si turbulent(e) ou agité(e) au point de bouger beaucoup plus que d'habitude	0	1	2	3
9. Penser que vous feriez mieux d'être mort(e) ou penser à vous blesser d'une façon ou d'une autre	0	1	2	3

Si vous avez coché au moins l'un des problèmes mentionnés dans ce formulaire, dans quelle mesure ce ou ces problèmes ont-ils rendu **difficile** l'accomplissement de votre travail ou de vos tâches à la maison, ou vos relations avec les autres ?

[ ] Pas du tout difficile [ ] Plutôt difficile [ ] Très difficile [ ] Extrêmement difficile

Au cours de **l'année passée**, vous êtes-vous senti(e) déprimé(e) ou triste la plupart du temps, même si parfois vous vous sentiez bien ?

[ ] Oui [ ] Non

Y a-t-il eu un moment au cours du **mois dernier** où vous avez sérieusement pensé à mettre fin à vos jours ?

[ ] Oui [ ] Non

Avez-vous **DÉJÀ**, au cours de votre VIE, essayé de vous tuer ou fait une tentative de suicide ?

[ ] Oui [ ] Non

Si vous avez pensé que vous feriez mieux d'être mort(e) ou à vous blesser d'une façon ou d'une autre, veuillez en discuter avec votre médecin traitant, vous rendre dans un service hospitalier des urgences ou appeler le 911.

RÉSERVÉ À L'USAGE INTERNE/OFFICE USE ONLY :

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_French_Feb2018

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Kesyonè PHQ-9: Modifye pou adolesan yo (gwoup laj 11-17)

Non: _____ **Dat:**_____

Machaswiv: Konbyen fwa chak nan sentòm sa yo ki anba a te rann ou mal alèz pandan **de semenn** ki sot paseyo? Pou chak sentòm mete yon **"X"** nan bwat anba repons la ki eksplike pi byen kouman ou te santi ou.

	(0) **Pa Ditou**	*(1)* **Plizyè Jou**	*(2)* **Plis Pase Demi Jounen**	*(3)* **Prèske Chak Jou**
1. Èske ou konn enterese oswa pran plezi lè ou ap fè yon bagay?	0	1	2	3
2. Èske ou konn santi ou dekouraje, deprime, an movèz imè oswa san espwa?	0	1	2	3
3. Èske ou konn gen pwoblèm pou tonbe dòmi, rete dòmi oswa dòmi twòp?	0	1	2	3
4. Èske ou konn santi ou fatige, oswa santi feblès?	0	1	2	3
5. Èske ou pèdi apeti, ou ap pèdi pwa, oswa manje twòp?	0	1	2	3
6. Èske ou konn santi ou kè fè ou mal pou tèt ou- oswa santi ou se yon echèk oswa ou santi ou pa regle anyen ak lavi ou oswa ou anbarase fanmi ou ?	0	1	2	3
7. Èske ou gen difikilte pou konsantre ou sou bagay tankou travay lekòl, fè lekti oswa gade televizyon?	0	1	2	3
8. Eksè ou fonksyone oswa pale tèlman dousman jis menm lòt moun ta ka remake sa? Oswa lekontrè- èske ou konn ajite oswa nève tèlman ou ap monte desann plis pase nòmal?	0	1	2	3
9. Èske ou konn ap panse ou tap miyò si ou te mouri, oswa panse fè tèt ou mal nan yon fason ?	0	1	2	3

Si ou fè eksperyans avèk nenpòt nan pwoblèm ki nan fòmilè sa a, nan ki nivo pwoblèm sa yo konn fè li **difisil** pou ou pou ou fè travay ou, jere bagay lakay oswa antann ak lòt moun?

[ ] Pa difisil ditou [ ] Yon jan difisil [ ] Vrèman difisil [ ] Ekstrèman difisil

Nan **ane ki sot pase a** èske ou te santi ou deprime oswa tris nan pifò jou yo, menm si ou te konn santi ou oke pafwa ?

[ ] WI [ ] Non

Èske te gen yon lè nan **mwa pase a** kote ou te panse vrèman mete yon fen nan lavi ou?

[ ] Wi [ ] Non

Èske ou te **JANM**, pandan TOUT LAVI ou, te eseye pou touye tèt ou oswa te fè yon tantativ pou ou komèt swisid?

[ ] Wi [ ] Non

Si ou te konn panse ou te ka pi bon si ou te mouri oswa fè tèt ou mal nan yon fason, tanpri diskite sa avèk Founisè Swen Sante ou an, ale nan sal ijans oswa rele 911

REZÈVE POU SEVIS BIWO AN SÈLMAN/ OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

प्रश्नावली PHQ-9: किशोरों के लिए संशोधित (आयु 11-17)

नाम: _____ **दिनांक:**_____

निर्देश: पिछले **दो सप्ताहों** के दौरान निम्नलिखित लक्षणों में से प्रत्येक से आप कितनी बार चिंतित हुए हैं? प्रत्येक लक्षण के लिए उस उत्तर के नीचे बॉक्स में **"X"** का निशान लगाएं जो आपको महसूस होने के तरीके को सबसे अच्छी तरह से वर्णित करता है।

	(0) **बिल्कुल नहीं**	*(1)* **कई दिन**	*(2)* **आधे से ज्यादा दिन**	*(3)* **लगभग रोजाना**
1. चीज़ों को करने में थोड़ी रुचि या खुशी मिलना?	0	1	2	3
2. उदास, अवसादग्रस्त, चिड़चिड़ा, या निराश महसूस करना?	0	1	2	3
3. नींद आने, सोते रहने, या बहुत ज्यादा सोने में कठिनाई होना?	0	1	2	3
4. थका हुआ, या बहुत कम ऊर्जा होना महसूस करना?	0	1	2	3
5. भूख कम लगना, वजन गिरना, या ज्यादा खाना?	0	1	2	3
6. खुद के बारे में बुरा महसूस करना - या यह महसूस करना कि आप एक असफल व्यक्ति हैं, या कि आपने खुद को या अपने परिवार को नीचा दिखाया है?	0	1	2	3
7. चीज़ों जैसे स्कूल के काम, पढ़ने, या टीवी देखने में ध्यान केन्द्रित करने में कठिनाई होना?	0	1	2	3
8. इतने धीरे से चलना या बोलना कि दूसरे लोगों का ध्यान जा सके? या इसके विपरीत - इतना व्याकुल या बेचैन होना कि आप आसपास सामान्य से ज्यादा चल-फिर रहे थे?	0	1	2	3
9. ऐसे विचार कि मर जाते तो बेहतर होता, या किसी तरीके से खुद को चोट पहुंचाना?	0	1	2	3

यदि आपको इस फॉर्म की किन्हीं समस्याओं का अनुभव हो रहा है, तो इन समस्याओं ने आपके लिए अपना काम करना, घर पर चीज़ों की देखभाल करना या अन्य लोगों के साथ मिलना-जुलना कितना **कठिन** बना दिया है?

[ ] बिलकुल कठिन नहीं [ ] थोड़ा बहुत कठिन [ ] बहुत कठिन [ ] अत्यधिक कठिन

पिछले वर्ष **में** क्या आपने अधिकांश दिनों में अवसादग्रस्त या दुखी महसूस किया है, भले ही आपको कभी-कभी ठीक महसूस हुआ था? [ ] हाँ [ ] नही

क्या **पिछले महीने** में ऐसा भी समय रहा है जब आपको अपना जीवन खत्म करने के बारे में गंभीर विचार आए हैं?

[ ] हाँ [ ] नहीं

क्या आपने अपने पूरे जीवन में **कभी-भी**, खुद को मारने की कोशिश की है या आत्महत्या का प्रयास किया है?

[ ] हाँ [ ] नहीं

यदि आपको ऐसे विचार आए हैं कि मर जाते तो बेहतर होता, या किसी तरीके से खुद को चोट पहुंचायी, तो कृपया इस बारे में अपने स्वास्थ्य सेवा चिकित्सक से चर्चा करें, किसी अस्पताल के आपात कक्ष में जाएं या 911 पर कॉल करें।

केवल कार्यालय उपयोग /OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

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).

설문지 PHQ-9: 청소년(만 11~17세)용으로 수정

이름: _____ **날짜:**_____

지침: 지난 2주 동안 얼마나 자주 각각의 다음 증상들로 인해 어려움을 경험했습니까? 각 증상에 대해 귀하가 느낀 바를 가장 잘 설명하는 답변 아래에 있는 상자에 "X" 표시를 하십시오.

	(0) **전혀 없음**	*(1)* **며칠 동안**	*(2)* **반나절 이상**	*(3)* **거의 매일**
1. 무엇인가를 하는 데에 관심이나 흥미가 거의 없었다	0	1	2	3
2. 기분이 저조하거나, 우울하거나, 불안하거나, 절망적이라고 느꼈다	0	1	2	3
3. 잠들기, 수면 유지 또는 수면 과다 등의 어려움이 있었다	0	1	2	3
4. 피곤함을 느끼거나 기운이 별로 없었다	0	1	2	3
5. 식욕 부진, 체중 감소 또는 과식을 겪었다	0	1	2	3
6. 자기 자신을 비관하거나 실패자라고 느끼거나 자기 자신이나 가족을 실망시켰다고 느꼈다	0	1	2	3
7. 학교 공부, 독서 또는 TV 시청과 같은 일에 집중하기 어려웠다	0	1	2	3
8. 다른 사람들이 알아챌 정도로 행동이나 말이 느려졌다 또는 반대로, 평소보다 많이 움직이면서 안절부절 못하거나 불안했다	0	1	2	3
9. 죽는 게 낫다고 생각하거나 어떤 식으로든 자해할 생각을 했다	0	1	2	3

이 형태의 어려움을 경험하고 있다면, 이 문제들이 귀하의 일, 집안일, 또는 다른 사람과의 관계를 얼마나 **어렵게** 만들었습니까?

[ ] 전혀 어렵지 않다 [ ] 어느 정도 어렵다 [ ] 아주 어렵다 [ ] 대단히 어렵다

지난 해에 때때로 괜찮다고 느끼면서도 거의 매일 우울하거나 슬프다고 느꼈습니까?

[ ] 예 [ ] 아니오

지난 달에 자살에 대해 심각하게 생각해본 적이 있습니까? [ ] 예 [ ] 아니오

일생 동안 **한 번이라도** 자살 시도를 한적이 있습니까? [ ] 예 [ ] 아니오

죽는 게 낫다고 생각했거나 어떤 식으로든 자해할 생각을 한 적이 있으면, 의료 담당자와 이에 대해 상의하고, 병원 응급실로 가거나 911로 전화하십시오.

공무란/OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

Kwestionariusz PHQ-9: Dostosowany pod kątem nastolatków (w wieku 11–17 lat)

Imię i nazwisko: _____ **Data:**_____

Instrukcje: Jak często w ciągu ubiegłych **dwóch tygodni** występowały u Ciebie następujące objawy? Przy każdym objawie zakreśl **„X"** w polu pod odpowiedzią, która najlepiej opisuje Twoje odczucia.

	(0) **Wcale**	*(1)* **Kilka dni**	*(2)* **Przez więcej niż połowę dni**	*(3)* **Prawie codziennie**
1. Małe zainteresowanie wykonywanymi czynnościami albo nieodczuwanie przyjemności z wykonywanych czynności?	0	1	2	3
2. Przygnębienie, depresja, drażliwość albo poczucie pustki?	0	1	2	3
3. Problemy z zasypianiem, spaniem albo zbyt długi sen?	0	1	2	3
4. Uczucie zmęczenia albo brak energii?	0	1	2	3
5. Spadek apetytu, utrata masy ciała albo przejadanie się?	0	1	2	3
6. Niezadowolenie z siebie – poczucie porażki, zawiedzenia siebie albo rodziny na sobie samym?	0	1	2	3
7. Problemy z koncentracją np. w szkole, w pracy, przy czytaniu albo oglądaniu telewizji?	0	1	2	3
8. Poruszanie się albo mówienie w sposób powolny, zauważalny przez inne osoby? Albo wręcz przeciwnie – wiercenie się albo niepokój powodujące ruchliwość w dużo większym stopniu niż zwykle?	0	1	2	3
9. Czy myślałeś/myślałaś, że lepiej by było nie żyć albo by zrobić sobie jakąkolwiek krzywdę?	0	1	2	3

Jeżeli dotyczą Cię którekolwiek z problemów wymienionych w niniejszym formularzu, w jakim stopniu problemy te **utrudniają** wykonywanie obowiązków w pracy albo w domu bądź też kontakty z innymi osobami?

[ ] W ogóle nie utrudniają [ ] Trochę utrudniają [ ] Bardzo utrudniają [ ] Niezwykle utrudniają

Czy przez większość dni w ciągu **ostatniego roku** odczuwałeś/odczuwałaś smutek albo depresję, mimo że czasami było w porządku?

[ ] Tak [ ] Nie

Czy w ciągu **ostatniego miesiąca** zdarzyło Ci się na poważnie myśleć o samobójstwie?

[ ] Tak [ ] Nie

Czy **KIEDYKOLWIEK** w swoim CAŁYM ŻYCIU próbowałeś/próbowałaś się zabić albo dokonałeś/dokonałaś próby samobójczej?

[ ] Tak [ ] Nie

Jeżeli myślałeś/myślałaś, że lepiej by było nie żyć albo żeby zrobić sobie jakąkolwiek krzywdę, porozmawiaj proszę ze swoim lekarzem, udaj się na szpitalny oddział ratunkowy albo zadzwoń pod numer 911

WYPEŁNIA PERSONEL/OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_Polish_Feb2018

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).

Опросник PHQ-9: модифицированная редакция для подростков (в возрасте от 11 до 17 лет)

Имя и фамилия: _____ **Дата:**_____

Инструкции: Как часто Вас беспокоил каждый из следующих симптомов в течение последних **2 недель**? Для каждого симптома поставьте крестик (**«X»**) в поле под ответом, который точнее всего описывает, как Вы себя чувствовали.

	(0) **Совсем нет**	*(1)* **Несколько дней**	*(2)* **Более половины дней**	*(3)* **Почти каждый день**
1. Отсутствие интереса или удовольствия от занятия чем-либо?	0	1	2	3
2. Подавленное настроение, чувство грусти, раздражения или безнадежности?	0	1	2	3
3. Трудности с засыпанием, поддержанием сна, или излишне продолжительный сон?	0	1	2	3
4. Чувство усталости или снижение энергичности?	0	1	2	3
5. Плохой аппетит, снижение массы тела или переедание?	0	1	2	3
6. Низкая самооценка, или чувство, что Вы — неудачник, или что Вы подвели себя или свою семью?	0	1	2	3
7. Трудности с концентрацией внимания на таких вещах, как выполнение школьных заданий, чтение или просмотр телепередачи?	0	1	2	3
8. Движения или речь были настолько замедлены, что другие люди это замечали? Или же наоборот — настолько сильная суетливость или неусидчивость, что Вы находитесь в движении намного больше, чем обычно?	0	1	2	3
9. Мысли о том, что Вам лучше было бы умереть, или о том, чтобы причинить себе какой-нибудь вред?	0	1	2	3

Если у Вас наблюдаются любые из проблем, перечисленных в этой форме, то насколько эти проблемы **затрудняли** выполнение Вами своей работы, домашних обязанностей, или затрудняли отношения с окружающими?

[ ] Совсем не затрудняли [ ] В некоторой степени затрудняли [ ] Очень сильно затрудняли [ ] Чрезвычайно сильно затрудняли

Чувствовали ли Вы себя подавленным (подавленной) или грустным (грустной) в большинство дней за **прошедший год**, несмотря на то, что в некоторые дни Вы, возможно, чувствовали себя нормально?

[ ] Да [ ] Нет

Был ли в течение **прошедшего месяца** период, в который Вы серьезно размышляли над тем, чтобы покончить жизнь самоубийством?

[ ] Да [ ] Нет

Вы пытались убить себя, или совершали попытку самоубийства **ХОТЯ БЫ ОДИН РАЗ** ЗА ВСЮ ЖИЗНЬ?

[ ] Да [ ] Нет

Если Вас посещали мысли о том, что Вам лучше было бы умереть, или о том, чтобы причинить себе какой-нибудь вред, пожалуйста, обсудите это с врачом, оказывающим Вам медицинскую помощь, или обратитесь в пункт неотложной помощи в больнице, или позвоните по телефону 911.

ПРЕДНАЗНАЧЕНО ДЛЯ ИСПОЛЬЗОВАНИЯ ИСКЛЮЧИТЕЛЬНО НА РАБОЧЕМ МЕСТЕ/OFFICE USE ONLY:

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_Russian_Feb2018

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سوالنامہ PHQ-9: نوعمروں (11-17 سال کی عمر) کے لیے ترمیم شدہ

نام: _____ **تاریخ:** _____

ہدایات: گزشتہ **دو ہفتوں** کے دوران آپ درج ذیل علامات میں سے ہر ایک سے کتنی بار پریشان رہے/رہیں؟ ہر علامت کے لیے جواب کے نیچے اس باکس پر **"X"** کا نشان لگائیں جو اس بات کو بہتر طور پر بیان کرتا ہو کہ آپ کیسا محسوس کرتے رہے/ رہی ہیں۔

	(0) **بالکل بھی نہیں**	*(1)* **کئی دن**	*(2)* **آدھے سے زیادہ دنوں میں**	*(3)* **تقریبا روزانہ**
1. چیزوں کو کرنے میں معمولی دلچسپی یا خوشی؟	0	1	2	3
2. مایوسی، افسردگی، چڑچڑے پن یا نا امیدی کا احساس؟	0	1	2	3
3. نیند آنے، سوئے رہنے میں دشواری، یا بہت زیادہ سونا؟	0	1	2	3
4. تھکن کا احساس، یا بہت کم توانائی ہونا؟	0	1	2	3
5. کم بھوک لگنا، وزن میں کمی، یا حد سے زیادہ کھانا؟	0	1	2	3
6. اپنے بارے میں خراب احساسات – یا یہ محسوس کرنا کہ آپ ایک ناکام شخص ہیں، یا آپ نے خود کو یا اپنے خاندان کو برباد کردیا ہے؟	0	1	2	3
7. چیزوں پر توجہ مرکوز کرنے میں دشواری، جیسے اسکول کا کام، مطالعہ یا ٹیلیویژن دیکھنا؟	0	1	2	3
8. اتنی آہستگی سے حرکت کرنا یا بولنا جسے دوسرے لوگ شاید ہی محسوس کرسکیں؟ یا اس کے برعکس — اتنا زیادہ مضطرب یا بے قرار ہونا کہ آپ معمول سے کافی زیادہ یہاں وہاں چلنے لگے/لگی ہوں؟	0	1	2	3
9. ایسے خیالات کہ آپ کا مرجانا ہی بہتر ہوتا، یا خود کو کسی طرح سے چوٹ پہنچانے کے بارے میں سوچنا؟	0	1	2	3

اگر آپ کو اس فارم پر بیان کردہ مسائل میں سے کسی کا تجربہ ہورہا ہے تو، بتائیں کہ ان مسائل نے آپ کےلیے اپنا کام کرنا، گھر پر چیزوں کی دیکھ بھال کرنا، یا دوسرے لوگوں کے ساتھ ملنا جلنا کتنا **دشوار**بنا دیا ہے؟

[ ] بالکل بھی دشوار نہیں [ ] کچھ حد تک دشوار [ ] بہت دشوار [ ] انتہائی دشوار

پچھلے سال کیا آپ نے زیادہ تر دنوں میں افسردگی یا غمگینی محسوس کی، اگرچہ کبھی کبھار آپ کو ٹھیک بھی محسوس ہوا؟ [ ] ہاں [ ] نہیں

کیا **گزشتہ مہینے** میں ایسے اوقات رہے ہیں جب آپ کو اپنی زندگی ختم کرنے کے بارے میں سنجیدہ خیالات آئے ہوں؟ [ ] ہاں [ ] نہیں

کیا آپ نے اپنی پوری زندگی میں**کبھی** اپنی جان لینے یا خودکشی کرنے کی کوشش کی ہے؟

[ ] ہاں [ ] نہیں

اگر آپ کو ایسی سوچیں رہی ہیں کہ آپ کا مرجانا ہی بہتر ہوتا یا خود کسی طرح سے چوٹ پہنچاتے، تو مہربانی کرکے اس پر اپنے نگہداشت صحت کے معالج سے بات کریں، کسی ہسپتال کے ایمرجنسی روم میں جائیں یا 911 پر کال کریں۔

صرف دفتری استعمال کے لیے /OFFICE USE ONLY :

SCORE: _____ ***Screener Name:*** _____ ***Date:*** _____ ☐

PHQ-9: Modified for Teens (ages 11-17)_Urdu_Feb201

Parent Report

Columbia Depression Scale - Parent Version

(formerly known as the Columbia DISC Depression Scale)

The 22 yes/no questions of this parent-report scale are the depression stem questions from the Diagnostic Interview Schedule for Children (DISC)-parent version, which is a structured clinical interview of parents that covers all major mental health diagnoses. Question 22 is not scored.

This scale includes questions about suicidal ideation and attempts. Free with permission: Contact Prudence.Fisher@nyspi.columbia.edu

Selected Reference

Shaffer D. Fisher P. Lucas CP. Dulcan MK. Schwab-Stone ME. 2000. NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child & Adolescent Psychiatry. 39(1):28-38.*

CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY PARENT OF FEMALE CHILD

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions about your daughter (female child) as honestly as possible.

In the last four weeks …	No	Yes
1. Has she often seemed sad or depressed?	0	1
2. Has it seemed like nothing was fun for her and she just wasn't interested in anything?	0	1
3. Has she often been grouchy or irritable and often in a bad mood, when even little things would make her mad?	0	1
4. Has she lost weight, more than just a few pounds?	0	1
5. Has it seemed like she lost her appetite or ate a lot less than usual?	0	1
6. Has she gained a lot of weight, more than just a few pounds?	0	1
7. Has it seemed like she felt much hungrier than usual or ate a lot more than usual?	0	1
8. Has she had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Has she slept more during the day than she usually does?	0	1
10. Has she seemed to do things like walking or talking much more slowly than usual?	0	1
11. Has she often seemed restless … like she just had to keep walking around?	0	1
12. Has she seemed to have less energy than she usually does?	0	1
13. Has doing even little things seemed to make her feel really tired?	0	1
14. Has she often blamed herself for bad things that happened?	0	1
15. Has she said she couldn't do anything well or that she wasn't as good looking or as smart as other people?	0	1
16. Has it seemed like she couldn't think as clearly or as fast as usual?	0	1
17. Has she often seemed to have trouble keeping her mind on her [schoolwork/work] or other things?	0	1
18. Has it often seemed hard for her to make up her mind or to make decisions?	0	1
19. Has she said she often thought about death or about people who had died or about being dead herself?	0	1
20. Has she talked seriously about killing herself?	0	1
21. Has she EVER, in her WHOLE LIFE, tried to kill herself or made a suicide attempt?	0	1
22. Has she tried to kill herself in the last four weeks?	0	1

October 11, 2007

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CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

TO BE COMPLETED BY PARENT OF MALE CHILD

If the answer to the question is "No," circle the 0; if it is "Yes," circle the 1.
Please answer the following questions about your son (male child) as honestly as possible.

In the last four weeks …	No	Yes
1. Has he often seemed sad or depressed?	0	1
2. Has it seemed like nothing was fun for him and he just wasn't interested in anything?	0	1
3. Has he often been grouchy or irritable and often in a bad mood, when even little things would make him mad?	0	1
4. Has he lost weight, more than just a few pounds?	0	1
5. Has it seemed like he lost his appetite or ate a lot less than usual?	0	1
6. Has he gained a lot of weight, more than just a few pounds?	0	1
7. Has it seemed like he felt much hungrier than usual or ate a lot more than usual?	0	1
8. Has he had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?	0	1
9. Has he slept more during the day than he usually does?	0	1
10. Has he seemed to do things like walking or talking much more slowly than usual?	0	1
11. Has he often seemed restless … like he just had to keep walking around?	0	1
12. Has he seemed to have less energy than he usually does?	0	1
13. Has doing even little things seemed to make him feel really tired?	0	1
14. Has he often blamed himself for bad things that happened?	0	1
15. Has he said he couldn't do anything well or that he wasn't as good looking or as smart as other people?	0	1
16. Has it seemed like he couldn't think as clearly or as fast as usual?	0	1
17. Has he often seemed to have trouble keeping his mind on his [schoolwork/work] or other things?	0	1
18. Has it often seemed hard for him to make up his mind or to make decisions?	0	1
19. Has he said he often thought about death or about people who had died or about being dead himself?	0	1
20. Has he talked seriously about killing himself?	0	1
21. Has he EVER, in his WHOLE LIFE, tried to kill himself or made a suicide attempt?	0	1
22. Has he tried to kill himself in the last four weeks?	0	1

October 11, 2007

Borrowed and adapted with permission from the Columbia Treatment Guidelines (2002). Depressive Disorders (Version 2). Columbia University, Department of Child and Adolescent Psychiatry, New York, NY.

CHILD & ADOLESCENT PSYCHIATRY AT COLUMBIA UNIVERSITY & NYSPI

Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)

PARENT-COMPLETED FORM

Add up "1"s ("yes") on items 1 to 21.

Score	Chance of Depression	How often is this seen?
0–4	Very Unlikely	in 2/3 of teens
5–9	Moderately Likely	in 1/4 of teens
10–12	Likely	in 1/10 of teens
13 and Above	Highly Likely	in 1/50 of teens

October 11, 2007

Borrowed and adapted with permission from the Columbia Treatment Guidelines (2002). Depressive Disorders (Version 2). Columbia University, Department of Child and Adolescent Psychiatry, New York, NY.

Clinician Assessment of Functioning

Children's Global Assessment Scale (C-GAS)

The C-GAS is a global measure of social and psychiatric functioning for children ages 4-16 years. Clinicians who have some knowledge of a child's social and psychiatric functioning can make a C-GAS rating. The measure is a single rating scale with a range of scores from 1 to 100, with 1 being the most impaired and 100 being the healthiest. At each 10-point interval are descriptors of functioning and psychopathology for that interval to help in finding the appropriate rating of severity for a child.

It takes a clinician approximately 5 minutes to make a C-GAS rating.

Selected Reference

Shaffer D. Gould MS. Brasic J. Ambrosini P. Fisher P. Bird H. Aluwahlia S. 1983 Nov. A children's global assessment scale (CGAS). *Archives of General Psychiatry. 40(11):1228-31.*

CHILDREN'S GLOBAL ASSESSMENT SCALE

For children 4–16 years of age

David Shaffer, M.D., Madelyn S. Gould, Ph.D.
Hector Bird, M.D., Prudence Fisher, B.A.

Adaptation of the Adult Global Assessment Scale

(Robert L. Spitzer, M.D., Miriam Gibson, M.S.W., Jean Endicott, Ph.D.)

Rate the subject's most impaired level of general functioning for the specified time period by selecting the *lowest* level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g., 35, 58, 62).

Rate actual functioning regardless of treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular rating.

Specified time period: 1 month

100–91 **Superior functioning** in all areas (at home, at school, and with peers), involved in a range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.). Likeable, confident, "everyday" worries never get out of hand. Doing well in school. No symptoms.

90–81 **Good functioning in all areas.** Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasional "blow-ups" with siblings, parents, or peers).

80–71 **No more than slight impairment in functioning** at home, at school, or with peers. Some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sib) but these are brief and interference with functioning is transient. Such children are only minimally disturbing to others and are not considered deviant by those who know them.

70–61 **Some difficulty in a single area, but generally functioning pretty well**, (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work, mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60–51 **Variable functioning with sporadic difficulties or symptoms in several but not all social areas.** Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50–41 **Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area**, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.

40–31 **Major impairment in functioning in several areas and unable to function in one of these areas**, i.e. disturbed at home, at school, with peers, or in the society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not sufficient criterion for inclusion in this category).

30–21 **Unable to function in almost all areas**, e.g., stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g., sometimes incoherent or inappropriate).

20–11 **Needs considerable supervision** to prevent hurting others or self, e.g. frequently violent, repeated suicide attempts OR to maintain personal hygiene OR gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10–1 **Needs constant supervision** (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

Chapter IV.
Treatment Information for Providers

Guide to the "Treatment Information for Providers" Section

Active Monitoring

Treatment Choices: Supportive Counseling and Problem-Focused Treatment

Treatment Choices: Evidence-based Psychotherapy

Evidence-based Pharmacotherapy

Depression Monitoring Flow Sheet

Suicidality in Adolescents and the Black Box Warning

Safety Planning for Depressed Adolescents

Assessment of High-Risk Teen Suicide Attempters

Guide to the "Treatment Information for Providers" Section

Adolescent depression can be addressed in many ways, including by using one or more of the following approaches: active monitoring, psychosocial interventions, manualized psychotherapies, and psychopharmacological interventions. Given the varying severity and episodic nature of depression, different treatments may be indicated at different times. Patients and their families should always be partners in treatment choices.

The section is divided into three parts.

Active Monitoring

The first part describes active monitoring, which may be appropriate for adolescents with new onset of mild to moderate depressive symptoms. Principles and examples of active monitoring are discussed. In one form or another, active monitoring is something that can be carried out by all clinicians in any practice setting.

Treatment Choices

The second part of this section outlines different types of active treatments: supportive counseling and problem-focused treatment, evidence-based psychotherapies, and evidence-based pharmacotherapies. A tracking form is included in order to help you keep track of the timing of your interventions as well as your patients' responses.

Suicidality in Adolescents

The third part of this section discusses the crucial issue of suicidality in adolescents, describes the boxed (formerly "Black Box") warning which the FDA applied to all antidepressants prescribed to depressed youth, and provides a list of safety planning steps that may lower the risk of suicide in depressed adolescents. In addition, a list of suicide risk factors is enclosed.

Active Monitoring

Given the tumultuous nature of adolescence, the episodic nature of depression, and the mixed data regarding response to even the most evidence-based treatments, immediate treatment of a new-onset mild to moderate depressive episode may not always be indicated. However, rather than **watchfully waiting** to see if depressed adolescents improve, this guideline advocates **active monitoring** instead. This subtle distinction in word choice is meant to discourage a passive approach and emphasize all of the important things a primary care physician can do BEFORE initiating a formal psychotherapeutic or pharmacological treatment. The following list contains only some of the various ways in which primary care physicians and/or care managers can actively engage with depressed youth while monitoring for changes in their clinical exam:

Schedule frequent visits

Prescribe regular exercise and leisure activities

Recommend a peer support group

Review self-management goals

Follow-up with patients via telephone

Provide patients and families with educational materials

Education of patients and family members (and — when indicated and informed consent is obtained — teachers and/or peers) is a crucial part of active monitoring that can broaden an individual's support network and improve the chances that clinical changes are observed. Please see the parent and adolescent educational materials sections for resources that may be copied for distribution to your own patients and families.

It is important to note that while active monitoring does not have to be continued indefinitely, it should be continued even after individuals improve. If, after a pre-determined amount of time, your patient's depression fails to improve or clinically worsens, an evidence-based treatment is then indicated.

In the patient handout section later in this toolkit, we provide a form labelled Self-Care Success. This tool should be used during active monitoring to structure the self-help techniques that the adolescent can employ.

Treatment Choices:
Supportive Counseling & Problem-Focused Therapy

(Adapted from the Macarthur Initiative on Depression & Primary Care)

Primary care clinicians are well suited to provide supportive counseling and to encourage use of effective coping strategies by depressed adolescents. Clinicians can work with youth in brief, but regular, intervals with a focus on finding solutions to youth-identified problems. Effective counseling involves empathizing with adolescent patients while helping them formulate clear, simple and specific behavioral change plans. For a simple, one-page fact sheet on supportive counseling and coping strategies, see page 31 of the Macarthur Initiative Toolkit: https://www.integration.samhsa.gov/clinical-practice/macarthur_depression_toolkit.pdf

Problem Solving Treatment for Primary Care (PST-PC) is a psychological treatment for depression that has been tested in adult populations and may be performed by primary care clinicians or staff who have been formally trained. It is based on the finding that depression is associated with life problems. Patients meet with the clinician for four to six 30-minute sessions over a 6-10-week period. The focus of PST-PC involves the following:

- identifying and clarifying problems,
- setting realistic goals and generating solutions, and
- evaluating progress and renewing problem-solving efforts, when indicated.

While a few studies have looked at interventions delivered to adolescents in primary care, none of them have examined a brief therapeutic intervention delivered by the pediatric primary care providers themselves. At this point, we must extrapolate from the adult literature.

Treatment Choices: Evidence-based Psychotherapy

Psychotherapy has been shown to be effective in treating young people with depression. Psychological counseling can be done individually (the youth alone with a mental health specialist) or in a group (a mental health specialist, the youth, and others with similar problems). More than half of youth with mild to moderate depression respond well to psychological counseling. While the length of time that people are involved in counseling differs, people with depression can typically expect to attend a weekly hour-long counseling session for 8-20 weeks. If the youth's depression is not noticeably improved after six to twelve weeks of counseling, this usually means that medication treatment may need to be added to treat youth depression. Psychological counseling by itself is not recommended as the only treatment for persons whose depression is more severe. Medication is needed for this type of depression, and it can be taken in combination with psychotherapy.

Two "brands" of psychotherapy have been shown to be helpful for youth depression (see Table 1): **CBT** (eg Brent et al., 1997; Lewinsohn et al., 1990; Wood, Harrington, & Moore, 1996) and **IPT-A** (eg Mufson et al., 1999).

CBT (Cognitive Behavioral Therapy) is based on the principle that one's thoughts, feelings, and behaviors affect one another. Certain negative thoughts, such as pessimism and self-denigration, evoke negative feelings that predispose to and/or are exacerbated in depression. The goal of treatment is to modify the negative thoughts and behaviors in the expectation that this will break the depressive cycle.

IPT-A (Interpersonal Therapy for Adolescents) is based on the principle that depression occurs in an interpersonal context (i.e., depression affects one's relationships and one's relationships affect one's mood). The goal of treatment is to address the interpersonal problems that may be contributing to or resulting from the patient's depression.

Although designed to be given by highly trained therapists as a "package," both of these treatments contain components that can usefully be included by experienced clinicians during the course of their therapeutic work with a depressed child and his/her family.

Borrowed and adapted with permission from the Columbia Treatment Guidelines (2002). Depressive Disorders (Version 2). Columbia University, Department of Child and Adolescent Psychiatry, New York, NY.

Table 1. Cognitive Behavioral Therapy and Interpersonal Therapy

Therapy	Key Components	Manuals/Websites
CBT	Thoughts influence behaviors and feelings, and vice versa. Treatment targets patient's thoughts and behaviors to improve his/her mood. Essential elements of CBT include increasing pleasurable activities (behavioral activation), reducing negative thoughts (cognitive restructuring), and improving assertiveness and problem-solving skills to reduce feelings of hopelessness	Treating Depressed Children: Therapist Manual for "Taking Action" Kevin Stark, Ph.D., and Philip C.Kendall, Ph.D., 1996 53pp. Adolescent Coping with Depression Course Gregory Clarke, Ph.D., Peter Lewinsohn, PhD, Hyman Hops, Ph.D. 1990 https://research.kpchr.org/Research/Research-Areas/Mental-Health/Youth-Depression-Programs#Downloads USING CBT WITH CHILDREN *MGH Academy* http://mghcme.org/page/cognitive_behavioral_therapy
IPT	Interpersonal problems may cause or exacerbate depression and that depression, in turn, may exacerbate interpersonal problems. Treatment targets patient's interpersonal problems to improve both interpersonal functioning and his/her mood. Essential elements of interpersonal therapy include identifying an interpersonal problem area, improving interpersonal problem-solving skills, and modifying communication patterns	Interpersonal Psychotherapy for Depressed Adolescents, 2nd ed. Laura Mufson, Kristen Pollack Dorta, Donna Moreau, and Myrna M. Weissman. New York, Guilford Press 2011 (paperback), 315 pp

CBT=Cognitive Behavioral Therapy

IPT=Interpersonal Therapy

Evidence-based Pharmacotherapy

Although CBT or IPT are proven therapy treatments for youth depression, they are often not available, and medication is sometimes indicated and/or preferred. Medication may be needed if the child has severe or persistent depression or has co-morbid anxiety disorders (e.g., panic, separation anxiety, social phobia, GAD, or OCD).

Currently, SSRIs are the medication of choice (see Table 2).

Fluoxetine (Prozac) and escitalopram (Lexapro) are the only SSRIs approved for use in adolescents with depression. Fluoxetine also has the indication for children with depression. Positive randomized clinical trials (RCTs) in anxiety disorders of children and adolescents using fluvoxamine (Luvox) and sertraline (Zoloft) have been published, and both are FDA approved for adolescent obsessive-compulsive disorder. Recent positive studies of citalopram (Celexa) and sertraline (Zoloft) in adolescent depression have also been published. Other SSRIs are possibly effective. The FDA reviewed treatment trials of SSRIs used with children and adolescents for safety and efficacy because of concerns that, in some children and adolescents, these agents may provoke extreme irritability, suicidal thinking and behavior, and/or other unusual symptoms.

Prior to starting a child on medication for depression, a **psychiatric evaluation** should be completed with the child and his/her parent(s). As part of this evaluation, **education** regarding the following issues should be included:

Diagnosis and etiology, expected course and prognosis of the disorder

Evidence-based treatments for the disorder

Medication and medication concerns

Family support and self-management

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Some of the important medication concerns to cover with parents and children are:

- The FDA's review of the SSRI safety data, including suicidality and common side effects associated with SSRI's
- The importance of supervision of medication administration and handling of medication by adults only
- The likely duration of treatment (i.e., 6 months to 1 year after cessation of symptoms)
- The possibility of discontinuation symptoms if medication is stopped without medical supervision

Selective serotonin reuptake inhibitors (SSRIs) are the first-line treatment of depressive disorders in children. Fluoxetine is FDA-approved for depression in children eight years of age and older while escitalopram is approved for depression in adolescents aged 12 years and older.

Because the picture of depression in children is often mixed, use of SSRIs in children may result in increased agitation, irritability, or decreased sleep. Discontinuing or decreasing the dose of the SSRI may be necessary in this situation.

Clarification of the diagnosis and treatment plan and/or consultation with a child and adolescent psychiatrist/APRN may be indicated.

Careful assessment of family relational support is indicated to promote adherence and ongoing self-management.

Choice of an SSRI can be based on:

- FDA approval for adolescents*
- Success of prior medication trials*
- SSRI half-life*
- Interactions with other medications
- Side effect profiles of the different medications
- Family history of successful medication treatment
- Patient's medical issues

*Due to its FDA approval, multiple successful medication trials, and long half-life (which minimizes adverse effects of poor compliance), if there are no contraindications, fluoxetine is recommended as the first-choice SSRI, but other SSRIs (see Table 2) may be considered "first-line" as well, especially escitalopram, which is also FDA-approved for adolescents.

Starting Medication

SSRIs are the first-line medication option for depression.

A list of these and guidelines for dosages are presented in Table 2.

As a precaution, SSRIs in adolescents should be started at less than therapeutic doses and titrated weekly to a therapeutic dosage if tolerated.

Finding the Optimal Dose

While the full effects of a medication will not be seen for 4-6 weeks, teens should have some response at 2-3 weeks of a therapeutic dose. If no positive response is noticed at 2-3 weeks, the dose should be increased. If a response is seen, continue for 4-6 weeks and reassess dosage at that point.

An optimal dose of a specific medication is one in which the benefits of wanted effects outweigh the cost of unwarranted side effects.

The doctor should follow up consistently by assessing the patient's response to the medication every 2-4 weeks, either in person or by phone if frequent in-person visits are not feasible.

This assessment can be achieved by targeting:

Changes in severity of symptoms

Changes in impairment

Side effects

How to determine adequate dosage

Dosing is adequate when significant changes occur in target symptoms, scores on baseline assessment instruments and severity scales improve, and side effects are absent or tolerable.

The dose prescribed should be increased after sufficient time (4-6 weeks) when the changes seen in target symptoms or baseline assessment scale scores or severity are not considered significant enough, and if there are no apparent intolerable side effects.

How to assess for side effects at each dose

If side effects are mild, wait 2-7 days to see if side effects are transient. If they persist but are tolerable, continue on that dose. If side effects are moderate, reduce the dose or change the dosing schedule. However, if the side effects are severe, discontinue medication as soon as possible. Be alert to unusual or unexpected side effects. Unless there are severe side effects, medication should be continued for at least 4-6 weeks to determine efficacy.

Some common side effects of SSRIs include the following:

- Dry mouth
- Constipation
- Diarrhea
- Sweating
- Sleep disturbance
- Sexual dysfunction
- Irritability
- "Disinhibition" (risk-taking behaviors, increased impulsivity, or doing things that the youth might not otherwise do)
- Agitation
- Jitteriness
- Headache
- Appetite changes
- Rashes

Some other, more serious side effects include the following:

- Serotonin syndrome (fever, hyperthermia, restlessness, confusion, etc.)
- Akathisia
- Hypomania
- Discontinuation syndrome (dizziness, drowsiness, nausea, lethargy, headache)

Table 2. SSRI Dosing and Adverse Effects

	Medication	Starting Dose*	Increments	Effective Dose	Maximum Dosage	Not to Be Used With	Common Adverse Effects	RCT Evidence for Efficacy
First Line	Fluoxetine	10 mg po qd	10-20 mg	20 mg	60 mg	MAOIs***	Headaches, GI upset, insomnia, agitation, anxiety	Y**
Second Line	Escitalopram (first-line: 12 and older)	5 mg po qd	5 mg	10-20 mg	20 mg	MAOIs***	Headaches, GI upset, insomnia	Y**
	Citalopram[a]	10 mg po qd	10 mg	20 mg	40 mg	MAOIs***	Headaches, GI upset, insomnia	Y
	Sertraline	25 mg po qd	12.5-25 mg	100 mg	200 mg	MAOIs***	Headaches, GI upset	Y

*Younger adolescents should be started on lower doses

**FDA approved

***MAOI, monoamine oxidase inhibitor

[a]Clinicians should consider an EKG given the warning of cardiac side effects

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Changing Medication

When to use a different SSRI*:* A different SSRI should be used when the maximum dose is reached and maintained for 4-6 weeks without response in target symptoms with a specific SSRI or there are major side effects with a specific SSRI.

When to use a second-line medication*:* Consider using a second-line medication for depression if a child fails 2 SSRIs and a course of CBT or IPT. A mental health specialist should be consulted regarding second-line medications. A doctor should also re-evaluate the diagnosis and consider a combination of medication if a child fails 3 medication trials.

Table 3 provides information about tapering and switching SSRI medications.

Table 3. SSRI Tapering/Switching Schedule

Medication	Tapering Increments	Time between each taper
Fluoxetine	10 mg	1-2 weeks
Sertraline	25 mg	1-2 weeks
Citalopram	10 mg	1-2 weeks
Escitalopram	5 mg	1-2 weeks
Fluvoxamine	50 mg	1-2 weeks
Paroxetine	5 mg	1-2 weeks

Note: May start second medication but need to inform patients/families about possible adverse events such as serotonin syndrome

Maintaining Medication

In order to maintain medication, the following is recommended:

Continue on medication for 6-12 months following cessation of symptoms. Some evidence suggests that adolescents who stay on their SSRI for 12 months have fewer relapses than those who stop earlier. Some depressed youth may need 2 or more years of maintenance to prevent relapse. (This is an extrapolation from adult data.). Those teens may need a psychiatric consult.

Once stabilized, follow-up appointments should occur monthly initially and may be increased but no longer than q3 months to check efficacy of medication.

Evaluate target symptoms, adverse reactions & medication compliance at each follow-up visit.

Obtain adolescent and parent symptom checklists every 3 months.

Stopping Medication

When discontinuing medication, taper medication slowly. See tapering schedule above.

Depression Monitoring Flow Sheet

Patient Name:			Collateral Contacts:			
Date of Initial Assessment (Week 0; depression as working diagnosis)		Initial Target Symptoms	Initial Assessment Tool Used	Baseline score on Assessment Tool	Baseline Suicidality (None, Passive, Active)	Initial Action (i.e., Education, Medication, Consultation)
Week	Date (write n/a if pt. not assessed in given week)	Assessing Clinician	Mode (s) of interview (i.e., Face-to-face, telephone)	Assessment Tool / Score (i.e., CGAS, PHQ-9)	Change in Target Symptoms / Side Effects (**Ask re SI**)	Action (i.e., Education, Medication, Consultation)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
Remember to assess response 6-8 weeks after initiating treatment.						

Borrowed and adapted with permission from the Columbia Treatment Guidelines (2002). Depressive Disorders (Version 2). Columbia University, Department of Child and Adolescent Psychiatry, New York, NY.

Suicidality in Adolescents and the Boxed Warning

(Adapted from the APA / AACAP's PhysiciansMedGuide)

Suicidality in Adolescents: Suicidal ideation and suicide attempts are common in adolescence and do not have the same prognostic significance for completed suicide as those behaviors in later life. Quoting data from the Youth Risk Behavior Study, the federal Centers for Disease Control and Prevention (CDC) reports that 8.6% of students had attempted suicide in the previous year.[1] Among high school students, 14.6% had a suicide plan in the previous year and 2.8% had made a suicide attempt that required medical attention. The suicide rate for teens aged 15 to 19 years was 14.2 per 100,000 in 2015. In total, 2,061 teens died by suicide in the US in 2015.[2]

The Boxed Warning: In 2004, the FDA reviewed detailed reports of 24 clinical trials involving more than 4,400 children and adolescents who had been prescribed any of nine antidepressants for treatment of major depression, anxiety, or obsessive-compulsive disorder.[3] **No suicides occurred in any of these trials**. The FDA concluded that more of the children and teens who were receiving an antidepressant medication *spontaneously* reported that they thought about suicide or made a suicide attempt than did those who received a placebo.

The FDA's analysis showed that about 2 out of 100 children not taking medication would *spontaneously* report suicidal thoughts and/or behaviors, compared to 4 out of 100 who were taking medication. These rates need to be understood in the context of findings from community samples cited previously, in which as many as half or more of teenagers with major depression were thinking about suicide at the time of diagnosis and some 16% to 35% had made a previous suicide attempt. Although only nine medications were re-examined in the analysis, the FDA applied the labeling changes to *all* antidepressant medications. This was done on the basis of the advisory committee's concern that applying the warning only to the newer antidepressants reviewed would give doctors and patients the false impression that older antidepressants such as TCAs had a more favorable risk-benefit ratio.

[1] Available at https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf

[2] Available at https://www.cdc.gov/nchs/nvss/deaths.htm

[3] Hammad,T.A., Laughren, T., & Racoosin, J. (2006). Suicidality in pediatric patients treated with antidepressant drugs. *Arch Gen Psychiatry,* 63(3):332-339, doi:10.1001/archpsyc.63.3.332

Safety Planning for Depressed Adolescents

(Adapted by GLAD-PC with permission from materials prepared by Families for Depression Awareness)

1. **Encourage adolescents and parents to make their homes safe.** In teens aged 10 to 19, the most common method of suicide is by suffocation (mostly hanging). followed closely by guns and firearms and poisoning. All ropes, cables, guns, and other weapons should be removed from the house, or at least locked up. Other potentially harmful items such as sharp knives, alcohol, drugs, and poisons should also be removed.
2. **Ask about suicide.** Providers and parents should ask regularly about thoughts of suicide. Providers should remind parents that making these inquiries will not promote the idea of suicide.
3. **Watch for suicidal behavior.** Behaviors to watch for in children and teens include:

   Expressing self-destructive thoughts

   Drawing morbid or death-related pictures

   Using death as a theme during play in young children

   Listening to music that centers around death

   Playing video games that have a self-destructive theme

   Reading books or other publications that focus on death

   Watching television programs that center around death

   Visiting internet sites that contain death-related content

   Giving away possessions

4. **Watch for signs of drinking.** If a child has depression, feels suicidal, and drinks a lot of alcohol, the person is more likely to take his or her life. Parents are usually unaware that their child is drinking. If a child is drinking, the parent will need to discuss this with the child and the clinician.
5. **Develop a suicide emergency plan and a safety plan**. Work with patients and parents to decide how to proceed if a child feels depressed and suicidal. It is important to be specific and provide adolescents with accurate names, phone numbers, and addresses.

Assessment of High-Risk Teen Suicide Attempters

"SAD PERSONS" + Family History

- *S*EX (females attempt more but males* complete)
- *A*GE over 16 *
- *D*EPRESSION (and comorbid conduct disorder/impulsive aggression/anxiety)

- *P*REVIOUS ATTEMPTS*
- *E*THANOL ABUSE (or substance abuse)
- *R*ATIONAL THINKING LOST (e.g., psychotic/intoxicated)**
- *S*OCIAL SUPPORTS LACKING *
- *O*RGANIZED PLAN **(highly lethal or unusual method with wish to die/concealment)
- *N*O SIGNIFICANT OTHER (no trusted friend or confidante)
- *S*ICKNESS (stressors)

- FIRST-DEGREE RELATIVE (of a completer)*

* Critical item

Adapted by GLAD-PC from Patterson W.M., et al. (1983). Evaluation of suicidal patients: The SAD PERSONS scale. *Psychosomatics,* 24 (4), 343-349.

This scale was designed and tested for the evaluation of all ages of attempters who presented to emergency rooms. It is adapted here for use with teens.

Chapter V.
Treatment Referrals and Follow-up

Guide to the "Treatment Referrals and Follow-Up" Section

Primary Care Clinician Guide to Mental Health Referrals

Forms to Facilitate the Referral Process

Guide to the "Treatment Referrals and Follow-up" Section

Referring depressed youth for treatment and making sure they receive proper follow-up care is a crucial but sometimes complicated endeavor. While many referral arrangements are possible, making sure kids don't fall through the cracks always requires careful planning and clear communication between primary care and mental health providers. This section provides the following tools to facilitate the process of both referring and following-up the care of depressed youth.

Primary Care Clinician Guide to Mental Health Referrals

This section outlines the referral process.

Forms to Facilitate the Referral Process

We provide sample forms to facilitate information sharing between primary care and mental health providers that is compliant with privacy (Canada) and HIPAA (U.S.) regulations.

Primary Care Clinician Guide to Mental Health Referrals

Sequence in Referral Process

1. Primary care provider (PCP) recognizes need for mental health referral.
2. PCP explains reasons for mental health referral and recommends appropriate level of care and type of mental health services (i.e., counselor, psychologist, psychiatrist).
3. Patient and family may not agree to seek help from a mental health specialist. If patient and/or family resists, clinician and/or office staff provides education, offers support and counseling, and reinforces the need for mental health referral.
4. If patient and family are amenable to the referral, a mental health specialist is selected based upon a variety of factors, such as geographic location, insurance coverage, goals of treatment, and whether combined therapy with antidepressants will be used.
5. Once a referral is made, the PCP should complete the Referral form (**Form I**), which will be given to the parent to give to the mental health provider (MHP). This form is designed to be useful even when the name of the MHP is not yet known. On this form, the PCP should include his/her office contact information to facilitate further communication and follow up. If the patient's parent or guardian has not signed the practice's HIPAA-compliant release-of-information form, he/she should sign one at this time. As the parent is giving the form directly to the MHP, no specific releases need to be signed. Alternatively, if the name of the MHP is known, the form can be sent directly to the MHP, providing that specific consent signatures have been obtained. PCPs should consult their own privacy (Canada) or HIPAA (U.S.) advisor.
6. In order to facilitate timely follow-up, the PCP may also provide the MHP with Release of Information and Report Forms (**Forms IIa and IIb). Form IIb** is designed to enable the MHP to promptly communicate basic impressions and recommendations from the evaluation to the PCP after release signatures are obtained. MHPs may need to use their own release forms instead of **Form IIa,** which should be vetted by their own representative before official use. The forms may be adapted.
7. The PCP should obtain consent for ongoing communication with the MHP if the MHP is to provide ongoing treatment.
8. PCPs and MHPs should carefully define and discuss follow-up roles and continue to coordinate patient care until presenting problems are resolved.

FORM I: Referral from Primary Care to Mental Health Provider (to be given to parent by PCP)

Dear Colleague:

I am happy to be referring: _____ on _____ for _____

(Patient's Name- Please Print) (Date) (Reason/Diagnosis)

Summary:

_____

_____

_____

_____

_____

The patient has the following allergies: _____----------

Is on these medications:_____----------

And has these significant health problems: _____----------

The patient had these recent tests:

Lab tests for the following: ____ **CBC** Date: _____ ____**Thyroid Studies** Date: _____
Results: _____ Results: _____

____ **Chem Panel** Date: _____ ____ **EKG** Date: _____
Results: _____ Results: _____

Other:_____

I am I am NOT willing to help manage mental health medications.

***I would like to hear back from you at your earliest convenience. I have attached Forms IIa and IIb to facilitate this feedback.

_____ _____ _____ _____----------

(Provider Signature) (Printed Name and Title) (Phone) (Fax)

Address:_____

FORM IIa: Release of Protected Health Information to Allow Report from MHP to PCP

Dear Parent/Guardian,

Communication between your mental health provider (MHP) and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your MHP to share protected health information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, lab tests, and medication if necessary.

I, _____, authorize _____, to release protected health information
(Parent/guardian name) (Mental health provider name and address, please print)

related to my child, _____ _____ to:
(Patient name) (Patient date of birth, MM/DD/YY)

_____ _____ _____
(Name and address of primary care provider) (PCP's phone number) (PCP's fax number)

A. I hereby permit the use or disclosure of the above information to the person identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be disclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program): _____.

I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my child's protected health information have already taken action because of my earlier authorization.

5. I do not have to sign this authorization and that my refusal to sign will not affect my child's ability to obtain treatment.
6. I have a right to inspect and copy my child's protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

B-1. One-Time Use /Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person identified above. My authorization will expire:

When acted upon

90 days from this date

Other _____

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person above as often as necessary to fulfill the purpose identified above. My authorization will expire:

When my child is no longer receiving services from (insert name of facility/program) _____

One year from this date

Other _____

C. Parent/Guardian Signature: I certify that I authorize the use of my child's health information as set forth in this document.

Signature of Parent or Guardian: _____ Printed Name: _____

Date: _____

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the parent/guardian of this patient.

Signature of authorized staff person: _____ Printed Name:_____

Date:_____

Form IIb: Report from MHP to PCP

(Information to be provided by mental health provider)

Dear Colleague,

I saw _____ on _____ for _____
(Patient name, please print) (date) (Reason/diagnosis)

Summary:_____
_____
_____
_____
_____
_____
_____

The following medication was or will be started (indicate medication, dosage and other instructions):
_____
_____
_____
_____

If no medication is prescribed, check as appropriate:
_____ Medication not indicated _____ Patient preference _____ Psychotherapy suggested before trying medication
_____Other (specify): _____

Additionally, I recommend
Lab tests for the following: _____ CBC _____ Thyroid studies _____ Chem panel _____EKG

Other treatment recommendations:
_____
_____

___I would ___I would NOT be interested in having you (PCP) help manage mental health medications.

_____ _____ _____ _____
(Provider signature) (Provider printed name) (Phone number) (Fax number)

Address:_____

Chapter VI.
Speaking with Adolescents and Parents

Guide to the "Speaking with Adolescents and Parents" Section

Given the stigma and conflicting information that continue to surround the diagnosis and treatment of adolescent depression, it is almost impossible to overstate the importance of clear communication with patients and parents.

This section is divided into three parts: a brief overview of some helpful things to discuss when speaking with patients and parents about depression, a short list questions (and answers to those questions) that are most frequently asked by adolescents and their families about depression, and checklists of educational materials for adolescents and families.

What to Discuss with Patients and Parents About Depression

The overview contains basic facts about depression that every adolescent patient and parent should know. Ideally this information will do several things, including:

1. ***De-stigmatize*** the experience of being depressed.
2. ***Educate*** the patient and family about the origins, time course, and treatment options for depression.
3. ***Empower*** the patient and family to get the help they need.

Frequently Asked Questions (and Answers) About Depression

The frequently asked question section, which is also available in pamphlet form, is provided as an additional source of information to improve communication between primary care providers, patients, and their families.

Checklists of Educational Materials

This section also contains checklist of educational materials, one for adolescents and one for parents. This checklist can be copied and placed in a patient's medical chart, along with the dates on which the materials were distributed. The educational materials themselves can be found the following two sections, "Educational Materials for Adolescents" and "Educational Materials for Parents."

What to Discuss with Adolescents and Parents About Depression

For the Primary Care Clinician

Etiology

Depression probably results from an innate predisposition coupled with recent stressors.

Importance of Recognizing Symptoms

Poor concentration, loss of pleasure in activities, and fatigue can affect school attendance and academic functioning.

Being irritable, short-tempered, and hard to please (all of which may be the result of depression) make peer and family relationships more difficult.

Feelings of worthlessness can affect self-confidence, which in turn can affect schoolwork, extracurricular activities, and self-esteem.

In the context of other depressive symptoms, aches and pains for which there are no medical causes may be explained.

Expected Course of Disorder

Treated depression will likely result in a return to regular functioning in weeks or months. Without treatment, depression may last many months or years and is likely to recur.

Risk of Suicide

Depressed patients are at an increased risk for suicide. In order to minimize the risks of a suicide attempt, it is important for parents to remove firearms, long ropes, cables, razors, drugs, and other dangerous objects from the house. It is also important to keep in mind that asking about suicidal thoughts is a crucial part of identifying a potentially dangerous plan. Asking about suicide may help prevent — not promote — suicide.

For information about the relationships among suicide, adolescents, and SSRI medication, please see the “Treatment Information for Providers” section

Multiple Treatment Options

Be clear about which specific treatments you can offer and which will require referral elsewhere.

Borrowed and adapted with permission from the Columbia Treatment Guidelines (2002). Depressive Disorders (Version 2). Columbia University, Department of Child and Adolescent Psychiatry, New York, NY.

If CBT is going to be used, discuss the following:

The principle of cognitive behavioral therapy (CBT) is that thoughts influence behaviors and feelings, and vice versa. Treatment targets patients' thoughts and behaviors to improve their mood.

Essential elements of CBT include increasing engagement in pleasurable activities (behavioral activation), reducing negative thoughts (cognitive restructuring), and improving assertiveness and problem-solving skills to reduce feelings of helplessness.

If IPT-A is going to be used, discuss the following:

The principle of interpersonal therapy for adolescents (IPT-A) is that interpersonal problems may cause or exacerbate depression and that depression, in turn, may exacerbate interpersonal problems. Treatment targets patients' interpersonal problems to improve both interpersonal functioning and mood.

Essential elements of IPT-A include identifying an interpersonal problem area, improving interpersonal problem-solving skills, and modifying communication patterns. IPT-A is for children 12 and older; there is no evidence of efficacy for children under 12.

If medication is going to be used, discuss the following:

The medications we recommend (first-line treatments) are safe, and dangerous side effects are rare.

Common side effects are GI disturbances, changes in appetite, sleep disturbance, and sexual dysfunction.

If your child develops a rash, contact the doctor immediately.

If your child becomes agitated, silly, speaks too fast, seems over-energetic, and/or sleeps less, stop the medication and call the doctor immediately.

It is important to supervise medication administration; if your child has threatened or attempted suicide, keep medication in a secure location.

The likely duration of medication treatment is 6 months to 1 year after symptoms improve and sometimes longer.

Medication, usually an SSRI, should be initiated concurrently with psychotherapy if the teen has severe symptoms and/or functional impairment or is at risk for suicide.

Medication should be stopped gradually under a doctor's supervision, due to the possibility of discontinuation symptoms such as recurrence of depression, drowsiness, nausea, lethargy, headache, and dizziness.

Adequate scientific data and extensive clinical data show that medication treatment for depression in teens is safe and effective.

Borrowed and adapted with permission from the Columbia Treatment Guidelines (2002). Depressive Disorders (Version 2). Columbia University, Department of Child and Adolescent Psychiatry, New York, NY.

Frequently Asked Questions About Depression

The article is adapted from one of a series of articles about depression by the American Psychiatric Association.

Q: How will I know if my treatment for depression is working?

A: As people recover from depression, the first symptoms that usually improve are problems with sleeping and loss of appetite (or excessive appetite). After that, energy and interest in activities improve, as do the ability to think clearly and to function more productively. The last symptom to improve is the feeling of being depressed and discouraged, which can happen many weeks after treatment has begun. Although this same sequence of improvements may not be what everyone goes through, it is what is commonly experienced.

You may be the last to recognize when the treatment is helping. Although others may see you getting better and while you may notice that you are able to function better, you may continue to feel depressed. This lingering feeling of depression may interfere with your ability to believe you are getting better, so it is important to stick with your treatment even when you have doubts about its effectiveness.

Q: Is there a difference in the way medications and psychotherapy work in the treatment of depression?

A: Psychotherapy is a series of private talks with a therapist where you discuss the feelings, thoughts, and behavior that cause difficulty. The goal of psychotherapy is to help you understand and master your problems so you can function better. Psychotherapy can help with the symptoms of depression, such as feelings of guilt and worthlessness, sadness, anger, doubt, and indecisiveness. Depression often is related to experiences or problems you have in your relationships with important people such as family, lovers, and friends. Through psychotherapy, you can examine and improve these relationships, or grieve and move beyond those that have been lost.

Antidepressant medications also help treat the psychological symptoms of depression, such as guilt, hopelessness, and anxiety. They are particularly effective in treating the neurovegetative symptoms of depression. *Neurovegetative* is a medical term referring to the physical symptoms commonly seen in depression, such as the loss of appetite (or excessive appetite), difficulty concentrating, feeling very nervous, or being unable to sit still.

Q: What do I do if I think the treatment I am receiving is not helping?

A: First, check your perception of how the treatment is working with others who see you regularly and whom you trust. As mentioned in a previous answer, you may not feel better even though you are getting better. However, if others agree that progress is not occurring, don't keep quiet about it. Talk to your psychiatrist, your primary care physician, or your therapist.

Open, direct communication is essential for treatment, and it needs to flow in both directions—from patient to doctor and vice versa. A good doctor will want to hear from you and will value your concerns. Anyone who dismisses what you say may not be worth working with.

Ask your doctor why progress is not occurring. Ask how else you might be helped. For example, are there other treatments that could be considered?

You should also feel free to ask your doctor for a second opinion about your treatment. This means you or your doctor ask another medical professional to review your care and make suggestions to improve it. Getting a second opinion is common in medical practice. It can offer a fresh perspective and the opportunity to change or enhance your treatment. In general, a doctor welcomes a second opinion; if he or she doesn't, you may not be working with the right doctor.

Last but not least, don't give up. Depression is a very treatable illness. Although some people respond to treatment in a month or two, others take longer. The statistics are encouraging: as many as 85 percent of people respond to appropriate treatment.

Q: Why do I need to keep taking antidepressant medications after I feel better?

A: You've heard medical doctors say you need to continue taking an antibiotic for as many days as prescribed—even if you feel better sooner. The same is true for antidepressants, although you have to take them even longer.

Antidepressant medications treat your symptoms, making you feel better, but the illness continues. The medication is needed to control the illness until full recovery is achieved. If this is your first episode of depression, don't be surprised if your doctor says you need to take the medicine for 6 to 12 months after you start feeling better. This is how long it takes the medicine to protect you against the depressive illness, which continues to cause imbalances in your brain chemistry and nerve cells. For someone who has suffered from more than one episode of depression, medication and psychotherapy may be necessary for longer periods of time.

Studies have shown the combination of psychotherapy and medication often is more effective than either treatment alone.

Once you begin feeling better, your doctor will focus treatment on helping you avoid a relapse, which is why he or she asks you to continue taking the medication. However, if you and your doctor decide to stop the medication, studies have shown the importance of stopping gradually. Abrupt discontinuation of antidepressant medications can increase the risk of a relapse.

Checklist of Educational Materials for Adolescents

Category	Handout	Date Provided
Depression Information	Childhood Depression	
Medication Information	Antidepressant Medication and YOU (12-21)	
	Antidepressant Medication and YOU (10-12)	
Psychological Counseling	Patient Handout on Psychological Counseling	
Self-Management	Self-Care Success	
	Monitoring Sheet for Depression	
	Depression Medication and Side Effects	
	Mental Health and Drugs and Alcohol	
	How Can You Help with Sleep Problems	
	Suicide: What Should I Know?	

Checklist of Educational Materials for Parents

Handout	**Date Provided**
NAMI's "A Family Guide"	
Family Support Action Plan	
How Can You Help with Sleep Problems	
Depression and the Family	

Chapter VII.
Educational Materials for Adolescents

Guide to the "Educational Materials for Adolescents" Section

Depression Information

Medication Information

Antidepressant Medication and YOU (12-21)

Antidepressant Medication and YOU (Ages 10-12)

Patient Handout on Psychological Counseling for Depression

Self-Management Tools

Self-Care Success

Monitoring Sheet for Depression

Depression Medication and Side Effects

Mental Health and Drugs and Alcohol

How Can You Help with Sleep Problems

Suicide: What Should I Know?

Guide to the "Educational Materials for Adolescents" Section

Included in this section are a number of information sheets as well as self-management tools to give to your patients if they have been identified as having depression. There is no need to overwhelm your patients with paper. Try to choose the materials that are appropriate for them.

Depression Information: Included is a very simply worded information sheet on depression that can help explain the disorder directly to your patients**. FOR OLDER TEENS, USE THE NAMI GUIDE IN THE NEXT SECTION.**

Medication Information: Included are two versions of an information sheet on antidepressants for those patients for whom you are considering medication or for whom you think the psychiatrist will consider medication. Choose the one appropriate to the developmental level of your patient.

Patient Handout on Psychological Counseling for Depression: This is a very brief form that explains therapy in general.

Self-Management Tools: These materials help patients participate in their own treatment by either setting goals or being alert to important signs and symptoms.

- **Self-Care Success:** It is preferred that you set these goals together with the patient.
- **Monitoring Sheet for Depression:** Decide how you would like your patient to use this sheet and whether you, your nurse, or a mental health professional will be the point of contact.
- **Depression Medication and Side Effects:** Decide how you would like your patient to use this sheet and whether you, your nurse, or a mental health professional will be the point of contact and whether this will involve phone or in-person communication.
- **Mental Health and Drugs and Alcohol:** This information sheet may help your patient stay away from self-medicating themselves with drugs and alcohol.
- **How Can You Help with Sleep Problems:** This sheet can empower your patients by teaching proper sleep hygiene.
- **Suicide: What Should I Know:** This sheet teaches teens about suicide warning signs and how to ask for help.

Childhood Depression

Why am I going to the doctor?

You're going to the doctor because you have an illness called depression.

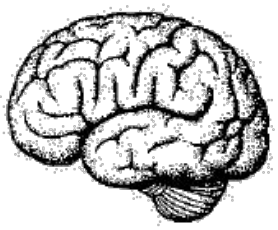
What does depression mean?

Some of the problems a child with depression may have are:

- Feeling sad most of the time
- Feeling mad and grouchy most of the time
- Wanting to be by yourself most of the time
- Not wanting your favorite foods any more OR eating too much just to feel better
- Getting a lot thinner or fatter
- Having a lot of stomachaches and headaches
- Not wanting to play with your favorite toys or friends
- Wanting to die or go away for forever
- Having trouble falling asleep at night or not wanting to get up in the morning
- Worrying a lot or feeling afraid that bad things will happen

Why am I depressed?

- Your brain controls your feelings.
- Sometimes you're happy, sad, angry, excited or worried; that's normal.
- But when you're sad most of the time, your brain isn't working right.
- Depression is not your fault.



What will the doctor do?

- The doctor will ask you and your family special questions about your feelings.
- The doctor will talk to you about how fast you will get better.
- The doctor will want you to come back to talk about your feelings and how your medicine is working.

With help, you can feel better again!

Texas Department of Mental Health and Mental Retardation
Revised 02-27-04
C-DEP

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

Antidepressant Medication and YOU

How will the medication help me?

When you take medication for depression, it works in your brain to help you:

Be less sad
Like doing things again
Feel less grouchy
Sleep and eat better

How does the doctor know that the medication is working?

Your doctor will talk with you, your family and your teacher to know if the medication is working right. He may need to change the amount or kind of medication you get to make sure it works the best for you.

Will the medication make me feel bad?

Probably not, but sometimes medications can cause side effects, which can make you feel strange. Some side effects are:

Trouble falling asleep
Stomach ache
Headaches
Blurry vision
Feeling thirsty a lot

If you notice any of these or if you are having any other problems, tell your parents and doctor. Most of the time side effects are not serious and will go away.

What is my role?

- Learn what medication you are taking, how much to take, and what it is for.
- It's very important to take your medication when your mom, dad or teacher tells you.
- You should help remember when to take your medication.
- Even if you feel okay, you need to take your medication every day.
- You should <u>never</u> share your medication with anyone else. It can be dangerous and it's against the law.

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
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Patient Handout
Psychological Counseling for Depression

Quick Facts About Psychological Counseling/Psychotherapy

In psychological counseling, youth with depression work with a qualified mental health care specialist who listens to them, talks, and helps them correct overly negative thinking and improve their relationships with others.

Treating Depression with Psychological Counseling/Psychotherapy

Psychological counseling has been shown to be effective in treating many youth with depression. Psychological counseling can be done individually (with only you and a mental health specialist) or in a group (with you, a mental health specialist, and other youth with similar problems). More than half of the people with mild to moderate depression respond well to psychological counseling. While the length of time that persons are involved in counseling differs, people with depression can typically expect to attend a weekly hour-long counseling session for 8-20 weeks. If your depression is not noticeably improved after six to twelve weeks of counseling, this usually means that you need to try a different treatment for your depression. Psychological counseling by itself is not recommended as the only treatment for people whose depression is more severe. Medication is needed for this type of depression, and it can be taken in combination with psychological counseling.

What Can You Do to Help Your Clinician Most Effectively Treat Your Depression with Psychological Counseling?

Keep all of your appointments with the mental health specialist.

Be honest and open and ask questions.

Work cooperatively with the mental health specialist (for example, complete tasks assigned to you as part of the therapy).

Keep appointments with your primary care clinician and tell him/her how the therapy is working (such as whether your depression is getting better or worse).

Adapted with permission by GLAD-PC from Rost K. Training Primary Care Nurses to Improve Depression Treatment. NIMH grant MH54444

Self-Care Success!

Things you can do to help yourself.

Name:_____ Date: _____

Instructions: When people are depressed they often forget to take care of themselves. By setting self-care goals you can take an active role in helping yourself feel better more quickly. Choose one or two of the areas below and set a goal. Make sure the goal is clear and reasonable. In the space below the boxes rate how likely you are to follow through on the goal(s) you set. If you are not very sure you can follow through on your goal you may want to find alternatives or make some adjustments.

Stay Physically Active

Each week during the next month I will spend at least ____ days doing the following physical activity for _____ minutes.

_____

_____

(Pick a specific date and time and make it reasonable!)

Schedule Pleasant Activities

Even though I may not feel motivated I will commit to scheduling ___fun activities each week for the next month. They are_____

_____

_____

(Specify when and with whom.)

Eat Balanced Meals

Even if I don't feel like it, I will eat ____ balanced meals per day to include

_____

_____

_____

_____

(Choose healthy foods.)

Spend Time With People Who Can Support You

During the next month I will spend at least ___ days for at least __ minutes at a time with:

_____ doing:_____

_____ doing_____

_____ doing:_____

(Who?) (What?)

(e.g. talking, eating, playing)

Spend Time Relaxing

Each week I will spend at least _____ days relaxing for ___ minutes by participating in the following activities: _____

_____

_____

(e.g. reading, writing in a journal, deep breathing, muscle relaxation)

Small Goals & Simple Steps

The problem is:_____

_____

My goal is:_____

_____

Step 1:_____

_____

Step 2:_____

_____

Step 3:_____

How likely are you to follow through with these activities prior to your next visit?

Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

What might get in the way of your completing these activities prior to your next visit?

_____

Solution(s) to the above barriers

_____

_____

_____

DEPRESSION

MEDICATIONS

These are the medications to take:

Name	Take When?			How Much?
_____	Morning	Mid-Day	Evening	_____
_____	Morning	Mid-Day	Evening	_____
_____	Morning	Mid-Day	Evening	_____
_____	Morning	Mid-Day	Evening	_____
_____	Morning	Mid-Day	Evening	_____

SIDE EFFECTS

For each side effect, circle the number that describes how much of a problem it was this week.
1=Not a Problem 3= Somewhat a Problem 5=Severe Problem

1 2 3 4 5
Trouble falling asleep

1 2 3 4 5
Upset stomach

1 2 3 4 5
Headaches

1 2 3 4 5
Trouble with eyes

1 2 3 4 5
Feeling thirsty a lot

1 2 3 4 5
Feeling restless

Other: _____

Reviewed 02-27-04

Texas Department of Mental Health and Mental Retardation
CAP-DEP

Mental Health and Drugs and Alcohol

Individuals with a mental health problem are at a much higher risk for pboelms with alcohol or drugs.

Sometimes children or teens will choose to use alcohol or drugs to “escape” from problems, stress, or difficult emotions they may be experiencing. However, alcohol and drugs can imitate the symptoms of mental illness, causing depressed mood, anxiety, irritability or moodiness, loss of appetite, sleeplessness, suspiciousness, and even hallucinations.

The use of alcohol or drugs can make it difficult to diagnose a mental health problem or tell if a problem is getting better. It can be difficult to separate what problems are caused by the alcohol or drug use and what is caused by the mental health problem.

Medications prescribed by a psychiatrist can be abused, just like illegal drugs, if taken differently than prescribed. Be sure you (or your child/adolescent) are taking the medications as your doctor has recommended. Don’t allow anyone else to take the medications. Giving or selling your prescribed medications can be against the law.

Most psychiatric medications (as well as other medications) should not be mixed with alcohol or drugs. Taking both can cause the psychiatric medication to be ineffective, new symptoms or side effects to arise, and **even serious physical harm and death.**

Some people worry that taking a stimulant for ADHD may make a person more likely to abuse drugs or alcohol. Actually, research suggests that children with ADHD who are treated with medication are **less** likely than those not treated to have substance abuse problems later in life.

For more information or help with alcohol or drug problems:

Alcoholics Anonymous AA General Service Office www.aa.org 212-870-3400	**Narcotics Anonymous** World Service Office www.na.org 818-773-9999
Alanon/Alateen Family Group Headquarters, Inc. www.al-anon.org 1-888-4AL-ANON	**National Clearinghouse for Alcohol and Drug Information** https://safesupportivelearning.ed.gov/resources/national-clearinghouse-alcohol-and-drug-information

Revised 09-30-03 Texas Department of Mental Health and Mental Retardation

How Can You Help with Sleep Problems

All of us need enough sleep to function well during the day. Having just one night of poor sleep can make it more difficult to pay attention to our school or work, make us sleepy throughout the day, cause us to make poor decisions, and leave us feeling irritable, grouchy, slowed down or restless. When many nights of little sleep add up, getting through the day can become a losing battle!

Sleep problems frequently occur as a part of depression. In fact, sleeping problems, either sleeping too much or having difficulty sleeping enough, are one of the symptoms of major depression. Although some sleep problems may require medication to get better, there are things **YOU** can do to help improve your sleep. By improving your sleep hygiene (your sleep habits), you can get rid of any habits that are making it harder for you to get a good night's rest.

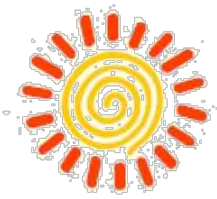
1. Keep a regular sleep schedule. Try to go to bed and wake up at the same time every day. It can take your body several days to weeks to adjust to a new sleep schedule, so staying up late on weekends and sleeping in really leaves your body confused.

2. Watch what you eat and drink near bedtime. Food or drinks with caffeine (e.g. sodas, tea, chocolate) can keep you up. Avoid eating big meals or being hungry before bedtime. Some people find milk or milk drinks (e.g. Ovaltine) to be helpful in falling asleep. Milk contains tryptophan, which causes sleepiness.

3. Eliminate bad habits. Drinking alcohol and smoking cigarettes both prevent you from getting a good night's sleep.

4. Make sure your bedroom is set up for sleep. Try to make sure the temperature of the room is comfortable, there are few noises, and the room is dark.

5. Exercise regularly. Getting vigorous exercise during the afternoon (but 4-6 hours before bedtime) has been found to result in better sleep.



6. Get outside and see the sun. Sunlight helps the body control its biological clock. This clock lets us know when to feel sleepy and when to be alert.

7. Use your bed only for rest or sleep. Don't watch TV or do homework in bed.

8. If you don't fall asleep within 10 or 15 minutes, get out of bed. Do a quiet, dull activity until you are feeling sleepy and try again.

9. Find a relaxing activity to do before bed. A warm bath, quiet music, and/or talking with a friend can all help you make the change from daytime to nighttime. Find what works best for you.

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Texas Department of Mental Health and Mental Retardation
PAC-DEP

Suicide: What Should I Know?

Why am I having these thoughts?

Many young people with depression think about hurting or killing themselves at some time. In fact, thoughts about death and dying are one of the symptoms of depression. Just like depression is treatable if you recognize it and get help, these feelings and thoughts can be treated and you can feel better. But it is up to you to let people know when you are feeling very depressed or out of control and it is up to you to let people help you through this time.

What are the warning signs?

Learn to recognize your own warning signs. Everybody is different and the things you notice when you begin to feel very depressed may be different from those other people report. But here is a list of some things that may signal a problem:

- ✓ Feeling very hopeless, like nothing will ever get better
- ✓ Not wanting to be around friends or family or take part in fun activities
- ✓ Not caring about anything anymore, like school or how you look
- ✓ Drinking or using drugs
- ✓ Doing risky things, such as driving recklessly or getting into fights
- ✓ Having lots of thoughts or dreams about death and dying
- ✓ Having a lot of stresses or life changes that seem hard to handle
- ✓ Feeling like you have a little more energy than usual

What can I do?

If you feel like things are getting out of control, you need to let someone know. Talk to your parents, your doctor, teacher, counselor, or a good friend! Don't keep these feelings inside. There are things you can do to help yourself get through these tough times. Don't be afraid to ask others to help you do these things as well.

- ✓ Keep your doctor or counselor informed about symptoms. Get symptoms treated early before they become worse.
- ✓ Keep in regular contact with someone on your treatment team. Set up a weekly (or even daily) time to check in with them and let them know how you are doing.
- ✓ Do what you can to reduce stresses. Learn what stressors are likely to really bother you and try to manage those first.
- ✓ Avoid alcohol and drugs. They may make you feel better temporarily but they will eventually make your depression and suicidal feelings worse.
- ✓ Let your parents have responsibility for giving you your medications and keeping all medications in a safe place.
- ✓ Develop a plan with others about what you will do if you feel suicidal. Carry phone numbers of people you can contact and who will stay with you until you are safe.
- ✓ Always try to find something to look forward to.

Suicide is a serious subject. Although it can be difficult, talking about it is an important step to getting better. By letting people know when you are thinking about death or hurting yourself, you can begin to get the help you need.

PEOPLE CAN AND DO GET BETTER!

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
A-DEP

Chapter VIII.
Educational Materials for Parents

Guide to the "Educational Materials for Parents" Section

NAMI's "A Family Guide"

Family Support Action Plan

How Can You Help with Sleep Problems

Depression and the Family

Guide to "Educational Materials for Parents"

This section contains important educational information and tools for parents. As always, it is important not to overwhelm the parents with paper, and you should choose the materials you think are most appropriate.

NAMI's "A Family Guide": This brief but informative guide presents a brief overview of adolescent depression, as well as treatment options. It includes a client-focused discussion of suicidality and the FDA's boxed warning.

Family Support Action Plan: This tool gives suggestions on how the family can help the adolescent meet self-management goals.

How Can You Help with Sleep Problems: Parents, as well as patients, must be aware of proper sleep hygiene before resorting to sleeping aids.

Depression and the Family: Adolescent depression can have reverberating effects on the rest of the family.

A FAMILY GUIDE

What Families Need to Know about Adolescent Depression

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Adolescent Depression

Adolescence is a time of many changes and challenges. Developing bodies and social and academic stresses make for a difficult period for many teens. Yet most teens get through these years with only short-term feelings of sadness or irritability.

While people sometimes use the word “depressed” to describe how they feel, there is also a serious mental health condition known as major depression or clinical depression. Unlike normal emotional experiences of sadness, loss or passing mood states, major depression is persistent and can significantly interfere with an adolescent’s thoughts, behavior, mood, activity and physical health.

Approximately 8 percent of adolescents have a major depressive episode in any given year and 20 percent experience depression in the teen years.[1] In adolescence, twice as many girls as boys are diagnosed with depression.[2] The compounding issues of sexual identity and stigma often raise the risk of depression in gay, lesbian, bisexual and transgender (GLBT) youth.[3] Children in military families also experience higher rates of depression than the general population with one in four of them experiencing symptoms of depression.[4]

Depression tends to be an episodic illness, with some youth spontaneously improving. Yet it also tends to be recurrent, with one episode of depression raising the risk for another. Four out of 10 youth will have a second episode of depression within two years. Repeated episodes of depression can take a great toll on a young mind.

Major depression in adolescents can be quite serious. Untreated, depression can lead to devastating consequences for adolescents, including ongoing problems in school, at home and with friends, the loss of critical developmental years and increased risk for substance abuse, involvement with the juvenile justice system and suicide.

Yet, the majority of youth living with depression are undiagnosed and untreated.[5] In particular, Asian American/Pacific Islander children have the lowest rates of mental health services usage.[6] Latino and African American

youth in urban areas are less likely to receive mental health care.[7]

Depression should be addressed just like any other physical illness. If your child is experiencing depression, it is a good idea to get an evaluation followed by effective services and supports to prevent the social isolation, negative self-esteem and safety risks that result from persistent depression.

This guide is designed to help provide you with guidance on getting an accurate diagnosis for your child and on understanding the various treatment options that have been shown to be effective in treating adolescent depression. It also provides you with the information you may need to advocate for these effective services and supports if they are not readily available for your child.

Causes and Symptoms of Depression

Adolescent depression is nobody's fault. Several factors, including biological and environmental factors, increase the risk of depression. For example, a family history of mood disorders and stressful life events in those who are genetically vulnerable to the condition can lead to the development of depression. Some individuals develop depression because of a chemical imbalance in the brain started by a triggering event, including stress from loss, physical or sexual abuse, substance use, humiliation or failure, or seemingly nothing at all. These factors increase the risk of depression but have different effects on different individuals. For example, a relationship breakup may make one teen unsettled for a few days but send another teen with biological risk into depression. Whatever the specific causes of depression, scientific research has firmly established that major depression is a biological, medical illness.

As outlined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.* (DSM-IV), a major depressive episode involves at least two weeks duration (and usually more) of reduced functioning with five or more of the symptoms listed below. It is important to not dismiss any of these symptoms as "acting out" or "just a phase."

- sleep problems (commonly more sleeping);
- loss of interest or pleasure in formerly fun activities;
- loss of interest in friends;
- appetite changes;

- energy loss;
- sadness or irritability;
- concentration problems;
- hopeless or guilty thoughts;
- body movement changes—feeling edgy or slowed down;
- persistent physical complaints and/or frequent visits to school nurses; or
- suicidal thoughts or preoccupation with death.

For many adolescents, suicidal thoughts are part of major depression. Suicide is seen as a permanent "solution" to what may be a temporary problem. Although teenage girls are at greater risk of depression, boys have a higher risk of suicide if they are depressed. But if diagnosed and treated promptly, almost everyone—children, adolescents and adults—recovers from depression. For more information on the risk of suicide, see page 23 of this guide.

All concerns about suicide require *immediate attention*. All statements about suicide need to be taken seriously and are a reason to immediately alert a health care provider or seek emergency help.

Depression often coexists with other conditions such as anxiety. Some-times, especially for girls, eating disorders such as anorexia nervosa or bulimia coexist with depression. Learning disabilities and Attention-deficit Hyperactivity Disorder (ADHD) raise the risk of depression. Substance abuse is also common in adolescents who are living with depression.

Depression may also be the first sign of what later turns out to be bipolar disorder. Bipolar disorder has important and additional symptoms that often include periods of feeling irritable, high or powerful, needing little sleep but still feeling full of energy and grandiosity, euphoria and hyper-sexuality. Adolescents living with bipolar disorder may also talk loudly and fast. Risk taking can be a symptom of both depression and bipolar disorder. It is important to get a comprehensive evaluation to determine if your child has coexisting conditions or if his or her depression is actually a symptom of bipolar disorder.

Differences between Adolescents and Adults Living with Depression

Adolescents living with depression often experience symptoms of irritability, anger and self-criticism more commonly than the feelings of sadness and loss of energy seen in adults. Also, school performance frequently drops off for adolescents living with depression—sometimes dramatically. They also often visit the school nurse more frequently with vague body complaints like headaches and stomach aches. They may engage in high-risk sexual activities and other risky behaviors, including shoplifting, physical fights and substance use. Adolescent males living with depression may mask feelings of sadness with anger. Loss of interest in peers is a "red flag" for depression in adolescents, as these relationships are key to normal development.

However, an adolescent's social relationships can be a double-edged sword—acting as an important source of support and normal development while also sometimes causing a great deal of pain and distress, particularly in adolescents who experience bullying. In general, those who experience verbal, physical or sexual assault or the threats of such assault are more vulnerable to mental health problems, including depression. GLBT youth fair the worse when it comes to bullying. Almost 90 percent of GLBT students have been harassed or assaulted during the past year.[8] Acts of racism and discrimination have been shown to correlate with the development of depression in ethnically and racially minority youth.

Long-term bullying may cause so much distress for an adolescent that it becomes a contributing factor in a suicide attempt. To learn more about how to address bullying, visit Stop Bullying Now! at www.stopbullying-now.hrsa.gov.

Understanding Self-harm

Self-harm includes cutting, picking, scratching, burning, biting or excessively piercing or tattooing one's body to reduce, express or cope with overwhelming, painful emotions. This behavior can be puzzling and scary to those who care for an adolescent who is self-harming.

Adolescents living with depression may self-harm if they do not have healthier alternatives in place to cope with or relieve negative feelings. Self-harm can also be used as a kind of "self-medication" for treating depression—not unlike drinking, using substances or overeating. Some individuals report that self-harm can be experienced as a "runners high" when "feel good" endorphins are released in the brain in response to the physical injury. Adolescents may also self-harm to communicate feelings of depression, hopelessness or worthlessness, exert control over their lives or combat feelings of numbness.

It is important to note that self-harm is not necessarily a suicide attempt. It can lead to unintentional, serious injuries, scarring and infections and become an ineffective coping tool. Thus, it is important to encourage adolescents to stop the behavior, but only if effective coping skills are in place. Since self-harming is a way to handle overwhelming emotions, it is important to offer alternatives and self-soothing strategies. To learn more about self-harm and how to treat it, visit NAMI's fact sheet on self-harm at www.nami.org/CAAC/selfharm.

Talking about Depression with Your Child

There are many points during an adolescent's development when effectively communicating with him or her may be difficult. Getting past these difficulties is never more important than when addressing depression. If you are concerned your child may be experiencing depression, it is important to talk to him or her about your observations and how he or she is feeling and to listen for key warning signs. Here are some tips for opening the door to talking about depression with your child:

- Get your child talking about his or her emotions by making gentle and open-ended observations (eg "I have noticed things have been especially hard for you recently, can you tell me about it?") and then listen to him or her without judgment.
- Ask your child if he or she feels "angry" "frustrated" or "upset" and

see if your child starts accepting your suggestions and also uses words like “sad” “afraid” “numb” or “hopeless.”

1) Try not to talk your child out of how he or she feels or to put a positive spin on his or her painful feelings.
2) Point out distinct changes in your child’s behavior. He or she may not be aware of the changes or may be grateful you have noticed.
3) Ask your child what he or she enjoys doing to help determine if your child is experiencing a loss of pleasure in daily activities.
4) Collect as much information as you can from your child’s teachers, friends, extended family members and others he or she interacts with. Try to enlist your child’s confidantes as your allies in addressing depression with your child. Adolescents may behave or communicate differently with different people in different settings so this information seeking is critical.
5) Let your child know that depression is a biological, treatable condition that can happen to anyone. Adolescents are very sensitive to suggestions that they are different or abnormal so it is important to address depression like any other medical condition that needs treatment.
6) Emphasize your unconditional support for your child, maintain a positive attitude and applaud him or her for any small step he or she takes to get better.
7) Avoid punishing your child for symptoms related to depression but set boundaries on his or her behavior if necessary. For example, find ways to encourage your child to spend time out of his or her room and with family rather than punish him or her for withdrawal and isolation.
8) If someone in your family has had depression, it may be helpful to share this reality with your child so he or she feels less alone.
9) Check back regularly. Sometimes it takes time for an adolescent to share information.

It is important to create an open, honest home environment where mental health issues are discussed and treated like any other health risks impacting adolescents. There are many resources available on talking about mental health issues with children at various ages. By opening the doors of communication about mental health early, before there is a problem, your child may be more likely to go to you when he or she is experiencing depression or another mental health related problem.

Getting an Accurate Diagnosis

If you are concerned that your child may have depression, the first step is to obtain an accurate diagnosis from a health care provider (primary care physician, therapist and/or child and adolescent psychiatrist). This evaluation should include a comprehensive understanding of your child's needs in multiple settings, including home, school and social settings. The health care provider should also take into account your child's cultural beliefs and their influence on his or her understanding of the symptoms of depression and the need for treatment.

Getting an accurate diagnosis can be challenging. Several factors contribute to this challenge, including the following:

1) symptoms—often including extreme behaviors and dramatic changes in behavior and emotions—may change and develop over time;
2) adolescents undergo rapid developmental changes in their brains and bodies as they get older and symptoms can be difficult to understand in the context of these changes;
3) adolescents may be unable or unwilling to effectively describe their feelings or thoughts, making it hard to understand what is really going on with them; and
4) it is often difficult to access a qualified mental health professional for a comprehensive evaluation because of the shortage of child and adolescent mental health care providers. This shortage emphasizes the critical role your child's primary care physician may need to play in the diagnostic and treatment process of adolescent depression, outlined in greater detail starting on page 12 of this guide.

Despite these challenges, there is still plenty you can do to help your child get an accurate diagnosis and ultimately receive the most effective treatment. Below are five areas you should consider when getting an accurate diagnosis for your child.

1. Record keeping. Organize and keep accurate records related to your child's emotional, behavioral, social and developmental history. The records should include observations of your child at home, in school and in the

community. They should be shared with your child's health care provider to ensure the best diagnosis. The records should include the following information:

- primary symptoms, behaviors and emotions of concern;
- a list of your child's strengths;
- a developmental history of when your child first talked, walked and developed social skills;
- a complete family history of mental illness and substance use disorders, if available. Many mental health conditions run in families, including depression;
- challenges your child is facing with school, social skill development, developmental milestones, behaviors and emotions;
- the times of day or year when your child is most challenged;
- interventions and supports that have been used to help your child and their effectiveness, including therapy, medication, residential or community services, hospitalization and more;
- settings that are most difficult for your child (eg school, home and social settings);
- any major changes or stresses in your child's life (eg divorce, death of a loved one);
- factors that may act as triggers or worsen your child's behaviors or emotions; and
- significant mood instability or disruptive sleep patterns.

2. Comprehensive physical examination. To make an accurate diagnosis, it is important to start the process with your child's primary care physician. A comprehensive physical examination should be done to rule out other physical conditions that may be causing symptoms that mimic depression. Additionally, your child's physician should also look for and interpret signs of physical or sexual abuse, which may contribute to or worsen depression.

3. Co-occurring conditions. Your child should be evaluated for co-occurring conditions that may lead to the development of or worsening of depression. Such conditions include learning disabilities, alcohol and drug use and sensory integration issues.

4. Specialists in children's mental health. After your child is evaluated for other physical conditions and co-occurring conditions, it is time to meet with a qualified mental health provider (such as a child and adolescent psychiatrist) for a mental health evaluation. Your child's primary care physician may be able to refer you to one. You can also ask for referrals from families involved with NAMI or other advocacy organizations. To contact your NAMI state organization or local affiliate, visit www.nami.org/local or call the NAMI HelpLine at 1 (800) 950-NAMI (6264). To find a child and adolescent psychiatrist, visit the American Academy of Child and Adolescent Psychiatry website at www.aacap.org (click on "Child and Adolescent Psychiatrist Finder").

As a result of the national shortage of child and adolescent mental health care providers, you may not be able to locate any in your community who are readily available. This is especially true for people living in rural communities and those seeking health care providers that are culturally and linguistically competent. Fortunately, a movement to integrate mental and physical health care is underway in many communities. In some areas, primary care physicians are now becoming trained in and can play a critical role in the screening, identification and treatment of depression in adolescents You can work with your child's primary care physician in diagnosing and treating your child's depression if no mental health care providers are available. To learn more about integration and the tools available to help primary care physicians address adolescent depression, see The Role of Primary Care Physicians section starting on page 12 of this guide.

Additionally, you may want to investigate telemedicine opportunities available in your community, which include appointments by video or telephone. Telemedicine is increasingly being used by mental health care providers to treat people in rural regions where mental health care providers are in short supply, however, its effectiveness has not yet been well established so it is important to proceed with caution.

5. The diagnostic and evaluation process. Your child's diagnosis should be made based on professional observation and evaluation, information provided by your family and other experts and the criteria found in the latest version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which provides standard

criteria for the classification of mental health conditions. This evaluation should include a comprehensive look at all aspects of your child's life in school, church and the community and with family and friends. The health care provider evaluating your child is likely to ask you to fill out a checklist that provides a detailed profile of your child and the challenges he or she is facing. If the health care provider doing the evaluation does not share your culture, race or ethnicity, you may want to explain to him or her any cultural issues that may be important to consider during the evaluation.

Once an accurate diagnosis of depression has been made, it is helpful to focus on effective treatment options. The goal should be to achieve the outcomes that are most important to your child and family.

The Role of Primary Care Physicians

In recent years, the federal government and national pediatric organizations have called for significantly stepped up efforts to identify depression in adolescents within the primary care setting as outlined in the following subsections. You may want to share the resources included in these sections with your child's primary care physician so he or she is better equipped to address depression in your child if no mental health care providers are readily available.

An increased focus on the early identification of depression and other mental health conditions in primary care promises to help address the under identification and treatment of adolescents living with depression.

The U.S. Preventive Services Task Force Recommends Depression Screening in Primary Care

In April 2009, the U.S. Preventive Services Task Force (USPSTF) released recommendations urging physicians across the country to perform routine depression screenings for adolescents aged 12-18 when appropriate services are in place to ensure accurate diagnosis, treatment and follow-up care. The task force indicated that screening, when followed by assessment and treatment, including psychotherapy, can help improve symptoms and help youth cope. Task force members also expressed confidence in the accuracy and safety of screening tests to identify major depression in adolescents.

The USPSTF is a panel of experts organized by the federal government to establish guidelines for treatment of a variety of health conditions in primary care. Its recommendations are considered the gold standard for clinical preventive services. To learn more about USPSTF's recommendations, visit www.uspreventiveservicestaskforce.org (click on "A-Z Topic Guide" and scroll down to "Depression in Children and Adolescents: Screening").

American Academy of Pediatrics Calls for Mental Health Screening in Primary Care

In June 2010, the American Academy of Pediatrics (AAP) released guidelines on mental health screening that included the following recommendations for pediatricians:

- pediatricians should screen children and adolescents for possible mental health issues and substance use at every visit to the doctor's office; and
- pediatricians should develop a network of mental health professionals in their community to whom they can refer families if they suspect a child needs further evaluation.

The AAP Mental Health Task Force was formed in 2004 to address children's mental health concerns in primary care and to ensure children are identified early and connected with effective services and supports. To assist pediatricians in meeting these recommendations, the AAP created a clinician's toolkit that includes multiple resources. To access these resources, visit www.aap.org/mentalhealth.

Treating Depression

Having an adolescent diagnosed with depression can be a frightening experience, especially if your child attempts suicide or engages in self-harm. It may be helpful to find a trusted friend, family member or professional or a support group for support and guidance. This will help you cope with your situation and provide your child with the support and advocacy that he or she may need to get treatment.

The first step in treatment is to obtain an accurate diagnosis. The next step is to develop an effective treatment plan. A treatment plan must address your child's unique and individual needs and his or her strengths, goals and interests. In developing an appropriate treatment plan, it is also important to keep the whole picture of your child's life in mind.

You will want to choose a health care provider—whether a primary care physician, therapist or child and adolescent psychiatrist—to work with you and your child in developing and implementing a comprehensive treatment plan that may include several health care providers. When choosing a health care provider, be sure to ask about his or her training and experience in treating adolescent depression. Also, ask about his or her experience working with adolescents with your child's background (eg racial, ethnic, sexual orientation, coexisting substance abuse, etc.). If the health care provider is not experienced or knowledgeable in working with adolescents with your child's experiences, you can always educate him or her or look for another health care provider. Follow your instincts about whether your child will connect with the health care provider and then check in with your child about the relationship once treatment begins.

There are many factors to determining if a health care provider is a "good fit" for your child and if he or she is able to develop an effective treatment plan for your child. It is important that your child's health care provider understands and respects the way you and your family perceive depression and any treatment options. It is important to find a health care provider you and your child trust. You may want to make a list of questions or issues important to you and your child before meeting with a health care provider to ensure they are addressed during the development of a treatment plan. It is also vital that you and your family become educated

about depression so you can play an active role in the treatment plan. Ask your child's health care provider about the latest studies on depression and educate yourself about the latest research findings by visiting the National Institute of Mental Health (NIMH) website at www.nimh.nih.gov.

The most common treatments for depression are psychosocial interventions, also called talk therapy, medication or a combination of both. These treatments are outlined in detail in the following sections. If your child is prescribed medication and is receiving a psychosocial intervention, make sure that there is a plan for all of the health care providers involved with your child's treatment, including primary care physicians, therapists and/or psychiatrists, to communicate with each other. Clear lines of communication, with you as the parent facilitating that communication, will improve treatment results. Also, you should talk with the health care provider/s about the need to protect your child's privacy, whenever possible, with the understanding that thoughts of hurting oneself or others will be shared with the family. You should also know that what you and your child share with any health care provider is confidential and should only be shared outside of the office with your permission or to protect your child's safety.

Addressing substance use is a key part of a treatment plan because it increases the risks associated with depression, especially the risk of suicide. It can be both a cause and a consequence of depression. Alcohol and substance use also impacts the effectiveness of medication. Ask your child's health care provider if he or she can suggest an effective intervention for any substance use. Alcoholics Anonymous (www.aa.org) or Narcotics Anonymous (www.na.org) groups that are tailored to young people can be extremely helpful for adolescents living with depression and substance use disorders. For more information on co-occurring mental health and substance use disorders, check out NAMI's article on the topic at www. nami.org/CAAC/substance use.

Having a connection to family members is a protection against depression. Keeping the lines of communication open can help to make treatment decisions more collaborative. Family therapy has not been well studied for the treatment of depression, however, if there are specific family-related stresses in an adolescent's life (eg divorce, serious illness or financial strains) or a lack of communication within the family, family therapy may

prove beneficial. Also, family therapy can be helpful because it gets the whole family involved in and supportive of treatment. With full family support, adolescents may be better able to participate in a treatment plan.

A sense of connection at school and with peers is also helpful for adolescents who are at risk of depression. If your child is depressed, talk with him or her about how to use his or her peers, extended family and other important people for support.

Aerobic exercise has had positive antidepressant effects in adults with mild to moderate depression and can also be a useful part of the treatment plan for adolescents. When teens exercise, it can help to improve their mood. Visit www.nami.org/heartsandminds to explore NAMI's free wellness program, Hearts & Minds.

Complementary and alternative medicine—those practices not generally considered part of conventional medicine—may also play a role in treatment. Complementary and alternative medicine includes dietary supplements, meditation, acupuncture, massage therapy, deep-breathing exercises and much more. To learn more about complementary and alternative medicine, visit the National Center for Complementary and Alternative Medicine at http://nccam.nih.gov/. Spirituality can also be an important component to include in a treatment plan depending on your child's beliefs.

Lastly, peer support groups can be beneficial to adolescents living with depression. They can help your child feel less alone, increase his or her social skills and stay positive. They can also be a powerful source of comfort

while your child is seeking and waiting for treatment. Contact your NAMI state organization and local affiliate to see if there are teen support groups available in your community. There are also online support communities available for adolescents. One such community is StrengthofUs.org, NAMI's online resource center and social networking website for young adults living with mental health conditions. To access this community, visit www. strengthofus.org.

Psychosocial Interventions

There is an ancient expression, "pain shared is pain halved." When an adolescent is depressed, feeling alone and isolated makes it much harder for him or her to cope, but talking can help. There are several psychosocial interventions that have been demonstrated by research to be effective in reducing or eliminating depressive symptoms. They are outlined in the following subsections. These interventions are usually provided by mental health care providers, including therapists, psychologists and psychiatrists. If you are working with your child's primary care physician, he or she may need to refer you out for these treatments. You can also access referrals through your NAMI state organization or local affiliate (www.nami.org/ local) or the American Academy of Child and Adolescent Psychiatry (www. aacap.org). It is important to learn about these interventions to ensure that your child receives the best possible care.

Although there is a growing emphasis on the importance of using these effective interventions in treating adolescent depression, these interventions are still not yet widely available in every community. You are encouraged to learn more about what interventions work for your child and family. Educated and informed families are in the best position to request the most effective treatments for their child, including the ones described in this guide, and ensure that these treatments are made available in their com-munities. Family advocacy promises to lead to the broader availability of treatments that work in communities across the country and to ultimately better outcomes for all children and their families. For more information on advocating for the broader availability of effective services and supports for your child, see NAMI's family guide on *Choosing the Right Treatment: What Families Need to Know About Evidence-based Practices* at www.nami.org/CAAC/ChoosingRightTreatment.

Cognitive Behavioral Therapy

One psychosocial intervention shown to be effective for adolescents living with depression is Cognitive Behavioral Therapy (CBT). CBT teaches youth how to notice, take account of and ultimately change thinking and behaviors that impact their feelings. In CBT, youth examine and interrupt automatic negative thoughts they may have that make them draw negative and inappropriate conclusions about themselves and others.

CBT breaks down negative thinking patterns and attempts to change them. For example, if an adolescent did poorly on a test and is thinking "I'm dumb and worthless," CBT helps him or her to think about what he or she could have done differently to do better on the test rather than focusing on negative thoughts about him or herself. There is good evidence to show that CBT helps to reduce symptoms of depression in adolescents; however, the best treatment outcomes are found when CBT is combined with antidepressant medication. More information about the research on CBT is provided starting on page 28 of this guide.

The average length of treatment for CBT is 12-16 weeks, with a 60- to 90-minute session each week. Youth participating in CBT are typically given homework with the expectation that they are working outside of the office. Family involvement in CBT includes parents reinforcing more sensible and positive thoughts and helping their child practice this new way of thinking at home.

To find mental health care providers qualified to provide Cognitive Behavioral Therapy for adolescents, visit the National Association of Cognitive-Behavioral Therapists at http://nacbt.org (click "CBT Referrals") or the Association for Cognitive Behavioral Therapies at www.abct.org (click "Find a Therapist").

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) is a psychosocial intervention that looks at relationships and transitions for adolescents and how they affect their feelings and thinking. IPT focuses on helping adolescents manage major changes in their lives such as divorce or significant loss. In IPT, the therapist helps the adolescent evaluate his or her relationships and interactions with others. The average length of treatment for IPT is 12 weeks, with weekly face-to-face sessions and regular phone contact.

Because relationships are key in adolescence, IPT is an appropriate treatment intervention for adolescent depression. However, IPT needs further study in adolescents to better understand its full effectiveness in treating depression. It is, however, well established as an effective treatment for adults living with depression.

It is not known how well a relationship with one therapist is helpful outside of CBT or IPT—it is hard to study something as unique as a relationship. Some adolescents feel the relationship alone is helpful—the therapist is a safe person outside of their family with whom they can share their thoughts and concerns.

Family Education and Support

Family education and support programs use experienced and trained parents of children receiving mental health services to provide education and support to other parents. The most common types of support include emotional support (empathy, reassurance and positivity to reduce distress, shame and blame) and information support (about conditions, treatment options, parenting skills, coping strategies, community resources and stress reduction). Through relationship-building, education, collaboration and problem-solving, these family education and support programs help adolescents and their families learn more about depression, master new and effective ways to manage the condition, acquire strategies for handling crises and relapse and much more. These programs also help families understand how best to support their child living with depression.

The evidence base for family education and support programs is growing and shows that these programs are effective in providing support and education to families.

In children's mental health, a limited number of studies have examined the impact of family education and support on children and families. One model of family education and support that has been studied is the Multifamily Psychoeducation Groups (MFPG) program, which is designed for children and adolescents living with mood disorders, including depression. MFPG focuses on working with families to identify symptoms and effective treatment for mood disorders and improving problem-solving and family communication skills. The program also includes sessions with children and adolescents that cover a number of topics, including symptoms, treatment, anger management, the connection between thoughts, feelings and actions, impulse control and improved communication skills.

There are also family education and support programs developed by family organizations and taught by trained family teachers. NAMI developed the NAMI Basics Education Program for parents and caregivers of children and adolescents living with mental health conditions. NAMI Basics is a six-week, peer-led program that provides the information and support parents and caregivers need to make the best decisions possible for their children, families and themselves and to cope effectively. Research on the program concluded that participation in NAMI Basics appears to be associated with increases in knowledge about childhood and adolescent mental health conditions, treatment and advocacy. For more information on NAMI Basics, visit www.nami.org/basics.

Medications

Sometimes psychosocial interventions alone can effectively treat mild to moderate depression in adolescents. Other times, medications may be recommended by your child's health care provider to treat more severe depression. A primary care physician or a psychiatrist can prescribe medications. It is up to you to weigh the pros and cons of starting your child on medication. Many families try psychosocial interventions and other treatment options first before medication. It is important for you and your child to understand the potential risks and benefits of antidepressant medications to make an informed decision about treatment.

Many health care providers prescribe antidepressant medications to treat adolescent depression. The most commonly prescribed antidepressant medications are selective serotonin reuptake inhibitors (SSRIs). There

are currently two SSRIs that have been approved by the Food and Drug Administration (FDA) for use in adolescents—Prozac (Fluoxetine) and Lexapro (Escitalopram). Before the FDA approves a medication, it reviews the medication manufacturer's data and proposed labeling. If this review establishes that the medication works correctly and its health benefits outweigh its known risks, the medication is approved for sale. The FDA does not actually test drugs itself, although it does conduct limited research in the areas of drug quality, safety and effectiveness standards. To see a full list of FDA-approved medications, visit www.fda.gov (search for "Drugs@ FDA").

All physicians have the option of prescribing medications for "off-label" use based on their clinical judgment of an individual's treatment needs. Off-label use consists of using a medication for medical conditions that are not recognized on the FDA-approved labeling for that medication. It is a common practice. Other SSRIs used to treat children and adolescents living with depression that are not FDA-approved include Zoloft (Sertraline), Celexa (Citalopram) and Luvox (Fluvoxamine). In June 2003, the FDA recommended that Paxil not be used to treat children or adolescents living with depression because of a possible increased risk of suicidal thinking and suicide attempts associated with the medication.

If your child's health care provider prescribes a medication for off-label use, be sure to ask him or her questions about why he or she prefers this medication for your child. You should approach the decision about whether antidepressant medications are appropriate for your child with Caution and care. This is true for all decisions related to the use of medica-tions—antidepressants are no exception.

Below are some recommended questions you may wish to ask your child's health care provider if he or she recommends medication. It is not only appropriate to ask questions, it is expected.

- What are the potential risks and benefits of the medication and other treatment options?
- What are the anticipated side effects of the medication?
- How are the other elements of the treatment plan (such as psychosocial interventions and school and family interventions) integrated with the decision about medication?

- Who should be called with questions about the medication or changes in behavior or symptoms?
- How will we monitor progress, behavior changes, symptoms and safety concerns?
- How can we best ensure that our child is actively involved in the discussion and decision-making related to the use of medications (whenever possible)?
- How can we ensure open lines of communication between our family, you and other health care providers?
- How does any family history of mental health conditions (especially a history of bipolar disorder) factor into the decision to use medication?
- How will you know when it is appropriate for our child to discontinue medication?

It is also important for your child's health care provider to understand how antidepressants may impact certain ethnic groups. For example, Asian Americans and African Americans may metabolize medications differently. This can have implications on the overall effectiveness and side effects of any medications prescribed to these racial groups.

Side Effects

If your child voices new or more frequent thoughts of wanting to die or to hurt him or herself, or takes steps to do so, you should immediately contact your child's health care provider. For more information on the risk of suicide with antidepressant medication, see The Black Box Warning subsection starting on page 24 of this guide. You should also know that when starting a new medication or changing the dosage, your child may show signs of increased anxiety or even panic, agitation, aggressiveness or impulsivity.

You should also be aware of akathisia, a rare side effect that may exist in a small percentage of youth taking medications. Akathisia is an internal sense of restlessness coupled with a strong need to move about for no reason that your child may be able to identify. To a child, this may feel like a sense of agitation and nervousness. You should immediately contact your child's health care provider or should seek immediate help if you are concerned that your child may be experiencing this rare side effect.

While taking antidepressants, your child may experience involuntary restlessness, an extreme degree of unwarranted elation or energy accompanied by fast, driven speech and unrealistic plans or goals. If you see any of these symptoms, consult your child's health care provider. It may be appropriate to adjust your child's medication dosage, change to a different medication or stop using the medication. Research has shown that about 40 percent of children and adolescents will not respond to an initial medication, but many of these individuals will respond to a different medication.[9]

Family History and Treatment

Family history is a clue to genetic risk for depression, but it is not enough to form a basis for a diagnosis or treatment plan.

If your family includes members living with bipolar disorder, you should be cautious about having antidepressant medications prescribed for your child and may want to talk with your child's health care provider about the appropriateness of combining antidepressant medication with a mood stabilizer. The chance that an adolescent could have undetected bipolar disorder is real, since the first episode of bipolar disorder can be depression.

A family history of depression or suicide may indicate the need for more aggressive treatment because these factors may lead to a heightened risk for suicide in your child. This is part of the risk-benefit analysis that should be discussed with your child's health care provider.

Sometimes it may be difficult to get a complete family history for your child since family members may hide their mental health condition or may not have been formally diagnosed. You may have to work off of your own observations to come up with a family history.

Risk of Suicide

It is estimated that about 3,000 youth die by suicide each year in our nation.[10] Suicide is the third leading cause of death in youth ages 10-24. Latino and African American female high school students have a higher percentage of suicide attempts (11.1 percent and 10.4 percent respectively) than their Caucasian and non-Latino peers (6.5 percent).[11] Suicide rates are 1.8 times higher than the national average among American Indians/Alaska Natives—making suicide the second leading cause of death within this

cultural group.[12] GLBT youth are up to four times more likely to attempt suicide than their heterosexual peers.[13]

Depression is a leading cause of suicide. Research shows that 90 percent of individuals who complete suicide have a diagnosable and treatable mental health condition, often depression.[14] Over one-half of youth living with depression will eventually attempt suicide, and at least seven percent will ultimately die as a result.

> Untreated depression is the single most significant risk factor for suicide.

When Your Child Is Thinking or Talking about Suicide

Health care providers have found that when an adolescent talks about suicidal thoughts, it often opens the door to communication that increases the likelihood that special safety or protective measures can and will be taken. Therefore, any treatment intervention that increases discussion of hidden suicidal thoughts or impulses is helpful.

It is also important to remember that teens often prefer to talk with friends about how they are feeling. You should take comments related to self-harm or suicidal thoughts or behaviors seriously from your child or his or her friends. Encourage your child to share his or her thoughts and feelings; you should not ignore those that signal distress or early warning signs that your child may be experiencing depression.

The Black Box Warning

A “black box warning” is a form of alert used by the FDA to warn the public and health care providers that special care must be taken in certain uses of a medication.

In 2004, the FDA required makers of all antidepressant medications to have a cautionary label, or black box warning, placed on their product labeling that warns about increased risks of suicidal thinking or behavior in children and adolescents living with major depression. The greatest risks associated with the use of antidepressant medications exist in the first few months of treatment. The warning also states that youth using these

medications should be observed closely for a worsening of symptoms, signs of suicidal thoughts or behavior or unusual changes in behavior. Visit www.fda.gov to see the full warning label.

What Prompted the Black Box Warning?

During 2004, a FDA advisory committee reviewed data on the safety and effectiveness of antidepressant medications. As part of this process, the FDA analyzed data from 24 clinical trials involving more than 4,400 children and adolescents who had been prescribed antidepressant medications for the treatment of major depression, anxiety and obsessive-compulsive disorder. This review showed that a small number of trial participants given antidepressant medications experienced a heightened rate of suicidal thinking or behavior. Most often, this occurred soon after an individual started medication. It is important to note that there were no suicides in any of the clinical trials.

Although no suicides occurred in the trials, 78 (or 1.7 percent) of the 4,400 trial participants receiving antidepressant medications experienced suicidal thoughts or engaged in some form of suicidal behavior. Based on this analysis, about two children out of 100 might be expected to experience these symptoms when taking antidepressant medications.

Does the FDA Warning Mean Medications are Unsafe?

No. Researchers and clinicians have found that antidepressant medications, often in combination with research-based therapy like Cognitive Behavioral Therapy, are safe and effective for most adolescents. However, all treatment decisions must be made on an individual basis and in close consultation with a trained and qualified professional. Also, the FDA warning is an important reminder about the critical need for close monitoring and observation.

No individual should abruptly stop taking antidepressants. Parents contemplating changing or terminating their child's antidepressant medication should always consult with their child's provider before taking such action.

If your child is currently taking antidepressant medication and doing well, he or she should continue with that treatment. Still, you should talk with your child about the possibility of rare and serious side effects, including suicidal thoughts and behaviors. Also, you, your child and your child's health care provider should discuss a safety plan. This plan should indicate whom your child will contact if thoughts of suicide or self-harm occur. It is also always important to closely monitor your child when he or she is taking medication.

Creating a Good Monitoring System

First, you should make sure that your child understands whom to talk with about concerns related to treatment and understands the potential side effects of medications. It is also important to make sure that your child understands the possible impact of not taking medications once they are prescribed.

Medication may promote "activation," a phase in which an adolescent may begin to improve from treatment and begin to feel more energy to act on continued negative thoughts, leading to a heightened risk of self-harm. This often happens in the first few weeks of treatment and is the reason that health care providers and families must be particularly vigilant in observing changes in a teen's behavior and symptoms during this time period.

The FDA recommends the following general guidelines for the close monitoring of children and adolescents being treated with antidepressant medications.

- During the first four weeks of treatment, a child or adolescent should be seen by the health care provider prescribing the medication at least once a week, with face-to-face contact with the family.
- In weeks five through eight of treatment, a child or adolescent should be seen every other week by the health care provider, with face-to-face contact.
- A child or adolescent should then be seen again by the health care provider at week 12, with face-to-face contact.
- A child or adolescent should be seen by the health care provider as clinically indicated after 12 weeks of treatment.

The close monitoring should involve closely observing your child for a worsening of symptoms, suicidal thinking or suicide attempts and unusual changes in behavior, especially during the initial few months of medication treatment. To assist with this monitoring, the FDA directed manufacturers to develop medication guides for families that could help improve monitoring. Medication guides are distributed at the pharmacy with each prescription or refill of a medication.

Your child's health care provider should give you the contact information necessary to reach him or her 24 hours a day, seven days a week, should your child exhibit serious or concerning side effects, like agitation or akathisia. You should also understand when to take your child to an emergency room for safety-related concerns.

> A prescription for an antidepressant medication without close monitoring and follow-up is not a good treatment plan.

Whenever possible, you should make the home environment open to communicating about depression. Talk about what is working and what is not, make suggestions for additional supports and take action to minimize risk of self-injurious or harmful behaviors. You need to agree with your child that there can be no secrets when it comes to safety. The key is to keep the conversation going, because isolation is a risk factor for suicide.

Creating a Safety Plan

Depression causes negative thinking and teens with depression may think about death. It is critical to develop a safety plan given the risk of suicide in teens with depression. Talk with your child's health care provider about what should be included in the safety plan. The plan should be specific and individualized to address the unique needs of your child. Your child needs to have a full working understanding of the safety plan, including who to call for help, what situations are most likely to cause a risk of self-harm and protective elements or people that can be brought into play during stressful times.

Talk with your child's health care provider about the risks in your home environment and how to reduce them. These risks can include guns, over-the-counter prescription medications and sharp objects. Additionally, ensuring the correct dosage of any prescribed medication is an important aspect of a safety plan.

"Self medication" (using alcohol or street drugs to change how one feels) is also a safety concern, as it increases the risk of suicide and other self-harming behaviors. It is important to talk with your child about getting support for sobriety if substance abuse is suspected.

Families sometimes must make extremely difficult decisions, including—as a last resort—the decision to hospitalize their child against his or her wishes. Taking this step may be the most painful thing that a parent or caregiver ever does. Be sure to get good input about safety-related concerns from a professional who is trusted and trained to treat adolescents living with depression. Many people who experience suicidality look back on it in the future with regret. Depression is a treatable condition and the goal of a safety plan is to ensure the worst outcome does not happen during a time of treatable vulnerability.

Research

There has been great progress over the past five to 10 years in determining the most effective treatment options for adolescents living with depression. There have been a number of research studies, some of which are outlined in the following pages, looking at treatment approaches for adolescent depression that show promising results. Families are encouraged to learn more about these studies and to seek interventions that have been found to be effective. For more information, visit the National Institute of Mental Health (NIMH) website at www.nimh.nih.gov.

Treatment for Adolescents with Depression Study

NIMH has funded multiple research studies examining effective treatment interventions for adolescent depression. The Treatment for Adolescents with Depression Study (TADS) assigned youth to one of four groups and looked at the effectiveness of the treatment in each of the groups over a 36-week trial.

1. Group one received Prozac only—an SSRI antidepressant medication.
2. Group two received Prozac combined with Cognitive Behavioral Therapy (CBT).
3. Group three received CBT only.
4. Group four received placebo treatment (a sugar pill).

The following are the research results after the initial 12 weeks of study:

- 71 percent of adolescents receiving Prozac combined with CBT (group two) showed much or very much improvement.
- 60 percent of adolescents receiving Prozac only (group one) showed improvement.
- 44 percent of adolescents receiving CBT treatment only (group three) showed improvement, slightly more than those receiving a sugar pill.

By the end of the 36-week research trial, the positive response rate for combination treatment (Prozac and CBT) still remained the highest at 86 percent, while response rates to Prozac only and CBT only essentially caught up at 81 percent each. The majority of adolescents (82 percent) who reached a sustained positive response by week 12 of the research study maintained this level of recovery through week 36 as outlined below.

- 89 percent of adolescents receiving combination Prozac and CBT maintained improvement for the full 36 weeks.
- 74 percent of adolescents receiving Prozac alone maintained their improvement.
- 97 percent of adolescents receiving CBT alone maintained their improvement.

The high long-term success effect of CBT suggests that for adolescents who initially respond well to CBT, this therapeutic intervention may have a preventive effect that helps to sustain positive improvements and potentially avoid relapse or recurrence of depression.

What Does TADS Tell Us?

The TADS study suggests that the combination of CBT and medication is the safest and most effective treatment overall for adolescents living with major depression. This finding is consistent with the studies that have been done with adults living with depression that show that the best treatment outcomes occur with combined psychotherapy and medication.

After the TADS trial ended, the adolescents who had been assigned to one of the three treatment groups were assessed up to four times during the following year to determine if improvements were sustained over time. The treatment provided in the TADS research study was no longer offered, but teens were encouraged to continue to seek treatment within their communities.

By the end of the 36-week trial, 82 percent of all participants had improved and 59 percent had reached full recovery. During the follow-up year, most participants maintained their improvements and the recovery rate climbed to 68 percent.

In addition, CBT was found to have a protective effect over the long-term. However, about 30 percent of the teens who were in remission at week 36 became depressed again during the following year, indicating the need for continuous monitoring and further improvements in long-term treatment of adolescents living with major depression.

A small, separate NIMH-funded pilot study found that adolescents living with major depression who received CBT after responding to an antidepressant medication were significantly less likely to experience a relapse or recurrence compared to teens who did not receive CBT. The significance of this small study is that introducing CBT in follow-up treatment after an adolescent has responded to an antidepressant medication may prevent relapse. Currently, a larger study to further evaluate the effectiveness of this treatment strategy is underway.

What Happened to Adolescents in the TADS Study with Suicidal Thinking or Suicide Attempts?

Suicidal thinking decreased substantially in all active treatment groups. However, during treatment, those taking Prozac alone had slightly higher rates of suicidal thinking or behavior (15 percent) than those in combination treatment (8 percent) and those in CBT alone (6 percent), particularly in the early stages of treatment. Suicidal thinking and suicide attempts occurred between the first and 31st week of the trial, indicating that the risk of suicide did not decrease after the first month of treatment.

Participants who showed serious suicidal thinking and severe depressive symptoms prior to the study were more likely to have suicidal thinking or suicide attempts during treatment. In addition, adolescents who experienced suicidal thinking or a suicide attempt tended to do so in the context of difficult interpersonal problems, such as conflicts with family members.

Treatment of SSRI-resistant Depression in Adolescents Study

NIMH funded a multi-site research trial to investigate treatment options for adolescents living with difficult-to-treat depression who had not responded to a previous two-month course of treatment with a selective serotonin reuptake inhibitor (SSRI) antidepressant medication. The Treatment of SSRI-resistant Depression in Adolescents (TORDIA) study looked at treatment outcomes for adolescents receiving one of four treatment interventions.

1. Group one switched from the SSRIs they were taking to a different SSRI medication (Paxil[i], Celexa or Prozac).
2. Group two switched to a different SSRI medication combined with CBT.
3. Group three switched to Effexor—a serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant medication.
4. Group four switched to Effexor medication combined with CBT.

After 12 weeks, about 55 percent of adolescents who switched to a different antidepressant medication and added CBT responded positively, while 41 percent of those who switched to a different medication alone responded positively. Adolescents with co-occurring conditions also responded positively to medication combined with CBT treatment, suggesting that CBT is effective with those who have complex diagnoses.

After 24 weeks, nearly 40 percent of adolescents participating in the TORDIA study recovered, regardless of which treatment they had been assigned. However, those who achieved recovery were more likely to have responded to treatment early—during the first 12 weeks.

Although none of the antidepressant medications seemed to be superior over the others, Effexor was associated with more adverse effects, such as skin infections and cardiovascular side effects. Thus, switching to a different SSRI rather than Effexor should be considered first.

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[i] Although the FDA does not recommend the use of Paxil for children and adolescents, it was included in this NIMH-funded study for youth that were not responding to other antidepressant medications.

*Adolescents who had severe depression at the beginning of the study, higher levels of suicidal thinking, a sense of hopelessness, anxiety, family conflict or were prone to self-harming behavior, were less likely to respond to treatment. This emphasizes the importance of early treatment in adolescents before the depression becomes more serious and chronic.

What Does TORDIA Tell Us?

The TORDIA study shows that adolescents living with treatment-resistant depression are more likely to get better when they switch from antidepressant medication alone to combination therapy (antidepressant medication and CBT). These results are similar to those found in the TADS study. It also shows that adolescents living with treatment-resistant depression can get better by trying several different treatment strategies. In light of this, adolescents living with major depression and their families need to be persistent and not give up in seeking alternative treatment options. Recovery is possible.

The study also underscores the importance of early treatment when it comes to addressing adolescents living with treatment-resistant depression. The study suggests that clinical guidelines recommending that adolescents stay with treatment for at least eight to 12 weeks before trying another treatment approach may need to be revisited. More research is needed to clarify the optimal time to change a treatment strategy for adolescents living with treatment-resistant depression.

What Happened to Adolescents with Suicidal Thinking or Suicide Attempts?

The study found that adolescents who had higher levels of suicidal thinking, higher levels of parent-child conflict and who used drugs or alcohol at the beginning of the trial were more likely to experience serious suicidal thinking or suicide attempts during treatment and less likely to respond to treatment. They were also less likely to complete treatment. Moreover, most serious suicidal thinking or suicide attempts happened early in the trial.

No statistically significant difference in suicidal thinking, suicide attempts or non-suicidal self-injury were found among the four treatment groups. Additionally, although CBT was found to have a protective effect over the long-term among adolescents living with depression in the TADS study, it

did not appear to reduce suicidal thinking or recent suicide attempts in the TORDIA study.

Treatment of Adolescent Suicide Attemptors Study

NIMH funded a multi-site pilot study, Treatment of Adolescent Suicide Attemptors, to identify factors that may predict and help prevent suicide reattempts among adolescents. The study used a new psychotherapy intervention, Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), to address the need for a specific psychotherapy designed to prevent or reduce the risk of suicide attempts in adolescents.

CBT-SP consisted of a 12-week acute treatment phase focused on safety planning, understanding the circumstances and vulnerabilities that lead to suicidal behavior and building life skills to prevent suicide reattempts. The study also included a maintenance continuation phase.

In the six-month study, 124 adolescents who had recently attempted suicide were either randomly assigned to or given the option of choosing one of three intervention groups:

1. antidepressant medication only;
2. CBT-SP only; and
3. antidepressant and CBT-SP.

Most teens chose the intervention they wanted to be placed in and most chose combined antidepressant medication and CBT-SP.

During the six-month treatment period, 24 of the 124 adolescents experienced a new onset or worsening of suicidal thinking or a suicide attempt—a rate lower than what previous studies showed among suicidal individuals, suggesting that this treatment approach may be a promising intervention. In addition, more than 70 percent of the adolescents—a population that is typically difficult to keep in treatment—completed the acute phase of the therapy.

The study found that most of the suicidal thinking or suicide attempts occurred within four weeks of the beginning of the study, before the teens received adequate treatment. This suggests that more intense therapy should be provided to suicidal adolescents early in treatment.

The study also revealed characteristics that could predict recurrent suicidal thinking or suicide attempts, including:

- high levels of self-reported suicidal thinking and depression;
- a history of abuse;
- two or more previous suicide attempts; and
- a strong sense of hopelessness.

In addition, a high degree of family conflict predicted suicidal thinking or suicide attempts, while family support and cohesion acted as a protective factor against suicidal thinking and suicide reattempts. These results echo those found in the TADS and TORDIA studies.

Advocating for Your Child

You are your child's strongest advocate. You have a right to any and all information available about the nature of your child's depression, the proposed treatment options and the risks and benefits of treatment. Do your best to ensure that your child receives a comprehensive evaluation and an accurate diagnosis. You should have no qualms about seeking a second opinion if you have questions or concerns. Ask a lot of questions about any proposed diagnosis or treatment. Help your child learn, in an age-appropriate way, about depression so that he or she can be an active partner in treatment.

Depression can sometimes affect a child's school attendance or performance. If this is the case for your child, it may be necessary for you to work with your child's teachers to advocate for school-based services and supports for your child. This will help ensure he or she succeeds academically, socially and functionally within the school environment. To access resources on advocating for your child in school, visit NAMI's Child and Adolescent Action Center website at www.nami.org/caac (click on "Schools and Education").

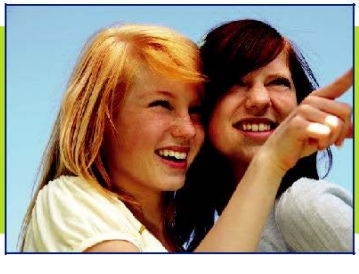
NAMI and other family advocacy organizations stand ready to help families with a loved one living with depression and other mental health conditions. Together, we can make a positive difference in the lives of our loved ones and friends. To learn more about NAMI and to connect with a NAMI state organization or local affiliate, visit www.nami.org.

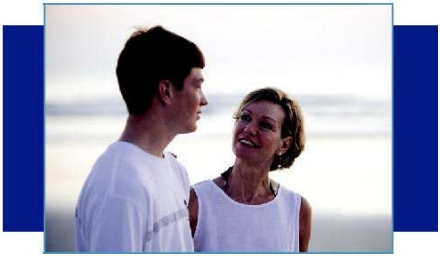
Resources for Families

For more information on depression and referral services, contact NAMI's HelpLine at 1 (800) 950-NAMI (6264), Monday through Friday, 10 a.m.-6 p.m. Eastern Time.

NAMI has developed a complete resource list for families at www.nami.org/ CAAC/resources.

For Spanish language resources on child and adolescent mental health conditions and treatment options, visit NAMI's Spanish language website at www.nami.org/espanol.





Family Support Action Plan

What Parents Can Do to Help Their Teens

Family support is a vital component in your adolescent's recovery from depression. It makes you a more engaged participant in your child's health care and helps rebuild your adolescent's confidence and sense of accomplishment. However, it can also be extremely difficult—after all, when your adolescent is depressed, he/she probably doesn't feel like accomplishing anything at all!

To help with family support, set goals to help you focus on your teen's recovery and recognize your child's progress. Find things that have helped your adolescent in the past—identify goals that are simple and realistic and match your teen's's natural "style" and personality. Work on only one goal at a time.

Adherence to Treatment Plan. Following through on health advice can be difficult when your adolescent is down. Your child's success will depend on the severity of his/her symptoms, the presence of other health conditions, and your adolescent's comfort level in accepting your support. However, your teen's's chances for recovery are excellent if you understand how you and your family naturally prefer to deal with your child's health problems. Knowing what barriers are present will help you develop realistic health goals.
Example goals: Remember to give your adolescent his/her medications. Participate in counseling. Help your teen keep appointments.

MY GOAL: _____

Relationships. It may be tempting for your child to avoid contact with people when he/she is depressed, or to "shut out" concerned family and friends. Yet fulfilling relationships will be a significant part of your adolescent's recovery and long-term mental health. Understanding your child's natural relational style for asking for and accepting help should guide the design of your family support plan.
Example goals: Encourage your adolescent to talk with a friend every day. Attend scheduled social functions. Schedule times to talk and "just be" with your child.

MY GOAL: _____

Nutrition and Exercise. Often, people who are depressed don't eat a balanced diet or get enough physical exercise—which can make them feel worse. Help your child set goals to ensure good nutrition and regular exercise.
Example goals: Encourage your child to drink plenty of water. Eat fruits and vegetables. Avoid alcohol. Take a walk once a day. Go for a bike ride.

MY GOAL: _____

Spirituality and Pleasurable Activities. If spirituality has been an important part of your child/adolescent's life in the past, you should help to include it in your child/adolescent's current routine as well. Also, even though he/she may not feel as motivated or get the same amount of pleasure as he/she used to, help him/her commit to a fun activity each day.
Example goals: Recall a happy event. Do a hobby. Listen to music. Attend community or cultural events. Meditate. Worship. Do fun family activities. Take your child to a fun place he/she wants to go.

MY GOAL: _____

(Adapted by GLAD-PC with permission from Intermountain Healthcare)

How Can You Help with Sleep Problems

All of us need enough sleep to function well during the day. Having just one night of poor sleep can make it more difficult to pay attention to our school or work, make us sleepy throughout the day, cause us to make poor decisions, and leave us feeling irritable, grouchy, slowed down or restless. When many nights of little sleep add up, getting through the day can become a losing battle!

Sleep problems frequently occur as a part of depression. In fact, sleeping problems, either sleeping too much or having difficulty sleeping enough, are one of the symptoms of major depression. Although some sleep problems may require medication to get better, there are things **YOU** can do to help improve your sleep. By improving your sleep hygiene (your sleep habits), you can get rid of any habits that are making it harder for you to get a good night's rest.

1. Keep a regular sleep schedule. Try to go to bed and wake up at the same time every day. It can take your body several days to weeks to adjust to a new sleep schedule, so staying up late on weekends and sleeping in really leaves your body confused.

2. Watch what you eat and drink near bedtime. Food or drinks with caffeine (e.g. sodas, tea, chocolate) can keep you up. Avoid eating big meals or being hungry before bedtime. Some people find milk or milk drinks (e.g. Ovaltine) to be helpful in falling asleep. Milk contains tryptophan, which causes sleepiness.

3. Eliminate bad habits. Drinking alcohol and smoking cigarettes both prevent you from getting a good night's sleep.

4. Make sure your bedroom is set up for sleep. Try to make sure the temperature of the room is comfortable, there are few noises, and the room is dark.

5. Exercise regularly. Getting vigorous exercise during the afternoon (but 4-6 hours before bedtime) has been found to result in better sleep.

6. Get outside and see the sun. Sunlight helps the body control its biological clock. This clock lets us know when to feel sleepy and when to be alert.

7. Use your bed only for rest or sleep. Don't watch TV or do homework in bed.

8. If you don't fall asleep within 10 or 15 minutes, get out of bed. Do a quiet, dull activity until you are feeling sleepy and try again.

9. Find a relaxing activity to do before bed. A warm bath, quiet music, and/or talking with a friend can all help you make the change from daytime to nighttime. Find what works best for you.

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
PAC-DEP

Depression and the Family

Having a family member with depression affects the whole family. Each family member is likely to react in his or her own way, and the response may, in turn, affect other family members. It is important to recognize the ways in which the illness affects your family and to take steps to reduce any negative impact. The depressed child or adolescent will find an easier path to recovery from the illness if the family can continue to be a strong, well-functioning unit.

Possible Ways the Family May React

- The family may begin to change family routines or rules. Family members may choose not to participate in activities that take them away from the home or stop trying to do things that may cause disruption or stress (such as requiring chores).
- Families may begin to avoid contacts with friends or social gatherings. Additionally, friends may begin to avoid members of the family. This can result in the family becoming isolated from others, with little to no support in a time when they need it most.
- Everyone may be walking on eggshells to avoid upsetting the depressed person.
- Family members may be irritable or angry, resulting in more family disagreements or stress.
- Family members may act out to get attention they feel they are not receiving.
- Parents may be stricter or more harsh with non-depressed children.
- There may be more arguments or disagreements between family members, especially around how to handle the depressed person. Having a depressed child can put enormous stress on relationships.
- Family members may blame themselves for the difficulties the depressed child is having. This self-blame can be intensified by messages from others that their parenting skills may be the cause of the child's problems.
- Individuals may feel frustrated and helpless and unable to change things for the depressed individual.
- Family members may feel resentful of the depressed person for the disruption that their illness has caused. Resentment may lead to even more problems in dealing with the depressed individual.
- Individuals may feel ashamed of the child's depression. Brothers or sisters may not want to have friends over or worry that others will find out. Parents may worry that outsiders will judge them.
- Other family members may begin to show signs of stress, even depression.

Most families will have one or even most of these experiences. But changing your family's life to center around your child's depression is not helpful for the family. The following are some suggestions to help lessen the impact that depression has on your family.

Dealing with Depression in the Family

- Take care of yourself and encourage other family members to do so also. You will be better able to help your child if you are healthy and well rested. Recognize when you need a break and arrange to take one, or better yet arrange some time off before you need it.
- Take time to go places and enjoy yourselves as a family, even if the depressed person does not participate.
- Encourage all family members to continue with regular activities. Try to take time to spend with each family member, not allowing the depressed child to monopolize all of the family's attention.
- Give yourself and your family permission to enjoy an activity, even if the depressed person does not.
- No one is able to remain patient and cheerful all the time. If you have a bad day, go easy on yourself.
- Remind yourself and your family that depression is a medical illness. No one in your family, including the depressed child, is to blame.
- Because depression affects the whole family, the family can benefit from treatment. Include family members in the treatment that your child is receiving. Family therapy may be helpful, and families can also benefit from education about the illness and its treatment and working with the child's counselor or psychiatrist to address specific problems in the family.
- Family members need to recognize depression in themselves and get help! Depression tends to run in families. Be a good role model and seek help for any mental health problems that you or other family members might experience.
- Consider joining a support group. Family members can find relief and good ideas by talking with others who have had similar experiences. Even brothers and sisters of the depressed person can benefit from a group with whom to share their feelings.

Reviewed 09-30-03

Texas Department of Mental Health and Mental Retardation
P-DEP

Chapter IX.
Billing

Guide to the "Billing" Section

American Academy of Pediatrics Standardized Screening/Testing Coding Fact Sheet for Primary Care Pediatricians: Developmental/Behavioral/Emotional

American Academy of Pediatrics Depression Coding Fact Sheet for Primary Care Clinicians

Guide to the "Billing" Section

In this section, you will find the American Academy of Pediatrics coding fact sheets on screening as well as on depression:

American Academy of Pediatrics Standardized Screening/Testing Coding Fact Sheet for Primary Care Pediatricians: Developmental/Behavioral/Emotional

American Academy of Pediatrics Depression Coding Fact Sheet for Primary Care Clinicians

These sheets can also be acessed on the AAP website at:

https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Coding-at-the-AAP/Pages/Coding-Fact-Sheets.aspx

One of the primary complaints among pediatricians is that they spend more time with patients with emotional issues and cannot get reimbursed.We have included the CPT codes suggested by the AAP. However, some third-party payors may still give you problems for mental health reimbursement. We suggest you call the payors if you are refused payment and discuss the coding and the denial. You may want to keep these codes in mind when you negotiate your new contracts. Call the AAP or your local primary care organization for advocacy help.

NEW FOR 2018: Integrated care codes. Please call your third-party payors to discuss their use.

> Psychiatric Collaborative Care Management Codes: 99492 – 99494, effective January 2018
>
> General Behavior Health Integration Code: 99484, effective January 2018

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

Standardized Screening/Testing Coding Fact Sheet for Primary Care Pediatricians: Developmental/Behavioral/Emotional

I. CODING

Developmental screening and assessment are often complemented by the use of standardized instruments, which vary in length. This coding fact sheet provides guidance on how pediatricians can appropriately report standardized developmental screening and testing services.

A. How To Report Developmental Screening/Testing

96110 *Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument*

The use of standardized developmental screening instruments (eg, PEDS, Ages and Stages, M-CHAT) is reported using Current Procedural Terminology(CPT®) code **96110** (*Developmental screening*). Code **96110** is reported when performed in the context of preventive medicine services. This code also may be reported when screening is performed with other evaluation and management (E/M) services such as acute illness or follow-up office visits.

In 2012, the **96110** code descriptor was revised to differentiate it from the "testing" that is referenced under code **96111**. *Screening* asks a child's observer to provide his/her observations of the child's skills, which are then recorded on a standardized and validated screening instrument. Screening is subjective and only reports the assessment of the patient's skills through observation by the informal observer. On the other hand, testing measures what the patient is actually able to do on a standardized psychometric instrument at that time. Screening does not imply a diagnosis; only the means by which information is collected on the patient.

Because clinical staff typically performs the **96110** service, the Medicare Resource-Based Relative Value Scale (RBRVS) relative values reflect only the practice expense (clinical staff time, medical supplies, medical equipment) and professional liability insurance -- there is no physician work value published on the Medicare physician fee schedule for this code.

On the less common occasion where a physician performs this service, it may still be reported with code **96110** but the time and effort to perform the screening itself should not count toward the key components (history, physical exam, and medical decision making) or time when selecting an E/M code for a significant, separately identifiable service performed during the same patient encounter. When a screening test is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96110** and the and E/M service should be reported and modifier **25** (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service)* should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit **or** modifier **59** *(distinct procedural service*) should be appended to the developmental

Note: Health Risk Assessments are not coded here and have their own fact sheet

screening code, showing the developmental screening services were separate and necessary at the same visit.

Additionally in 2012, code **96110** was revised to clarify that the instrument used must be standardized and that the code may be reported more than once on a single date of service. The code descriptor states "per standardized instrument." Therefore, if you are performing multiple standardized screens on a patient (eg, an M-CHAT and ASQ), you will report **96110** with 2 units (or on separate line items). Modifier **59** may be required to indicate that the services are distinct.

In 2015, the descriptor for code **96110** was revised to remove reference to "with interpretation and report" and replace it with "scoring and documentation" since this more accurately reflects the work performed. A notation was also added which refers the physician to code **96127** for emotional/behavioral assessment. This code will be discussed below.

96111 *Developmental testing (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report*

Developmental testing using standardized instruments (eg, Bayley Scales of Infant Development, Woodcock-Johnson Tests of Cognitive Abilities (Third Edition) and Clinical Evaluation of Language Fundamentals (Fourth Edition) are reported using CPT code **96111**. This service may be reported independently or in conjunction with another code describing a distinct patient encounter provided on the same day as the testing (eg, an evaluation and management code for outpatient consultation). A physician or other trained professional typically performs this testing service. Therefore, there are physician work RVUs published on the Medicare physician fee schedule (Resource-Based Relative Value Scale or RBRVS) for this code.

When **96111** is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the key components (history, physical exam, and medical decision making) or time for selecting the accompanying E/M code. Just as discussed for **96110**, if the E/M code is reported with **96111**, modifier **25** (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service)* should be appended to the E/M code **or** modifier **59** *(distinct procedural service*) should be appended to the developmental testing code, showing that the developmental testing services were separate and necessary at the same visit.

In 2005, the CPT code descriptor of **96111** was revised to reflect the deletion of the test examples as well as the "per hour" designation. Thus, effective January 1, 2005, physicians reported the service without regard to time. The typical testing session, including the time to perform the interpretation and report, was found in the American Academy of Pediatrics (AAP) survey used to value the service to be slightly over an hour.

B. When To Report Developmental Screening/Testing

96110

The frequency of reporting **96110 (***Developmental screening***)** depends on the clinical situation. The AAP Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule recommends

developmental/behavioral surveillance at each preventive medicine visit, and the AAP "Developmental Surveillance and Screening of Infants and Young Children" policy statement recommends that physicians use validated/standardized developmental screening instruments to improve detection of problems at the earliest possible age to allow further developmental assessment and appropriate early intervention services.

Thus, the use of screening instruments seems to enhance the task of developmental assessment typically done in the preventive medicine setting. The exact frequency of testing therefore depends on the clinical setting and the provider's judgment as to when it is medically necessary. When physicians ask questions about development as part of the general informal developmental survey or history (eg, surveillance) or complete checklists, this is not formal "screening" as such, **and is not separately reportable**. Examples of validated/standardized screening instruments along with clinical vignettes are provided below.

96111

Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code **96111** (*Developmental testing*). These tests are typically performed by physicians, psychologists or other trained professionals and require upwards of an hour of time. They also are accompanied by an interpretation and formal report, which may be completed at a time other than when the patient is present.

Like code **96110**, the frequency of reporting code **96111** is dependent on the needs of the patient and the judgment of the physician. When developmental surveillance or screening suggests an abnormality in a particular area of development, more extensive formal objective testing is needed to evaluate the concern. In contrast to adults, the limited ability of children to maintain focused selective attention and testing speed may mean that several sessions are needed to properly evaluate the problem. Code **96111** is reported only once per date of service. There must be an accompanying report describing and interpreting all testing.

Additionally, subsequent periodic formal testing may be needed to monitor the progress of a child whose skills initially may have not been "significantly low," but who was clearly at risk for maintaining appropriate acquisition of new skills.

II. CLINICAL VIGNETTES

96110 Vignette # 1

At a follow-up visit for bilateral otitis media, the pediatrician notes the patient missed her 12 month well-child visit. He requests and the child's father completes the Ages and Stages Questionnaire (ASQ.) The father endorses no concerns in any developmental domain. The pediatrician reviews the father's completed ASQ and asks him if his daughter is using single words to convey her wants and is using words to label common objects. The father assures him that she is doing this and, in fact, other non-family adults have commented on her clear articulation. No concerns at all are reported and this is consistent with what the pediatrician has observed in the office visits. He tells the father they will continue to monitor for any evidence the child is not acquiring skills at an expected rate. All this is noted in a few sentences in the chart note.

CPT	ICD-10-CM
99392-25* Preventive medicine service established patient, age 1-4	**Z00.129** Encounter for routine child health examination w/o abnormal findings
96110 Developmental screening	**Z00.129**

*NOTE: Some payers may require alternate reporting wherein the modifier **59** is appended to the developmental screening code, however according to *CPT* guidelines, that is not appropriate and actually no modifier is required.

96110 Vignette #2

At a 24-month well child check, the mother describes her toddler as "wild," completes the PEDS (Parent Evaluation of Developmental Status), and responds positively to the question "Do you have concerns about your child's language skills?" The nurse scores the PEDS and places the answer sheet on the front of the chart with a red arrow sticker next to it. When the pediatrician examines the child, he is alerted to ask the mother about her observations of the child's language ability. He then confirms the delay in language, and makes a referral to a local speech pathologist.

CPT	ICD-10-CM
99392-25* Preventive medicine service established patient, age 1-4	**Z00.121** Encounter for routine child health examination w/ abnormal findings
96110 Developmental screening	**Z00.121** **F80.1** Expressive language disorder

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the developmental screening code, however according to CPT guidelines, that is not appropriate and actually no modifier is required.

If the pediatrician spent significant extra time evaluating the language problem, then an E/M service office/outpatient code from the **99201-99215** series may be reported using a modifier 25, linked to the appropriate ICD-10-CM code(s) as appropriate (eg, **F80.1**, *Expressive language disorder*; **F80.2**, *Mixed receptive-expressive language disorder*; **F80.89**, *Other developmental disorders of speech or language*).

96110 Vignette #3

At a five-year health maintenance visit, a father discusses his daughter's difficulty "getting along with other little girls." "Doctor, she wants friends, but she doesn't know how to make — much less keep — a friend." Further questioning indicates the little girl is already reading and writing postcards to relatives, but has not learned how to ride her small bicycle, is awkward when she runs and she avoids the climbing apparatus at the playground. Her father wondered if her weaker gross motor skills affected her ability to play successfully with other children. She seems very happy to sit and look at books about butterflies — her all consuming interest! The child's physical exam consistently fell in the range of 'normal for age' in previously health maintenance visits. The pediatrician asks her nurse to administer the Australian Scale for Asperger's Syndrome and the father's responses yield 16/24 items with an abnormal score being >3. The pediatrician reviews the form, writes a brief summary, and discusses her observations with the father. A referral is made to a local physical therapist who has a playground activities group and to a local psychologist who has expertise in diagnosing autism spectrum disorders.

CPT	ICD-10-CM
99393-25* Preventive medicine service established patient, age 5-11	**Z00.121** Encounter for routine child health examination w/ abnormal findings
96110 Developmental screening	**Z00.121** **F82** Specific developmental disorder of motor function **F98.9** Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the developmental screening code, however according to CPT guidelines, that is not appropriate and actually no modifier is required.

96111 Vignette #1

An eight-year-old boy with impulsive, overly active behavior and previously assessed "average" intelligence is referred for evaluation of attention deficit disorder. He has by prior history reading and written expression skills at first grade level, and received speech and language therapy during his attendance at Head Start when he was four years old.

Behavior and emotional regulation rating scales completed by the parent and teacher were reviewed at an earlier evaluation and management service appointment. History, physical and neurological examination were also completed at that visit.

On this visit, standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These scores and observations were integrated into a formal report to be used to individualize his education and treatment plan. Testing and the report took approximately 75 minutes. The family schedules a follow up visit to discuss this report and the final diagnosis and treatment plan with the physician.

CPT	ICD-10-CM
96111 Developmental testing	**F90.-** Attention deficit disorder 4th digit **0** = inattentive type **1** = hyperactive type

96111 Vignette #2

A 5 4/12 year old boy just beginning kindergarten was seen for developmental testing. At a previous visit, his mother's responses on the Pediatric Evaluation of Developmental Status (PEDS) suggested expressive language delays. After greeting the parent and child and explaining to the child that he and the doctor would do some 'non-school' activities to see how he 'used words to tell others about (his) good ideas', the child and the examiner spent fifty minutes together completing the tasks on the Peabody Picture Vocabulary Test-Fourth Edition, and the Clinical Evaluation of Language Fundamentals-Fifth Edition. The examiner scored the two tests in five minutes and there was a significant discrepancy detected between the Receptive Language Composite and the Expressive Composite on the CELF- 5. Both test scores were abnormal, however, indicating a mixed receptive–expressive language disorder.

Note: Health Risk Assessments are not coded here and have their own fact sheet

CPT	ICD-10-CM
96111 Developmental testing	**F80.2** Mixed receptive-language disorder expressive language disorder

96111 Vignette #3:

A 9 year old girl, being treated for ADHD and receiving language therapy to improve her weak receptive and expressive language skills, comes in for a medication visit. Her mother and teacher both feel the current dosage of her stimulant medication is effective and neither perceives a need for any changes. Your services meet the "limited" level of complexity for the visit. However, while asking about her school performance, the child's mother volunteers, "I know she has been seeing the speech pathologist once a week for 7 months now, but I can't see any signs her vocabulary is increasing." You administer and score the Peabody Picture Vocabulary Test [Fourth Edition]. The performance standard score had increased by one standard deviation from her initial performance eight months ago. You show her mother the improvement and document the test administration, results and interpretation in the medical record.

CPT	ICD-10-CM
99213-25* Office service, established patient, 15 minutes "typical time"	**F90.1** Attention-deficit hyperactivity disorder **F80.2** Mixed receptive-expressive language disorder
96111 Developmental testing	**F90.1** **F80.2**

III. DOCUMENTATION GUIDELINES

Each administered developmental screening instrument is accompanied by scoring and documentation (eg, a score or designation as normal or abnormal). This is often included in the test itself, but these elements may alternatively be documented in the progress report of the visit. Physicians are encouraged to document any interventions based on abnormal findings generated by the tests.

Following are examples of appropriate documentation for some testing tools:

96110

PEDS (Parents' Evaluation of Developmental Status)
This questionnaire is designed to identify any parent/primary caretaker's concerns about a birth through eight-year child's developmental attainment and behavioral/mental health concerns. There are eight specific domain queries and one asking, "please list any concerns about your child's learning, development and behavior" and a final "please list any other concerns." The parent answers are scored into the risk categories of high, moderate, or low. The report form is included with the questionnaire.

ASQ (AGES AND STAGES Questionnaire)

This parent report instrument, covering ages 1 month through 60 months, includes objective information as the adult notes whether the child performs the skill identified. There are six questions in each of five domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal-Social. All questions are scored on a point system, with summary scores indicating the need for further evaluation. The ASQ also has a non-specific comprehensive section where general concerns are addressed. No score is provided for these answers, but the instrument developers note any "Yes" responses should prompt a referral.

96111

In general, the documentation of developmental testing includes the scoring, interpretation, and the development of the report. This typically includes all or some of the following: identifying data, time and location of testing, the reason for the type of testing being done, and the titles of all instruments offered to/completed by the child; presence (if any) of additional persons during testing, child's level of cooperation and observations of child's behavior during the testing session. Any assistive technology, prosthetics or modifications made to accommodate the child's particular developmental or physical needs should be described, and specific notations should be made if any items offered resulted in a change in the child's level of attention, willingness to participate, apparent ease of task accomplishment. The item results should be scored and the test protocol and any/all scoring sheets should be included in the medical chart (computer scanning may be needed for electronic medical records). A brief interpretation should be recorded and notation should be made for further evaluation or treatment of the patient or family. A legible signature should also appear.

How to Report Emotional/Behavioral Assessment

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

This code (**96127**) was introduced in 2015 to allow for the appropriate reporting of standardized emotional and/or behavioral assessments.

Because clinical staff typically performs the **96110** service, the Medicare Resource-Based Relative Value Scale (RBRVS) relative values reflect only the practice expense (clinical staff time, medical supplies, medical equipment) and professional liability insurance -- there is no physician work value published on the Medicare physician fee schedule for this code.

On the less common occasion where a physician performs this service, it may still be reported with code **96127** but the time and effort to perform the screening itself should not count toward the key components (history, physical exam, and medical decision making) or time when selecting an E/M code for a significant, separately identifiable service performed during the same patient encounter. When an assessment is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96127** and the and E/M service should be reported and modifier **25** (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the

Note: Health Risk Assessments are not coded here and have their own fact sheet

same visit or modifier **59** (distinct procedural service) should be appended to the developmental screening code, showing that developmental screening services were separate and necessary at the same visit.

When to Report Emotional/Behavioral Assessment
The frequency of reporting **96127** (emotional/behavioral assessment) is dependent on the clinical situation. The AAP Bright Futures "Recommendations for Preventive Pediatric Health Care" schedule recommends developmental/behavioral surveillance at each preventive medicine visit, and a formal assessment (eg, PHQ-2) for depression is recommended at every annual visit beginning at age 11 with a validated/standardized assessment instrument to improve detection of depression at the earliest possible age to allow for appropriate intervention services.

Thus, the use of assessment instruments as a screening mechanism seems to enhance the task of identifying those who may be suffering from an emotional or behavioral disorder. The exact frequency of testing therefore depends on the clinical setting and the provider's judgment as to when it is medically necessary. When physicians ask questions about a patients emotional or behavioral health as part of the general informal history (eg, surveillance), this is not a formal "screen" as such, and is not separately reportable. Examples of validated/standardized screening instruments along with clinical vignettes are provided below.

Developmental Screening Vs Behavioral Emotional Assessment
At first glance, it may be difficult to discern if a standardized instrument falls under a developmental screen (**96110**) or an emotional/behavioral assessment (**96127**). Developmental screening really takes a look at a patient's overall development and will include questions on motor skills, language skills, cognitive function, as well as may include questions on social, emotional and behavioral issues. However, the emotional and behavioral questions are being asked as part of an overall developmental inventory. An emotional or behavioral assessment instrument will look specifically at behavior and emotional health related to key symptoms of those conditions classified as behavioral or emotional conditions, such as ADHD, depression or anxiety.

96127 Vignette # 1
A 12 year old girl presents with her dad for her annual preventive medicine service. Patient's history and interview do not show any concerns of depression, however following Bright Futures guidelines, the patient is given a PHQ-2. The patient answers the questions and the screen is normal.

CPT	ICD-10-CM
99394-25* Preventive medicine service established patient, age 1-4	**Z00.121** Encounter for routine child health examination
96127 Behavioral/Emotional Assessment	

Note: Health Risk Assessments are not coded here and have their own fact sheet

96127 Vignette #2

A seven year old boy with previously diagnosed ADHD is being seen for a health maintenance visit. At the end of the visit his mother asks if she can discuss her son's medication. She hands you 2 Vanderbilt ADHD rating scales completed two weeks ago by his classroom teacher and tutor. You give these to your medical assistant to score while you obtain more interim history from Bobby's mother. After reviewing the scored teacher Vanderbilt form and discussing the results with Bobby's mother, you both decide to increase his stimulant medication. A follow-up appointment is scheduled for four weeks.

CPT	ICD-10-CM
99392-25* Preventive medicine service established patient, age 1-4	**Z00.121** Encounter for routine child health examination w/ abnormal findings
99213-25 Office service, established patient, 15 minutes "typical time"	**F90.2** Attention-deficit hyperactivity disorder, combined type
96127 Behavioral/Emotional Assessment **96127-59**	

*NOTE: Some payers may require alternate reporting wherein the modifier **59** is appended to the developmental screening code. Some payers may also require the **96127** to be reported in 2 units on one line item.

The Affordable Care Act and Standardized Screening

There is much confusion as to whether codes **96110** and **96127** fall under the no cost-sharing provision in the Affordable Care Act (ACA). The answer is - it depends. Only those services performed as part of routine screening services as either recommended under the United States Preventive Medicine Services Task Force (Recommendation A or B) or under the AAP's Periodicity Schedule are covered as part of the ACA no cost sharing. However, when **96110** or **96127** is performed and reported as part of a diagnostic service (ie, a problem is suspected) or when the screen is done outside of the routine recommendations (ie, more than the recommendations stipulate), the codes may fall under a cost sharing arrangement. Of course any plan that is not required to follow ACA provisions will have their own rules on this. One way to ensure that the developmental or behavioral/emotional screen service is covered under ACA provisions (as appropriate) is to link the service to either the "well baby/child" ICD code or the "screening for" code. Note that in order to report the "screening for" ICD code the patient has to be asymptomatic.

IV. SAMPLE ASSESSMENT/TESTING TOOLS

[NOTE: These are provided as examples only; the AAP implies no endorsement or restriction of code use to these instruments. If you choose to use an instrument not listed below, be sure they are validated/standardized.]

Instrument	Abbreviation	CPT Code
Ages and Stages Questionnaire-Third Edition	ASQ	**96110**
Ages and States Questionnaire: Social-Emotional	ASQ:SE	**96127**
Australian Scale for Asperger's Syndrome	ASAS	**96127**
Battelle Developmental Inventory Screening Tool	BDI-ST	**96110**
Bayley Infant Neuro-developmental Screen	BINS	**96110**
Beck Youth Inventories - Second Edition	BYI-II	**96127**
Beck Anxiety Inventory	BAI	**96127**
Beck Depression Inventory	BDI	**96127**
Beery-Buktenica Developmental Test of Visual-Motor Integration-6th Ed	BEERY-VMI	**96111**
Behavior Assessment Scale for Children-Second Edition	BASC-2	**96127**
Behavioral Rating Inventory of Executive Function	BRIEF	**96127**
Brigance Screens-II		**96110**
Child Behavior Checklist	CBCL	**96127**
Children's Depression Inventory	CDI	**96127**
Child Development Inventory (CDI)	CDI	**96110**
Clinical Evaluation of Language Fundamentals-Fifth Edition	CELF-5	**96111**
Clinical Evaluation of Language Fundamentals-Preschool Version-2		**96111**
Columbia DISC Depression Scale		**96127**
Comprehensive Test of Nonverbal Intelligence Second Edition	CTONI-2	**96111**
Connor's Rating Scale		**96127**
Developmental Test of Visual Perception-Third Edition	DTVP-3	**96111**
Hamilton Anxiety Scale		**96127**
Hamilton Rating Scale for Depression	HRSD	**96127**
Infant Development Inventory		**96110**
Kaufman Brief Intelligence Test-Second Edition	KBIT-2	**96111**
Modified Checklist for Autism in Toddlers	M-CHAT	**96110**
Multidimensional Anxiety Scale for Children	MASC	**96127**
Patient Health Questionnaire	PHQ-2 or PHQ-9	**96127**
Parents' Evaluation of Developmental Status (Developmental Milestones)	PEDS / PEDS-DM	**96110**
Peabody Picture Vocabulary Test-Fourth Edition	PPVT™-4	**96111**
Pediatric Symptom Checklist	PSC / PSC-Y	**96127**
Screen for Child Anxiety Related Disorders	SCARED	**96127**
Test of Auditory-Perceptual Skills-Third Edition	TAPS-3	**96111**
Test of Language Competence-Expanded Edition		**96111**
Test of Nonverbal Intelligence-Fourth Edition		**96111**
Test of Problem Solving 3: Elementary Version	TOPS 3: Elementary	**96111**
Test of Word Knowledge		**96111**
Vanderbilt Rating Scales		**96127**
Woodcock-Johnson® Test of Cognitive Abilities-Third Edition		**96111**
Kaufman Brief Intelligence Test-Second Edition	KBIT-2	**96111**

Note: Health Risk Assessments are not coded here and have their own fact sheet

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

Depression Coding Fact Sheet for Primary Care Clinicians

[A]Current Procedural Terminology (CPT®) (Procedure) Codes

Initial assessment usually involves a lot of time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office or outpatient evaluation and management (E/M) code using time as the key factor[a] or a consultation code for the initial assessment.

[B]Physician Evaluation and Management Services

99201 Office or other outpatient visit, *new*[c] patient; self limited or minor problem, 10 min.
99202 low to moderate severity problem, 20 min.
99203 moderate severity problem, 30 min.
99204 moderate to high severity problem, 45 min.
99205 high severity problem, 60 min.

99211 Office or other outpatient visit, *established* patient; minimal problem, 5 min.
99212 self limited or minor problem, 10 min.
99213 low to moderate severity problem, 15 min.
99214 moderate severity problem, 25 min.
99215 moderate to high severity problem, 40 min.

99241 Office or other outpatient *consultation,* new or established patient; self-limited or minor problem, 15 min.
99242 low severity problem, 30 min.
99243 moderate severity problem, 45 min.
99244 moderate to high severity problem, 60 min.
99245 moderate to high severity problem, 80 min.

NOTE: Use of these codes (**99241-99245**) requires the following:
1) Written or verbal request for consultation is documented in the patient chart.
2) Consultant's opinion as well as any services ordered or performed are documented in the patient chart.
3) Consultant's opinion and any services that are performed are prepared in a written report, which is sent to the requesting physician or other appropriate source (*Note:* Patients/parents may not initiate a consultation).
For more information on consultation code changes for 2010 see www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Documents/Private/AAP_Position_Medicare_Consultation_Policy.pdf Member log-in requires.

[a]Time may be used as the key or controlling factor when greater than 50% of the total physician face-to-face time is spent in counseling and/or coordination of care
[c]*A new patient is one who has not received any professional services face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.*

Reporting E/M services using "Time"

- When counseling or coordination of care dominates (more than 50%) the physician/patient or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time shall** be considered the key or controlling factor to qualify for a particular level of E/M services.

- This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

- For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

- When codes are ranked in sequential typical times (such as for the office-based E/M services or consultation codes) and the actual time is between 2 typical times, the code with the typical time closest to the actual time is used.

- Prolonged services can only be added to codes with listed typical times such as the ones listed above. In order to report prolonged services the reporting provider must spend a minimum of 30 minutes beyond the typical time listed in the code level being reported. When reporting outpatient prolonged services only count face-to-face time with the reporting provider. When reporting inpatient or observation prolonged services you can count face-to-face time, as well as unit/floor time spent on the patient's care. However, if the reporting provider is reporting their service based on time (ie, counseling/coordinating care dominate) and not key components, then prolonged services cannot be reported unless the provider reaches 30 minutes beyond the listed typical time in the highest code in the set (eg, **99205**, **99226**, **99223**). It is important that time is clearly noted in the patient's chart.

+99354 Prolonged physician services in office or other outpatient setting, with direct patient contact; first hour *(use in conjunction with time-based codes **99201–99215, 99241–99245, 99301–99350, 90837**)*

+99355 each additional 30 min. *(use in conjunction with **99354**)*

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- Time spent does not have to be continuous.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
- For clinical staff prolonged services, see **99415-99416**.

[B]Physician Non–Face-to-Face Services

99339 Care Plan Oversight—Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99340 30 minutes or more

99358 Prolonged physician services without direct patient contact; first hour
NOTE: This code is no longer an "add-on" service and can be reported alone.

+99359 each additional 30 min. (*use in conjunction with 99358*)

99367 Medical team conference by physician with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more

99441 Telephone evaluation and management to an established patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

99444 Online evaluation and management service provided by a physician or other qualified healthcare professional to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network

[B]Psychiatric Diagnostic or Evaluative Interview Procedures

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

90791 Psychiatric diagnostic interview examination evaluation

90792 Psychiatric diagnostic evaluation with medical services

[B]Psychotherapy

90832 Psychotherapy, 30 min with patient and/or family;
+90833 with medical evaluation and management (Use in conjunction with **99201–99255, 99304–99337, 99341–99350)**

90834 Psychotherapy, 45 min with patient and/or family;
+90836 with medical evaluation and management services (Use in conjunction with **99201–99255, 99304–99337, 99341–99350)**

90837 Psychotherapy, 60 min with patient and/or family;
+90838 with medical evaluation and management services (Use in conjunction with **99201–99255, 99304–99337, 99341–99350)**

+90785 Interactive complexity (Use in conjunction with codes for diagnostic psychiatric evaluation **[90791, 90792],** psychotherapy **[90832, 90834, 90837],** psychotherapy when performed with an evaluation and management service **[90833, 90836, 90838, 99201–99255, 99304–99337, 99341–99350],** and group psychotherapy **[90853])**

- Refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical encounters include
  - Patients who have other individuals legally responsible for their care
  - Patients who request others to be present or involved in their care such as translators, interpreters, or additional family members
  - Patients who require the involvement of other third parties such as child welfare agencies, schools, or probation officers

90846 Family psychotherapy (without patient present)

90847 Family psychotherapy (conjoint psychotherapy) (with patient present)

90849 Multiple-family group psychotherapy

90853 Group psychotherapy (other than of a multiple family group)

- For interactive group psychotherapy, use code **90785** in conjunction with code **90853.**

[B]Other Psychiatric Services/Procedures

+90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (Use in conjunction with **90832, 90834, 90837)**

- For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report E/M codes, use the appropriate E/M codes **(99201–99255, 99281–99285, 99304–99337, 99341–99350)** and the appropriate psychotherapy with E/M service **(90833, 90836,90838).**
- Note that code **90862** was deleted.

90885 Psychiatric evaluation of hospital records, other psychiatric reports, and psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

90887 Interpretation or explanation of results of psychiatric, other medical exams, or other accumulated data to family or other responsible persons, or advising them how to assist patient

90889 Preparation of reports on patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

[B]Screening and Testing

96101 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the *psychologist's or physician's* time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

96102 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), with *qualified health care professional* interpretation and report, administered by technician, per hour of technician time, face-to-face

96103 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), administered by a computer, with *qualified health care professional* interpretation and report

96105 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

[B]Nonphysician Provider (NPP) Services
Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

Codes **99415, 99416** are used when a prolonged E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description.

+ **99415** Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
+ **99416** each additional 30 minutes

Codes **99415-99416**

- Must always be reported in addition to an appropriate office/outpatient E/M service (ie, **99201-99215**)
- Require that the physician or qualified health care professional is present to provide direct supervision of the clinical staff.
- Are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged services, even if the time spent by the clinical staff on that date is not continuous.
- Are not reported for time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.
- Requires a minimum of 45 minutes spent beyond the typical time of the E/M service code being reported. May require that the clinical staff spend more time if the physician does not meet the time criteria of the E/M service being reported
- May not be reported in addition to **99354** or **99355**.

99366 Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more, participation by a nonphysician qualified healthcare professional

99368 Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more, participation by a nonphysician qualified healthcare professional

96150 Health and behavior assessment performed by nonphysician provider (health-focused clinical interviews, behavior observations) to identify psychological, behavioral, emotional, cognitive or

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

social factors important to management of physical health problems, 15 min., initial assessment

96151 re-assessment

96152 Health and behavior intervention performed by nonphysician provider to improve patient's health and well-being using cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems, individual, 15 min.

96153 group (2 or more patients)

96154 family (with the patient present)

96155 family (without the patient present)

[B]Non–Face-to-Face Services: NPP

Care management and transition care management are reported under the directing physician or other qualified health care professional, however, the time requirement can be met by clinical staff working under the direction of the reporting physician or other qualified health care professional.

Care Management Services:

Codes are selected based on the amount of time spent by clinical staff providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored.

Do not report 99490 for chronic care management services that do not take a minimum of 20 minutes in a calendar month.

99487 Complex chronic care management services;

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Do not report 99487 for chronic care management services that do not take a minimum of 60 minutes in a calendar month.

+99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Complex chronic care management is reported by the physician or qualified health care professional who provides or oversees the management and coordination of all of the medical, psychosocial, and daily living needs of a patient with a chronic medical condition. Typical pediatric patients

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)

2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline

3. commonly require the coordination of a number of specialties and services.

99495 Transitional care management (TCM) services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. Any additional E/M services provided after the initial may be reported separately.
Refer to the *CPT* manual for complete details on reporting care management and TCM services.

98966 Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967 11-20 minutes of medical discussion
98968 21-30 minutes of medical discussion

98969 Online assessment and management service provided by a qualified nonphysician healthcare professional to an established patient or guardian not originating from a related assessment and management service provided within the previous seven days nor using the internet or similar electronic communications network

[B]Miscellaneous Services
99071 Educational supplies, such as books, tapes or pamphlets, provided by the physician for the patient's education at cost to the physician

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[A]*International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* Codes
- Use as many diagnosis codes that apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

code, plus any other symptoms that the patient is exhibiting as secondary diagnoses that are not part of the usual disease course or are considered incidental.

- ***ICD-10-CM* codes are only valid on or after October 1, 2015.**

[B]Depressive Disorders

F32.0 Major depressive disorder, single episode, mild
F32.1 Major depressive disorder, single episode, moderate
F32.2 Major depressive disorder, single episode, severe without psychotic features
F32.3 Major depressive disorder, single episode, severe with psychotic features
F32.4 Major depressive disorder, single episode, in partial remission
F32.5 Major depressive disorder, single episode, in full remission
F32.8 Other depressive episodes (eg, atypical depression, post-schizophrenic depression)
F32.9 Major depressive disorder, single episode, unspecified
F33.0 Major depressive disorder, recurrent, mild
F33.1 Major depressive disorder, recurrent, moderate
F33.2 Major depressive disorder, recurrent severe without psychotic features
F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40 Major depressive disorder, recurrent, in remission, unspecified
F33.41 Major depressive disorder, recurrent, in partial remission
F33.42 Major depressive disorder, recurrent, in full remission
F33.8 Other recurrent depressive disorders
F33.9 Major depressive disorder, recurrent, unspecified
F34.1 Dysthymic disorder (depressive personality disorder, dysthymia neurotic depression)
F39 Mood (affective) disorder, unspecified

[B]Anxiety Disorders

F40.8 Phobic anxiety disorders, other (phobic anxiety disorder of childhood)
F40.9 Phobic anxiety disorder, unspecified
F41.1 Generalized anxiety disorder
F41.8 Anxiety depression (mild or not persistent)
F41.9 Anxiety disorder, unspecified
F93.0 Separation anxiety disorder of childhood

[B]Somatic Symptoms and Related Disorders

F44.4 Conversion disorder with motor symptom or deficit
F44.5 Conversion disorder with seizures or convulsions
F44.6 Conversion disorder with sensory symptom or deficit
F44.7 Conversion disorder with mixed symptom presentation

[B]Feeding and Eating Disorders/Elimination Disorders

F50.8 Eating disorders, other
F50.9 Eating disorder, unspecified
F98.0 Enuresis not due to a substance or known physiological condition
F98.1 Encopresis not due to a substance or known physiological condition
F98.3 Pica (infancy or childhood)

[B]Obsessive-Compulsive and Related Disorders

F42 Obsessive-compulsive disorder
F63.3 Trichotillomania/hair plucking
F63.9 Impulse disorder, unspecified
F98.8 Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence (nail-biting, nose-picking, thumb-sucking)

[B]Trauma- and Stressor-Related Disorders

F43.20 Adjustment disorder, unspecified
F43.21 Adjustment disorder with depressed mood
F43.22 Adjustment disorder with anxiety
F43.23 Adjustment disorder with mixed anxiety and depressed mood

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

F43.25 Adjustment disorder with mixed disturbance of emotions and conduct
F43.29 Adjustment disorder with other symptoms
F43.0 Acute stress reaction
F43.8 Other reactions to severe stress
F43.9 Reaction to severe stress, unspecified

[B]Neurodevelopmental Disorders
F70 Mild intellectual disabilities
F71 Moderate intellectual disabilities
F72 Severe intellectual disabilities
F73 Profound intellectual disabilities
F79 Unspecified intellectual disabilities
F80.89 Other developmental disorders of speech and language
F80.9 Developmental disorder of speech and language, unspecified
F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type
F95.0 Transient tic disorder
F95.1 Chronic motor or vocal tic disorder
F95.2 Tourette's disorder
F95.9 Tic disorder, unspecified

[B]Other
F07.81 Postconcussional syndrome
F07.89 Personality and behavioral disorders due to known physiological condition, other
F07.9 Personality and behavioral disorder due to known physiological condition, unspecified
F45.41 Pain disorder exclusively related to psychological factors
F45.42 Pain disorder with related psychological factors (Code also associated acute or chronic pain **G89.-)**
F48.8 Nonpsychotic mental disorders, other (neurasthenia)
F48.9 Nonpsychotic mental disorders, unspecified
F45.41 Pain disorder exclusively related to psychological factors
F51.01 Primary insomnia
F51.02 Adjustment insomnia
F51.03 Paradoxical insomnia
F51.04 Psychophysiologic insomnia
F51.05 Insomnia due to other mental disorder (Code also associated mental disorder)
F51.09 Insomnia, other (not due to a substance or known physiological condition)
F93.8 Childhood emotional disorders, other

[B]Substance-Related and Addictive Disorders:
If a provider documents multiple patterns of use, only one should be reported. Use the following hierarchy: use–abuse–dependence (eg, if use and dependence are documented, only code for dependence).

When a minus symbol (-) is included in codes **F10–F17,** a last digit is required. Be sure to include the last digit from the following list:
0 anxiety disorder
2 sleep disorder
8 other disorder
9 unspecified disorder

[C]Alcohol
F10.10 Alcohol abuse, uncomplicated
F10.14 Alcohol abuse with alcohol-induced mood disorder
F10.159 Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.18- Alcohol abuse with alcohol-induced
F10.19 Alcohol abuse with unspecified alcohol-induced disorder
F10.20 Alcohol dependence, uncomplicated
F10.21 Alcohol dependence, in remission
F10.24 Alcohol dependence with alcohol-induced mood disorder

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

F10.259 Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.28- Alcohol dependence with alcohol-induced
F10.29 Alcohol dependence with unspecified alcohol-induced disorder
F10.94 Alcohol use, unspecified with alcohol-induced mood disorder
F10.959 Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.98- Alcohol use, unspecified with alcohol-induced
F10.99 Alcohol use, unspecified with unspecified alcohol-induced disorder

[C]Cannabis
F12.10 Cannabis abuse, uncomplicated
F12.18- Cannabis abuse with cannabis-induced
F12.19 Cannabis abuse with unspecified cannabis-induced disorder
F12.20 Cannabis dependence, uncomplicated
F12.21 Cannabis dependence, in remission
F12.28- Cannabis dependence with cannabis-induced
F12.29 Cannabis dependence with unspecified cannabis-induced disorder
F12.90 Cannabis use, unspecified, uncomplicated
F12.98- Cannabis use, unspecified with
F12.99 Cannabis use, unspecified with unspecified cannabis-induced disorder

[C]Sedatives
F13.10 Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.129 Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13.14 Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13.18- Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced
F13.21 Sedative, hypnotic or anxiolytic dependence, in remission
F13.90 Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13.94 Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.98- Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced
F13.99 Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder

[C]Stimulants (eg, Caffeine, Amphetamines)
F15.10 Other stimulant (amphetamine-related disorders or caffeine) abuse, uncomplicated
F15.14 Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced mood disorder
F15.18- Other stimulant (amphetamine-related disorders or caffeine) abuse with stimulant-induced
F15.19 Other stimulant (amphetamine-related disorders or caffeine) abuse with unspecified stimulant-induced disorder
F15.20 Other stimulant (amphetamine-related disorders or caffeine) dependence, uncomplicated
F15.21 Other stimulant (amphetamine-related disorders or caffeine) dependence, in remission
F15.24 Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced mood disorder
F15.28- Other stimulant (amphetamine-related disorders or caffeine) dependence with stimulant-induced
F15.29 Other stimulant (amphetamine-related disorders or caffeine) dependence with unspecified stimulant-induced disorder
F15.90 Other stimulant (amphetamine-related disorders or caffeine) use, unspecified, uncomplicated
F15.94 Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant-induced mood disorder
F15.98- Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with stimulant-induced
F15.99 Other stimulant (amphetamine-related disorders or caffeine) use, unspecified with unspecified stimulant-induced disorder

[C]Nicotine (eg, Cigarettes)
F17.200 Nicotine dependence, unspecified, uncomplicated
F17.201 Nicotine dependence, unspecified, in remission

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

F17.203 Nicotine dependence unspecified, with withdrawal
F17.20- Nicotine dependence, unspecified, with
F17.210 Nicotine dependence, cigarettes, uncomplicated
F17.211 Nicotine dependence, cigarettes, in remission
F17.213 Nicotine dependence, cigarettes, with withdrawal
F17.218- Nicotine dependence, cigarettes, with

Z72.0 Tobacco use

[B]Symptoms, Signs, and Ill-Defined Conditions

- Use these codes in absence of a definitive mental diagnosis or when the sign or symptom is not part of the disease course or considered incidental.

G44.209 Tension-type headache, unspecified, not intractable
G47.9 Sleep disorder, unspecified
R10.84 Generalized abdominal pain
R45.81 Low self-esteem
R45.82 Worries
R45.83 Excessive crying of child, adolescent or adult
R45.84 Anhedonia
R45.851 Suicidal ideations
R45.86 Emotional lability
R45.87 Impulsiveness
R45.89 Other symptoms and signs involving emotional state
R53.81 Other malaise
R53.82 Chronic fatigue, unspecified
R53.83 Other fatigue

[B]Z Codes

Z codes represent reasons for encounters. Categories **Z00–Z99** are provided for occasions when circumstances other than a disease, injury, or external cause classifiable to categories **A00–Y89** are recorded as 'diagnoses' or 'problems'. This can arise in 2 main ways.
(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem is in itself not a disease or injury.
(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

Z13.89 Encounter for screening for other (eg, depression, anxiety) disorder
Z62.6 Inappropriate (excessive) parental pressure
Z62.810 Personal history of physical and sexual abuse in childhood
Z62.811 Personal history of psychological abuse in childhood
Z62.812 Personal history of neglect in childhood
Z62.819 Personal history of unspecified abuse in childhood
Z62.820 Parent-biological child conflict
Z62.821 Parent-adopted child conflict
Z62.822 Parent-foster child conflict
Z63.31 Absence of family member due to military deployment
Z63.32 Other absence of family member
Z63.4 Disappearance and death of family member
Z63.5 Disruption of family by separation and divorce
Z63.8 Other specified problems related to primary support group
Z65.3 Problems related to other legal circumstances
Z70.0 Tobacco use
Z81.0 Family history of intellectual disabilities (conditions classifiable to **F70–F79)**
Z81.1 Family history of alcohol abuse and dependence (conditions classifiable to **F10.-)**
Z81.2 Family history of tobacco abuse and dependence (conditions classifiable to **F17.-)**
Z81.3 Family history of other psychoactive substance abuse and dependence (conditions classifiable to

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

	F11–F16, F18–F19)
Z81.8	Family history of other mental and behavioral disorders
Z86.2	Personal history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z86.39	Personal history of other endocrine, nutritional and metabolic disease
Z86.59	Personal history of other mental and behavioral disorders
Z86.69	Personal history of other diseases of the nervous system and sense organs
Z86.79	Personal history of other diseases of the circulatory system
Z87.09	Personal history of other diseases of the respiratory system
Z87.19	Personal history of other diseases of the digestive system
Z87.798	Personal history of other (corrected) congenital malformations
Z91.5	Personal history of self-harm

+ Designated *add-on* codes, report them separately in addition to the appropriate primary code for the service provided

Chapter X.
Organizational Change

Guide to the "Organizational Change" Section

Adolescent Depression Change Concepts

Adolescent Depression Change Concepts Grid

Key Measures for Improvement of Adolescent Depression Care

Guide to the "Organizational Change" Section

Embarking on a quality improvement program to improve your treatment of adolescent depression will likely require organizational change in your practice setting. Following the concepts behind the chronic care model may help you improve care for your depressed adolescent patients. While you may not be ready to incorporate all of these change concepts at once, making small goals now can help you make big changes.

Adolescent Depression Change Concepts

Adolescent Depression Change Concepts Grid

We have included a list of 6 Adolescent Depression Change concepts and a blank grid for you to fill out the organizational change goals you plan to fulfill.

Key Measures for Improvement of Adolescent Depression Care

Any quality improvement involves measuring change. We have included a blank form for you to put in your goals and how you plan to measure the attainment of these goals.

Adolescent Depression Change Concepts

Organization of Healthcare

1. Make sure senior leaders and staff visibly support and promote the effort to improve chronic care
2. Make improving chronic care a part of the organization's vision, mission, goals, performance improvement, and business plans
3. Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources
4. Assign day-to-day leadership for continued clinical improvement
5. Integrate collaborative models into the quality improvement program

Clinical Information Systems

1. Establish a registry
2. Develop processes for use of the registry, including designating personnel to enter data, assuring data integrity, and maintaining the registry
3. Use the registry to generate reminders and care planning tools for individual patients
4. Use the registry to provide feedback to care team and leaders
5. Make sure providers have access to pertinent information at the time of the patient visit

Delivery System Design

1. Identify depressed patients during visits for other purposes
2. Use the registry to proactively review care and plan visits
3. Assign roles, duties, and tasks for planned visits to a multidisciplinary care team. Use cross training to expand staff capability.
4. Use planned visits in individual and group settings
5. Make designated staff responsible for follow-up by various methods, including parent advocates/outreach workers, telephone calls, and home visits
6. Use parent advocates and community health programs for outreach

Decision Support

1. Develop tool/protocol to evaluate presence of clinically significant depression in youth and relevant comorbidities
2. Know about and be capable in using and recommending evidence-based psychotherapies and medications
3. Know how to determine whether a patient has responded to treatment
4. Know when and to whom to refer for additional mental health specialty consultation
5. Know how to engage patients and involve them in self-management and their role in treatment

Self-Management Support

1. Know about evidence-based psychosocial and medication treatments
2. Participate actively in treatment plan development and implementation
3. Set and document self-management goals collaboratively with patients and treatment staff

Community

1. Provide materials to teachers; encourage participation in other activities
2. Establish links to community resources for defrayed medication costs, educational accommodations, etc.
3. Encourage participation in community education classes, support groups, and other activities
4. Encourage linking to advocacy groups

Courtesy of Institute for Healthcare Improvement/Bureau of Primary Health Care Health Disparities Collaborative on Adolescent Depression

Adolescent Depression Change Concepts Grid

Organization of Health Care	Clinical Information System	Delivery System Design	Decision Support	Self-Management Support	Community

Key Measures for Improvement of Adolescent Depression Care Grid

Measure	Population Statistic	Typical Levels	Appropriate Goal
Data Gathering Plan			
Data Gathering Plan			
Data Gathering Plan			