Patient Health Questionnaire Modified for Teens (PHQ-9 Modified)

Overview
The PHQ-9 Modified for Teens is a 13-item self-completion screening questionnaire designed to detect symptoms of depression and suicide risk in adolescents. In addition to the 9 core items that ask about symptoms of depression, there are two items that inquire about the severity of symptoms (or impairment) and two additional items that ask about suicide risk. The questionnaire takes less than five minutes to complete and score, and it can be scored by the doctor, nurse, medical technician or other office staff prior to the patient’s exam with the PCP. The PHQ-9 Modified is derived from the PHQ-9 that is used for adults. Both the American Academy of Pediatrics and the U.S. Preventive Services Task Force recommends that depression screening be conducted annually.

Administration
It is recommended that parents are informed that depression screening will be administered as part of the exam. On order to obtain honest answers, patients should be left alone to complete the PHQ-9 Modified on a private environment and should be informed of their rights regarding confidentiality before the questionnaire is administered.

The PHQ-9 Modified comes in the form of a tear-off pad and is available in both English and Spanish. You may choose to distribute a copy of the questionnaire to patients in the waiting room as the patient comes in for their appointment.
Scoring and Interpreting the Results
Below are the scoring and instructions for the PHQ-9 Modified:

<table>
<thead>
<tr>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>For every X:</td>
</tr>
<tr>
<td>Not at all = 0</td>
</tr>
<tr>
<td>Several days = 1</td>
</tr>
<tr>
<td>More than half the days = 2</td>
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<tr>
<td>Nearly every day = 3</td>
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<tr>
<td>Add up all “X” ed boxes on the screen.</td>
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</tbody>
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Defining a Positive Screen on the PHQ-9 Modified:
- Total Scores > 11 are positive.

Suicidality:
Regardless of the PHQ-9 Modified total score, endorsement of serious suicidal ideation OR past suicide attempt (questions 12 and 13 on the screen) should be considered a positive screen.

Interpreting the Screening Results
- Patients that score positive on the questionnaire should be evaluated by their primary care provider (PCP) to determine if the depression symptoms they endorsed on the screen are significant, causing impairment and/or warrant a referral to a mental health specialist or follow-up treatment by the PCP.
- It is recommended that the PCP inquire about suicidal thoughts and previous suicide attempts with all patients that score positive, regardless of how they answered these items on the PHQ-9 Modified.
- For patients who score negative on the PHQ-9 Modified, it is recommended that the PCP briefly review the symptoms marked as “more than half days” and “nearly every day” with the patient.
- The questionnaire indicates only the likelihood that a youth is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

Depression Severity
- The overall score on the PHQ-9 Modified provides information about the severity of depression, from minimal depression to severe depression.
- The interview with the patient should focus on their answers to the screen and the specific symptoms with which they are having difficulties.
- Additional questions on the PHQ-9 Modified also explore dysthymia, impairment of depressive symptoms, recent suicide ideation and previous suicide attempts.

Total Score: Depression Severity
- 1-4: Minimal depression
- 5-9: Mild depression
- 10-14: Moderate depression (. 11 = Positive Score)
- 15-19: Moderately severe depression
- 20-27: Severe depression
Pediatric Symptom Checklist (PSC-Y)

Overview

The Pediatric Symptom Checklist for Youth (PSC-Y) is a 35-item self-completion screening questionnaire designed to detect a broad range of behavioral and psychosocial problems in youth. It includes questions that focus on internalizing, externalizing and attention problems. Two additional questions regarding suicidal thinking and attempts have been added to the PSY-C. The questionnaire takes less than five minutes to complete and score, and it can be scored by a nurse, medical technician or other office staff prior to the patient’s exam with the PCP.

Administration

It is recommended that parents are informed that a mental health checkup will be administered as part of the exam. In order to obtain honest answers, patients should be left alone to complete the PSC-Y in a private environment and should be informed of their rights regarding confidentiality before the questionnaire is administered.

The PSC-Y comes in the form of a tear-off pad and is available in both English and Spanish. You may choose to distribute a copy of the questionnaire to patients in the waiting or exam room as the patient comes in for their appointment.
### Scoring and Interpreting the Results

Below are the scoring instructions for the PSY-C:

#### Scoring

- **Each item on the PSC-Y is scored as follows:**
  - Never = 0
  - Sometimes = 1
  - Often = 2

- **To calculate the score, add all of the item scores together:**
  
  \[
  \text{Total Score} = \sum \text{item scores} \quad (\text{range 0-70})
  \]

  - If items are left blank, they are scored as 0.
  - If four or more items are left blank, the questionnaire is considered invalid.
  - Note if either suicide question has been endorsed (Questions 36 and 37).

- **Score is positive if:**
  - Total Score > 30
  - Recent suicidal ideation is reported (Q36)
  - Past suicide attempt is reported (Q37)

#### Interpreting the Screening Results

### Individual Problem Areas (For Interpretation Only)

- **Internalizing Problems** (i.e. Depression or Anxiety)
  - Feel sad, unhappy
  - Worry a lot
  - Feel hopeless
  - Seem to be having less fun
  - Down on yourself

- **Attention Problems** (i.e. ADHD)
  - Fidgety, unable to sit still
  - Distract easily
  - Act as if driven by motor
  - Daydream too much
  - Have trouble concentrating

- **Externalizing Problems** (i.e. Conduct Disorder, Oppositional Defiant Disorder)
  - Fight with other children
  - Tease others
  - Do not listen to rules
  - Refuse to share
  - Do not understand other people’s feelings
  - Blame others for your troubles
  - Take things that do not belong to you

- **Suicidality** (if either question is endorsed further assess for suicidal thinking and behavior and depression)
  - Recent suicide ideation
  - Prior suicide attempt

### Non-Categorized Items

- Complains of aches or pains
- Spend more time alone
- Tire easily, little energy
- Do not show feelings
- Have trouble with teacher
- Less interested in school
- Are afraid of new situations
- Are irritable, angry
- Less interested in friends
- Absent from school
- School grades dropping
- Visit doctor with doctor finding nothing wrong
- Have trouble sleeping
- Feel that you are bad
- Want to be with parent more than before
- Take unnecessary risks
- Get hurt frequently
- Act younger than children your age