TeenScreen Primary Care

Screening Questionnaire Overview

PSC-Y, PHQ-9, CRAFFT

TeenScreen® Primary Care

TeenScreen® National Center for Mental Health Checkups at Columbia University

Introduction

This document is designed to provide additional information about the screening questionnaires offered through TeenScreen Primary Care. Information about administering, scoring, interpreting the screening results, the psychometrics and research references are provided for each of the questionnaires offered through TeenScreen Primary Care.

Contents

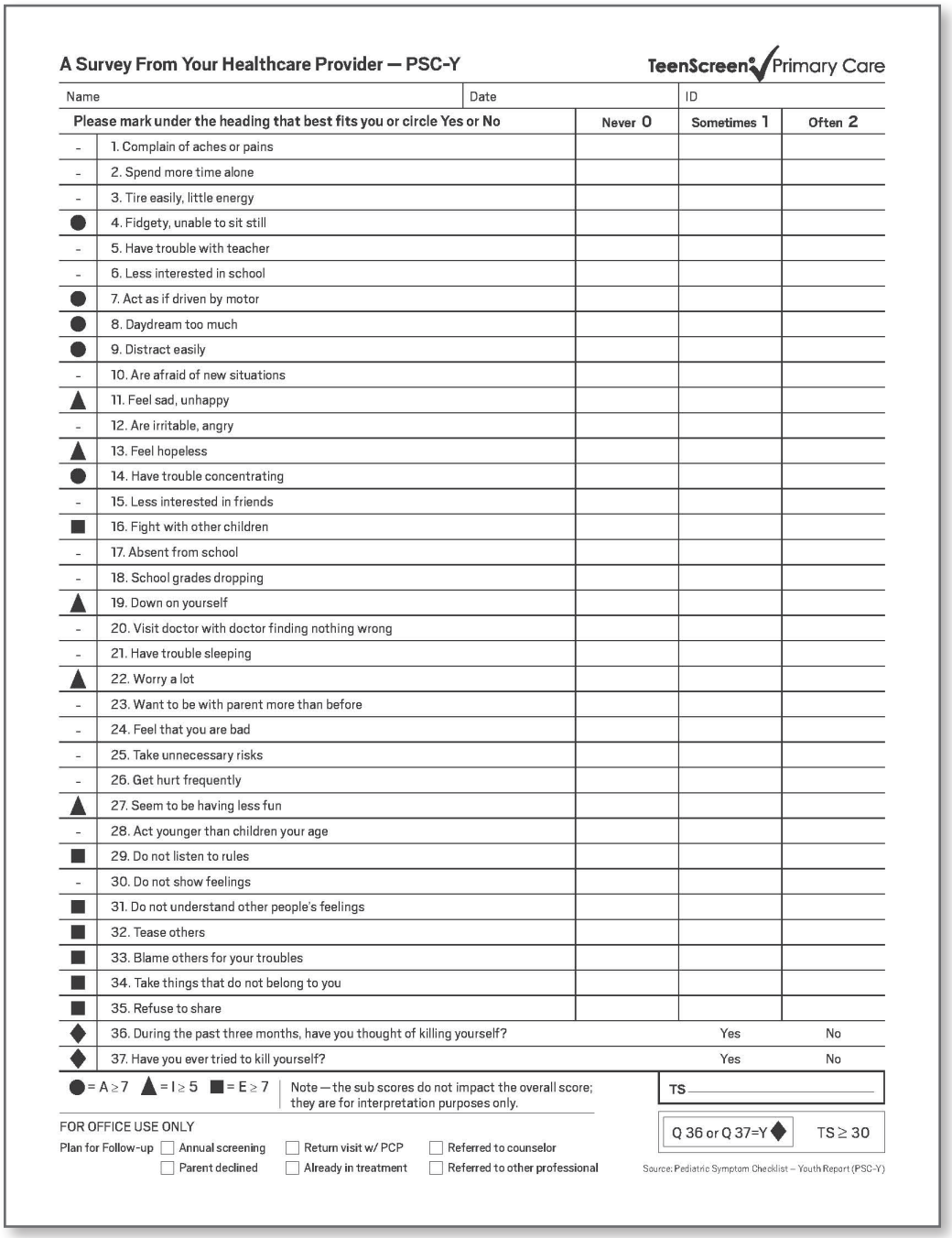
Pediatric Symptom Checklist (PSC-Y)

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 PSC-Y. 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 primary care provider (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.



A Survey From Your Healthcare Provider — PSC-Y

TeenScreen® Primary Care

Name	Date	ID

	Please mark under the heading that best fits you or circle Yes or No	Never 0	Sometimes 1	Often 2
–	1. Complain of aches or pains			
–	2. Spend more time alone			
–	3. Tire easily, little energy			
●	4. Fidgety, unable to sit still			
–	5. Have trouble with teacher			
–	6. Less interested in school			
●	7. Act as if driven by motor			
●	8. Daydream too much			
●	9. Distract easily			
–	10. Are afraid of new situations			
▲	11. Feel sad, unhappy			
–	12. Are irritable, angry			
▲	13. Feel hopeless			
●	14. Have trouble concentrating			
–	15. Less interested in friends			
■	16. Fight with other children			
–	17. Absent from school			
–	18. School grades dropping			
▲	19. Down on yourself			
–	20. Visit doctor with doctor finding nothing wrong			
–	21. Have trouble sleeping			
▲	22. Worry a lot			
–	23. Want to be with parent more than before			
–	24. Feel that you are bad			
–	25. Take unnecessary risks			
–	26. Get hurt frequently			
▲	27. Seem to be having less fun			
–	28. Act younger than children your age			
■	29. Do not listen to rules			
–	30. Do not show feelings			
■	31. Do not understand other people's feelings			
■	32. Tease others			
■	33. Blame others for your troubles			
■	34. Take things that do not belong to you			
■	35. Refuse to share			
◆	36. During the past three months, have you thought of killing yourself?		Yes	No
◆	37. Have you ever tried to kill yourself?		Yes	No

● = A ≥ 7 ▲ = I ≥ 5 ■ = E ≥ 7 | Note — the sub scores do not impact the overall score; they are for interpretation purposes only.

TS _____

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Plan for Follow-up ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor
☐ Parent declined ☐ Already in treatment ☐ Referred to other professional

Q 36 or Q 37=Y ◆ TS ≥ 30

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)

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 PSC-Y:

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:**
  - Total Score = _____ (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
  OR
  Recent suicidal ideation is reported (Q36)
  OR
  Past suicide attempt is reported (Q 37)

Interpreting the Screening Results

- Patients that score positive on their PSC-Y should be evaluated by the primary care provider (PCP) to determine if the symptoms endorsed on the questionnaire are significant, causing impairment and warrant a referral to a mental health specialist or follow-up or treatment by the PCP.
- For patients who score negative on the PSC-Y, it is recommended that the PCP briefly review the symptoms marked as "sometimes" and "often" with the patient.
- For help assessing mental illness and suicide risk, order the TeenScreen *Post-Screening Interview Guide*.
- The questionnaire indicates only the likelihood that a youth is at risk for a significant mental health problem or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

Individual Problem Areas (For Interpretation Only)

Internalizing Problems ▲ *(i.e., Depression or Anxiety)*	Attention Problems ● *(i.e., ADHD)*	Externalizing Problems ■ *(i.e., Conduct Disorder, Oppositional Defiant Disorder)*	Suicidality ◆ *(if either question is endorsed, further assess for suicidal thinking and behavior and depression)*
▪ Feel sad, unhappy ▪ Worry a lot ▪ Feel hopeless ▪ Seem to be having less fun ▪ Down on yourself	▪ Fidgety, unable to sit still ▪ Distract easily ▪ Act as if driven by motor ▪ Daydream too much ▪ Have trouble concentrating	▪ 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	▪ Recent suicide ideation ▪ Prior suicide attempt

Non-Categorized Items

▪ Complain 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

PSC-Y Psychometric Characteristics

PSC-Y Prevalence:

- 14% of 13-18 year olds in a school-based health center located in a small city scored positive on the PSC-Y.
- 20% of 9-14 year olds in an inner-city public school scored positive on the PSC-Y.

Suicide Prevalence:

- 3% of 11-18 year olds endorsed the suicide ideation question added to the PSC-Y in a primary care sample.
- 2% of 11-18 year olds endorsed the suicide attempt question added to the PSC-Y in a primary care sample.

PSC-Y Psychometrics:

- 94% Sensitivity
- 88% Specificity
- 12% False Positive
- 6% False Negative

Factor Analysis:
The authors of the PSC did a factor analysis to determine what items on the questionnaire were most predictive of internalizing, externalizing and attention problems. These are indicated on the questionnaire through symbols and can be helpful for health care providers to assist with interpreting the screening results.

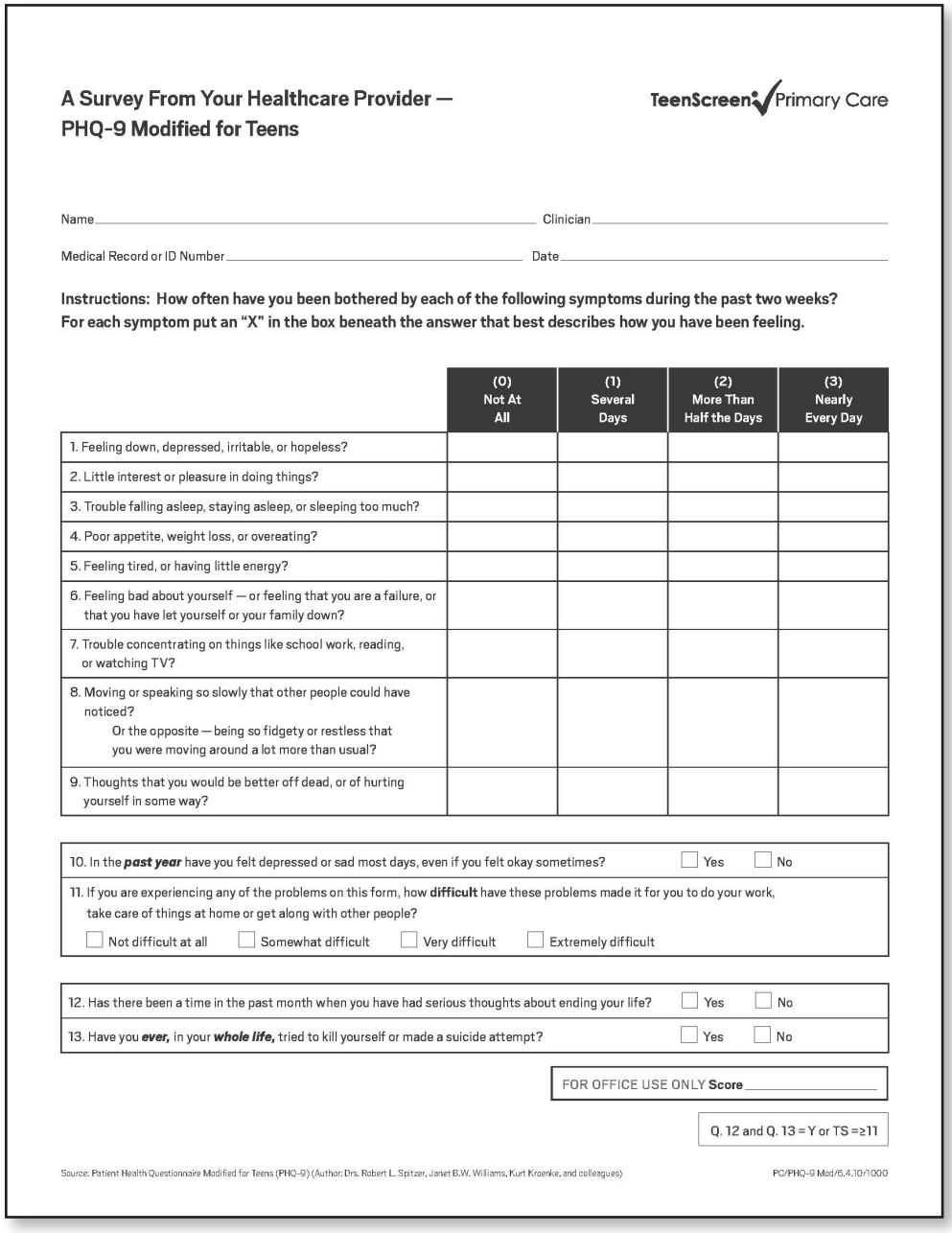
Patient Health Questionnaire Modified for Teens (PHQ-9 Modified)

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. In order to obtain honest answers, patients should be left alone to complete the PHQ-9 Modified in a private environment and should be informed of their rights regarding confidentiality before the questionnaire is administered.



A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

TeenScreen Primary Care

Name _____ Clinician _____

Medical Record or ID Number _____ Date _____

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

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

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

11. 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

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY **Score** _____

Q. 12 and Q. 13 = Y or TS = ≥11

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

PC/PHQ-9 Mod/6.4.10/1000

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 or exam room as the patient comes in for their appointment.

Scoring and Interpreting the Results

Below are the scoring instructions for the PHQ-9 Modified:

Scoring

- **For every X:**

Not at all = 0
Several days = 1
More than half the days = 2
Nearly every day = 3
Add up all "X"ed boxes on the screen.

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

PHQ-9 Psychometric Characteristics

The PHQ-9 Modified offered through TeenScreen Primary Care is a version of the adult PHQ-9 that has been slightly adapted (see below under Important Information). The adult version of the PHQ-9 has been studied and demonstrated good criterion and construct validity among adolescents, with high levels of sensitivity and specificity in this age group. A PHQ-9 score of ≥ 11 has the following sensitivity and specificity for detecting youth meeting DSM-IV criteria for major depression in the prior month[1]:

- 89.5% Sensitivity
- 78.8% Specificity
- 21.2% False Positive
- 10.5% False Negative

1 Richardson, L.P., McCauley, E., Grossman, D.C., McCarty, C.A., Richards, J., Russo, J.E., Rockhill, C., Katon, W. (2010). Evaluation of the Patient Health Questionnaire-9 Item for Detecting Major Depression Among Adolescents. Pediatrics, November 1, 2010..

Important Information:

Diagnostic criteria for a major depressive episode are slightly different for adults and children or adolescents in the DSM-IV-TR. In addition to the symptoms presented by adults, adolescents may experience irritability, and failure to meet expected weight gains should be considered. The PHQ-9 Modified is a version of the adult PHQ-9 that has been adapted to reflect these symptomatologic differences. The PHQ-9 Modified item 1 includes the assessment of irritable mood and item 4 includes weight loss. These modifications are minor and do not involve symptom substitution.

A recent study has shown that the adult version of the PHQ-9 has satisfactory psychometric properties in adolescents (Richardson et al., 2010). To date, no study has published psychometric data on the PHQ-9 Modified. However, as the PHQ-9 and PHQ-9 Modified are identical with the exception of 2 additional symptoms added to the PHQ-9 Modified version (in Questions 1 and 4), it is reasonable to apply cutoff scores derived from the PHQ-9 in an adolescent population.

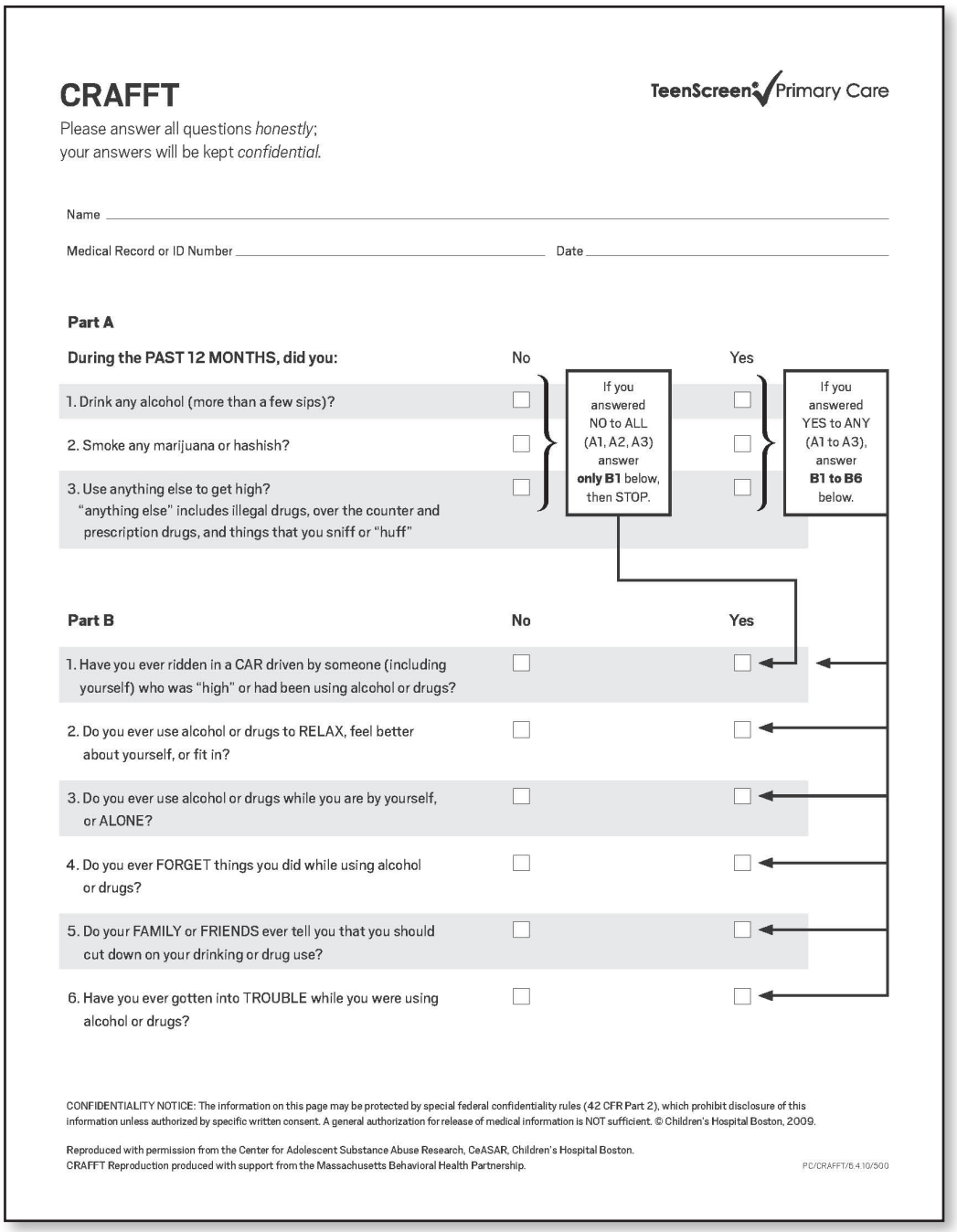
CRAFFT

Overview

The CRAFFT is a brief substance and alcohol use screening questionnaire that can be used in conjunction with the other mental health screening questionnaires offered by TeenScreen Primary Care. The CRAFFT is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents, ages 11-21. 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.

Administration

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



CRAFFT

TeenScreen Primary Care

Please answer all questions *honestly*;
your answers will be kept *confidential*.

Name _____

Medical Record or ID Number _____ Date _____

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? "anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"	☐	☐

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1 to A3), answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

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PC/CRAFFT/6.4.10/500

The CRAFFT 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 CRAFFT:

Scoring

Each "Yes" response to the CRAFFT questions **Scored as 1 point**

Score = 0

Adolescents who report no use of alcohol or drugs and have a CRAFFT score of 0 should receive praise and encouragement.

Score = 0 or 1

Those who report any use of alcohol or drugs and have a CRAFFT score of 1 should be encouraged to stop and receive brief advice regarding the adverse health effects of substance use.

Score = ≥ 2

A score of 2 or greater is a "positive" screen and indicates that the adolescent is at high-risk for having an alcohol or drug-related disorder and requires further assessment.

Interpreting the Screening Results

If the adolescent answers "No" to all 3 opening questions, they only need to answer the first question— the CAR question. If the adolescent answers "Yes" to any 1 or more of the 3 opening questions, they have to answer all 6 CRAFFT questions.

NO to all 3 opening questions and NO to CAR question.

Give praise, encouragement, and advise to avoid riding with an intoxicated driver. At next regular visit, ask how this is going. (1-2 minutes)

NO to all 3 opening questions and YES to CAR question.

Ask patient to agree to avoid riding with a driver who has used drugs or alcohol. (1-2 minutes)

YES to any opening question.

Look at the patient's overall CRAFFT score. (each "Yes" = 1)

Are there no major problems AND patient believes he/she will be successful in making a change?

NO to Both: Consider making a referral to an allied health professional or treatment program. Ask youth to agree to avoid riding with a driver who has used substances. Make a follow-up appointment.

YES to Both: Express concern, caring and empathy. Ask patient to stop using and avoid riding with a driver who has used substances, and agree to sign an *Abstinence Challenge*. Make a follow-up appointment. At follow-up visit, confirm whether patient stopped using.

CRAFFT Score = 0 or 1

If Yes to CAR question: Ask patient to agree to "avoid riding with a driver who has used drugs or alcohol. (1-2 minutes)

If Yes to any other question except the CAR question: Counsel patient to stop using substances.

Provide brief advice linking substance use to undesirable health, academic, and social consequences.

Follow up at next visit. (2-5 minutes)

CRAFFT Score = ≥ 2

Conduct brief assessment of substance use to understand whether disorder exists. (<15 minutes)

Assessment questions

1. Tell me about your alcohol/substance use.
2. Has it caused you any problems?
3. Have you tried to quit? Why?

See box at left.

Information adapted from the CRAFFT Toolkit — Massachusetts Department of Public Health Bureau of Substance Abuse Services. Provider Guide: *Adolescent Screening, Brief Intervention, and Referral to Treatment Using the CRAFFT Screening Tool*. Boston, MA.

CRAFFT Psychometric Characteristics

The CRAFFT screening questionnaire is a valid means of screening adolescents for substance-related problems and disorders, which may be common in some general clinic populations. The following was taken from the CRAFFT's validation study conclusions:

> A CRAFFT score of 2 or higher was optimal for identifying any problem (sensitivity, 0.76; specificity, 0.94; positive predictive value, 0.83; and negative predictive value, 0.91), any disorder (sensitivity, 0.80; specificity, 0.86; positive predictive value, 0.53; and negative predictive value, 0.96) and dependence (sensitivity, 0.92; specificity, 0.80; positive predictive value, 0.25; and negative predictive value 0.99). Approximately one fourth of participants had a CRAFFT score of 2 or higher. Validity was not significantly affected by age, sex, or race.[2]

Additional Information

To obtain additional information about the CRAFFT and download the entire CRAFFT Toolkit, visit: http://www.mass.gov/Eeohhs2/docs/dph/substance_abuse/sbirt/crafft_provider_guide.pdf.

Developed by Substance Abuse Services. Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment Using the CRAFFT Screening Tool. Boston, MA. Massachusetts Department of Public Health, 2009.

2 Knight, J.R., Sherritt, L., Shrier, L.A., Harris, S.K., Chang, G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Archives of Pediatric Adolescent Medicine, (2002), 156(6), 607-14..

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**For more information, please visit: http://www2.massgeneral.org/allpsych/psc/psc_home.htm.

Patient Health Questionnaire (PHQ-9)

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CRAFFT

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