TeenScreen Primary Care
Screening Questionnaire Overview
PSC-Y, PHQ-9, CRAFFT
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.
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.

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 (Q35)
  - OR
  - Past suicide attempt is reported (Q37)

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**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

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**Interpreting the Screening Results**

**Individual Problem Areas (For Interpretation Only)**

**Internalizing Problems (i.e., Depression or Anxiety)**

- Feel sad and 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
- Distractions 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
- Plan suicide attempt

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**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

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.

1. Feeling down, depressed, irritable, or hopeless?
   (0) Not at all (1) Several days (2) More than half the days (3) Nearly every day
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 sad 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?
   (0) No (1) Yes
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?
   (0) Not difficult at all (1) Somewhat difficult (2) Very difficult (3) Extremely difficult
12. Has there been a time in the past month when you have had serious thoughts about ending your life?
   (0) No (1) Yes
13. Have you, ever, in your whole life, tried to kill yourself or made a suicide attempt?
   (0) No (1) Yes

FOR OFFICE USE ONLY Score

Q. 12 and 0, 13 = Y or TS ≥ 11

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.

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**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.

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**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:

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

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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.
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.
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.

<table>
<thead>
<tr>
<th>NO to all 3 opening questions and NO to CAR question. Give praise, encouragement, and advice to avoid riding with an intoxicated driver. Ask patient to agree to avoid riding with a driver who has used drugs or alcohol. (1-2 minutes)</th>
<th>NO to all 3 opening questions and YES to CAR question. Look at the patient’s overall CRAFFT score. (each “Yes” = 1)</th>
<th>YES to any opening question except the CAR question: Counsel patient to stop using substances. Provide brief advice on linking substance use to undesirable health, academic, and social consequences. Follow up at next visit. (2-3 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRAFFT Score = 0 or 1</td>
<td>CRAFFT Score = ≥ 2</td>
<td>CRAFFT Score = ≥ 2</td>
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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 on linking substance use to undesirable health, academic, and social consequences. Follow up at next visit. (2-3 minutes)

**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 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.

**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.


References

Pediatric Symptom Checklist (PSC) – Validation Articles


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

Patient Health Questionnaire (PHQ-9)


CRAFFT