NASBHC National Assembly on School-Based Health Care

Bringing Health Care To Schools For Student Success

WEBINAR

Behavioral Health Screening in School-Based Health Care: Principles & Practice

Presenters:

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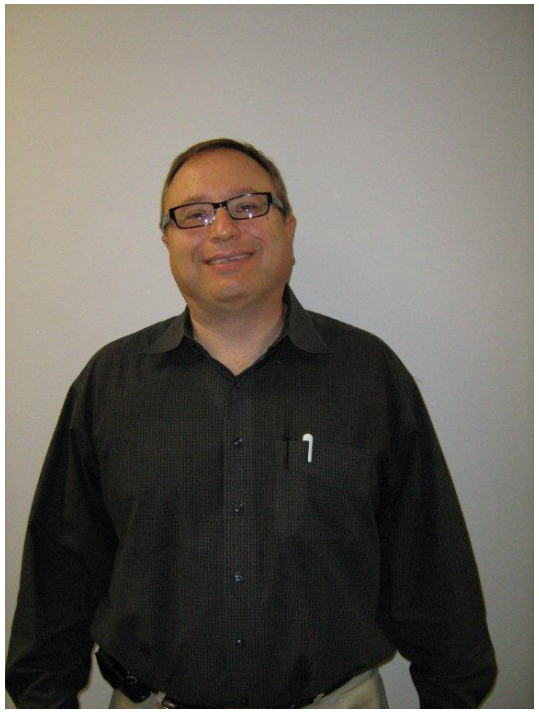
Dan Rifkin, MD, Child & Adolescent Psychiatrist Envision New Mexico, UNM School-Based Health Centers, & UNM-HSC Pediatric Clinic , Assistant Professor of Pediatrics and Psychiatry.

Dan Rifkin, MD is a board-certified child and adolescent psychiatrist who provides psychiatric services in school-based health centers (SBHCs) as well as training and consultation to SBHC medical and behavioral health providers around New Mexico. Dan has presented several previous NASBHC Convention workshop sessions, some in collaboration with Mike Palanza and others. His consultation with schools and SBHCs emphasizes multidisciplinary, collaborative behavioral health screening, assessment, and treatment.



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Mike Palanza, MA, LPA, Staff Psychologist, Wilmington Health Access for Teens, Wilmington, NC

Mike Palanza has provided psychological services to students in middle and high school in Southeastern North Carolina for the past nine years. These services include psycho-education, psychotherapy, and psychological evaluation/assessment. During the last three years, Mike has been based at the Wilmington Health Access for Teens serving as Staff Psychologist. In his role there, he provides psychological evaluation and behavioral health consultation to staff at four school-based and school-linked centers. Through collaboration with medical staff, administrators, teachers, and local agencies Mike has added substance abuse prevention/education, health education, and other mental health prevention services at the centers and their schools.

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May 19, 2010

Presenters

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<Goal>

Behavioral Health Screening

for

Students

{ Ultimately: Screen all students !! }

Presentation Parts

I. Principles

II. Practice

Part 1: Principles

Quiz Time

Depression screening involves:

A) Early identification of risk factors
B) Assessment / Diagnosis
C) Treatment
D) B & C
E) All of the above

Principle Objectives

- Define screening
- Describe:

Depression & Substance Abuse epidemiology
{Why Screen?!}

1 screening **theory**

4 **attributes** of effective clinical screening tools

Why Screen Youth?

Prevalence!

It is estimated that 25%, or one in four, young people suffers some sort of behavioral health problem sufficient enough to impair his or her ability to maintain daily activities, such as attending school, completing homework, participating in family activities, or spending time with friends.

Centers for Disease Control and Prevention.
http://www.cdc.gov/HealthyYouth/yrbs/pdf/yrbss07_mmwr.pdf

Youth Prevalence

In any given year, it is estimated that fewer than one in five of these youth receive needed treatment.

> "Prevalence of serious emotional disturbance in children and adolescents." Mental Health, United States, 1996. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1996.

Why Screen Youth for Depression?

- Depression common and treatable !!
- Suicide & other harmfulness preventable !!
- Depression causes morbidity, impairment, mortality
- Screening identifies risk factors for:
  - Depression and mental illness
  - Suicidality; other harmfulness; associated problems
  - Comorbidity (e.g. substance abuse)
- Risk factor ID leads to assessment & treatment
- Intervention becomes Prevention
- Otherwise, many youth not identified/helped
  - Depression in most youth undiagnosed and untreated !!!

Youth Depression Epidemiology

- **One of the most serious and common problems** encountered by youth of all ages.
- National statistics:
  - Nearly 2 million U.S. teens suffer from clinical depression, yet most undiagnosed and untreated

    (2009 national task force)
  - As many a 1 in 33 children (3%) may have clinical depression*
  - More than 1 in 8 adolescents (12.5%) may have clinical depression*

(*MHA/NC, 5/6/2010: Mental Health Association in North Carolina compiled from multiple national sources ; distributed on National Children's Mental Health Awareness Day)

NM Depression Epidemiology

- In the 2007 NM Youth Risk and Resiliency Survey (YRRS), of students in grades 9-12:
  - 30.8% had persistent feelings of sadness or hopelessness
  - 19.3% seriously considered attempting suicide
  - 14.3% attempted suicide one or more times

Why Screen Youth for Substance Abuse?

- Undesirable consequences associated with adolescent (Wu & Kahn, 2005) substance use/abuse including:
  - STD, unintended pregnancy, injury from fights, motor vehicle accidents, & possibly death.
  - Poor academic performance
  - Comorbid mental health disorders including depression & suicidal behavior.
- Combination of high prevalence of use/abuse & vulnerability of adolescent brain.

Youth Substance Abuse Epidemiology (2007 National YRBS)

Youth in grades 9 through 12:

- 23.8% of students drank alcohol for first time before age 13 years.
- 26.0% of students had had five or more drinks of alcohol in a row, within a couple hours, at least once during the 30 days before the survey.
- 38.1% of students had used marijuana one or more times during their life.
- 19.7% of students had used marijuana one or more times during the 30 days before the survey.
- 8.3% of students had tried marijuana for the first time before age 13 years.
- 3.3% of students had used any form of cocaine (e.g., powder, crack, or freebase) one or more times during the 30 days before the survey.
- 13.3% of students had sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during their life.

NC Substance Abuse Epidemiology

- In the 2007 NC Youth Risk and Behavior Survey (YRBS), of students in grades 9-12:
  - 19.1% of students reported using marijuana one or more times during the past 30 days
  - 37.7% of students reported having at least one drink of alcohol on one or more of the past 30 days
  - 24.7% of students report riding one or more times during the past 30 days in a car or other vehicle driven by someone who had been drinking alcohol

Screening in School-Based Health Care

Identifies

students at ***risk for***

depression,

substance abuse,

and other

Behavioral Health ***problems***

Risk Factor Identification

Permits

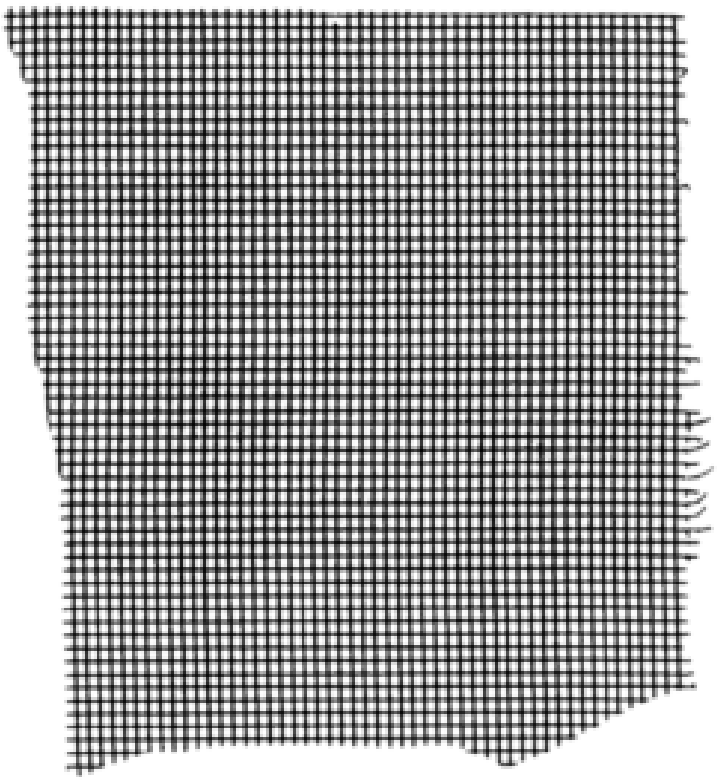
Prevention

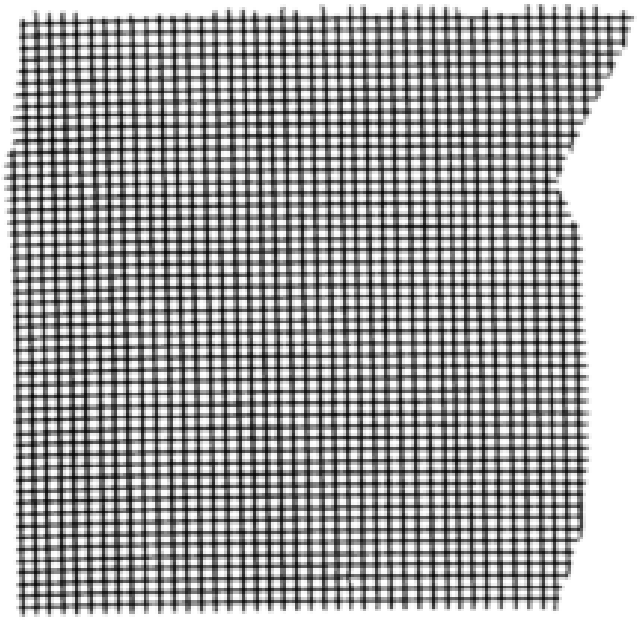
Primary: reduce risk before onset of disease or behavior

Secondary: reduce disability from disease or behavior

Tertiary: reduce consequences of disability from disease or behavior

Objective: Define Screens





Screening Defined

- Systematic approach to
  early identification of **risk factors***
- i.e. systematically identify high-risk youth

*Guidelines for Adolescent Depression in Primary Care (GLAD-PC, Version 1, 2007, p.19) describe screening as "a systematic protocol to identify those (youth) with risk factors for depression."

Screening Theory

- Disease detection in a population
  - Screening separates apparently healthy individuals into groups with either a high or low probability of developing disease for which the screening test is being used.
  - Both Sensitivity and Specificity are independent of the disease prevalence in population tested.
- **Sensitivity**
  - Test's ability to identify correctly those individuals who truly have the disease.
- **Specificity**
  - Test's ability to identify correctly those individuals who truly do not have the disease.

Screening Theory, cont.

- **Predictive value**
  - Positive Predictive Value: test's ability to identify those individuals who truly have the disease [true-positives (TP)] among all those who screened positive.
  - Negative Predictive Value: test's ability to identify those individuals who truly do not have the disease [true-negatives (TN)] among all those who screened negative.
  - Bayes theorem: probability of disease given a positive test increases with increasing disease prevalence in the population.

Screening Test Parameters

	True Diagnosis:	
Screening Test:	Disease	No Ds
Positive	TP	FP
Negative	FN	TN

Good Screen Attributes

- High Sensitivity
- Low Specificity
- Consequently, high incidence of FPs !!!
- User Friendly: brief, easy

Screening Examples

- **Preventive Medicine/Public Health** (everyone)
  - PPD (Purified Protein Derivative) for TB
  - Phenylketonuria (PKU)
  - Guaiac “stool cards” (fecal occult blood)
- **Lab Medicine** (patients)
  - Erythrocyte Sedimentation Rate (ESR)
  - Random Blood Glucose
  - Thyroid Stimulating Hormone (TSH)

Screening Example: Substance Abuse

- **CRAFFT**-6 questions**:**

C-Have you ever ridden in a **C**ar driven by someone (including yourself) who was "high" or had been using alcohol/drugs?

R-Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in?

A-Do you ever use alcohol or drugs while you are **A**lone?

F-Do you ever **F**orget things you did while using alcohol/drugs?

F-Do your **F**amily or **F**riends ever tell you that you should cut down on drinking or drug use?

T-Have you ever gotten into **T**rouble while using alcohol/drugs?

Brief is Better!

Example: 2-item adol. Substance Abuse Screen

{NB: ***not*** *recommended here***!!!**}

briefer SBIRT Screening Technique for Adolescents:

- How many times in the last month have you had 4 or more drinks in a two hour period?
  - '**1 or more**' triggers an intervention
- Do you use recreational drugs?
  - '**Yes**' triggers an intervention

from Judith Bernstein, RNC, MSN, PhD, BNI-ART Institute, Boston Univ, 2007

How Brief is Better?

“Principle” ex: 1-item adult Substance Abuse Screen

{NB: ***not*** *recommended here***!!!**}

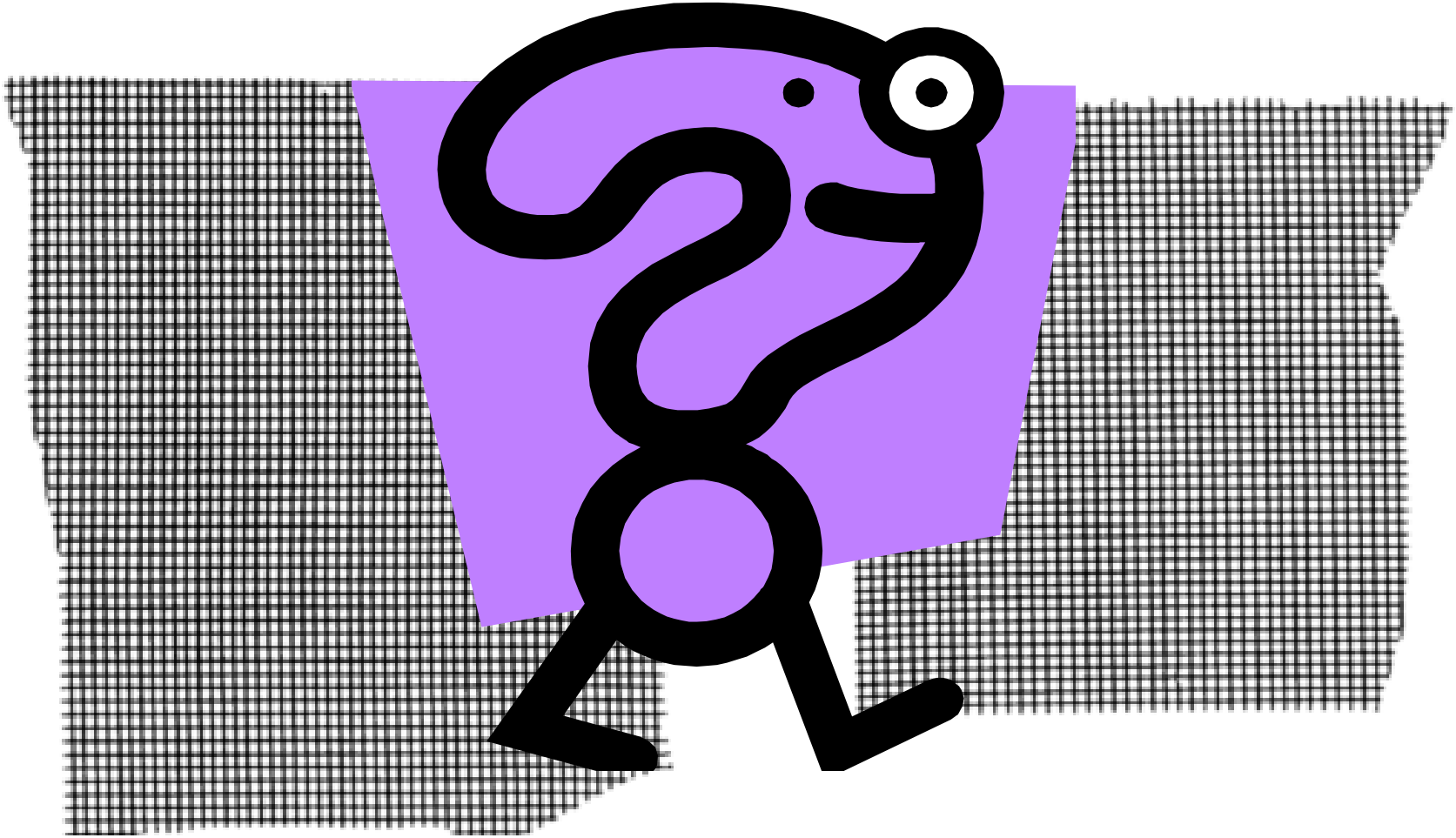
- Single screening question recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) accurately identified unhealthy alcohol use in a sample of adult primary care patients, supporting use of this brief screen in primary care, according to the results of a cross-sectional study

- Adult primary care patients were asked, "How many times in the past year have you had X or more drinks in a day?" (X = 5 for men and 4 for women). More than 1 indicated a positive screen.

J Gen Intern Med. Published online March 12, 2009

Your Questions??

Concerns, Comments, Protests



Part 2: Practice

Practice Objectives

- Distinguish *brief* screening tools from *longer* assessment instruments
- Select effective depression and substance abuse screening tools
- Discuss screening implementation in school-based health care

Examples

- Childhood Depression Inventory (CDI)
- Columbia Depression Scale (“C…Teen Screen”)
- Center for Epidemiological Studies Depression Scale for Children (CES-DC)
- NICHQ Vanderbilt Assessment Scale
- Pediatric Symptom Checklist
- Student Health Questionnaire (SHQ)
- Patient Health Questionnaire-**9** (PHQ-9)
- Patient Health Questionnaire-**2** (PHQ-2)

What does your team use?

Ask yourself and your colleagues…

- Does your SBHC team use any of the "examples" listed in previous slide, or other(s)?
- Used for **screening -or- assessment** (Dx)???
  i.e., as "**screening -or- "assessment**
  tool" **instrument"**???
  -both?
  Who knows?
  (Who cares?)

Childhood Depression Inventory (CDI)

- Child/adolescent counterpart of, derived from, the Beck Depression Inventory (BDI; Aaron Beck, PhD)
- 27 items, multiple choice, for youth 7-17 yrs
  1st grade reading level; self-administered, read to young children / parental assistance.
- Measures presence & degree of child's cognitive, affective, & behavioral signs of depression (Kovacs & Beck, 1977)
- More assessment/diagnostic instrument than screening tool

Columbia Teen Screen & CES-DC

Columbia Depression Scale-Teen Version, aka "Columbia Teen Screen"

-and-

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

- Reputedly useful screening tools
- Length (21/20 items) & content make both more useful as assessment/diagnostic instruments than screening tools for primary care settings

NICHQ Vanderbilt Assessment Scale

- Endorsed by the National Initiative for Child Healthcare Quality (NICHQ) and the American Academy of Pediatrics (AAP)
  - Created for primary care practitioners to use in implementing AAP guidelines for ADHD assessment & treatment
- Assesses ADHD & other disruptive behavior disorders
- Screens for depression/anxiety comorbidity
- Versions {length}: —PARENT Informant {55 items}
  —TEACHER Informant {43 items}
  - Follow-up versions of each

Pediatric Symptom Checklist

- Multimodal, validated screen
- Recognizes cognitive, emotional, and behavioral problems
- Sensitivity for depression, anxiety, and disruptive behaviors
- Both the Parent-Completed Version (PSC) and Youth Self-Report (Y-PSC) have 35 items
  - www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf

    Available @ http://www.nasbhc.org→mental health→screen

Pediatric Symptom Checklist

<Particulars>

- Parent-Completed Version (PSC): Cutoff scores indicating psychological impairment identified for two age brackets:
  - Ages 4 and 5, the PSC cutoff score is 24 or more
  - Ages 6 through 16, a cutoff score of 28 or more
- Youth Self-Report (Y-PSC): administered to adolescents, and pre-adolescents, ages 11 and up. Cutoff score is 30 or higher.
- Scored by adding rating for each item (numeric):
  - “Never(0),” “Sometimes(1),” or “Often(2)” present.
  - Items left blank are ignored (i.e., score 0).
  - Questionnaire invalid if four or more items left blank

Student Health Questionnaire (SHQ)

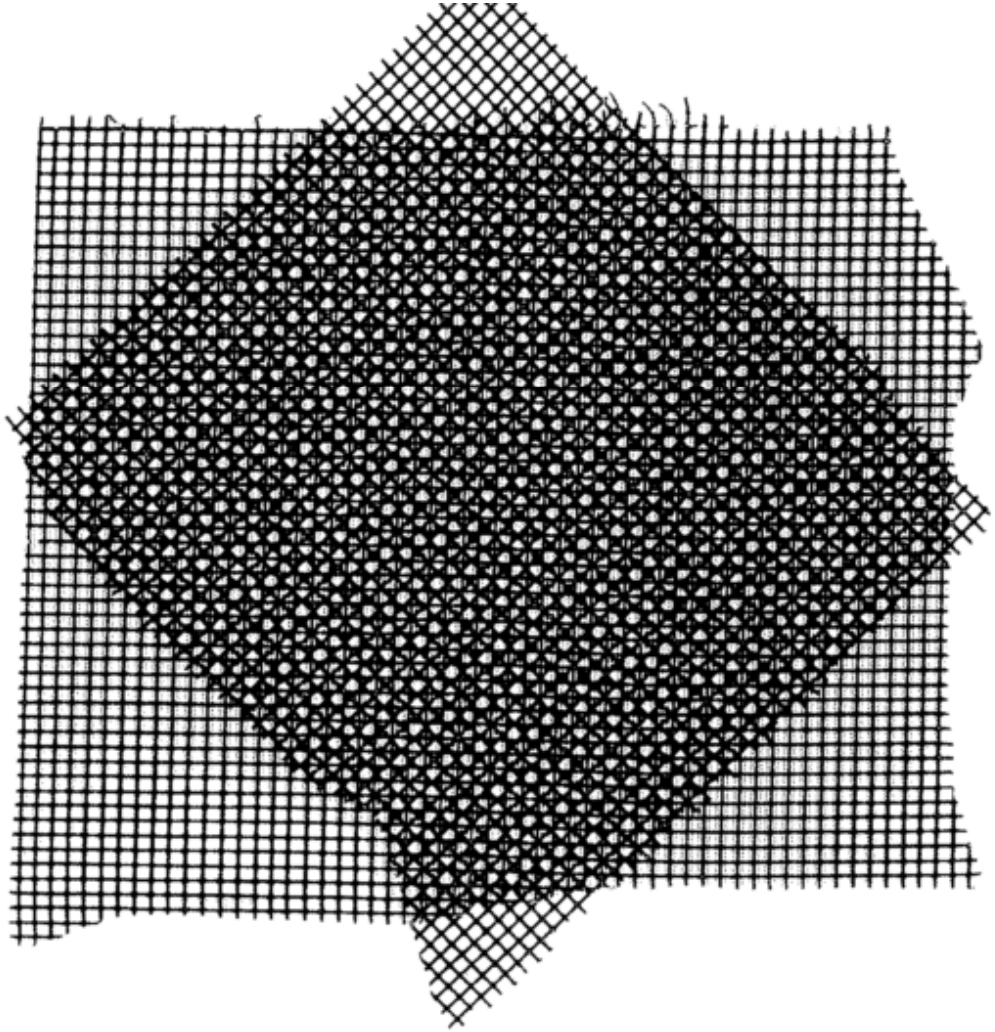
- Multiphasic screen
  - concerned with detecting multiple diseases
- Based on the *Guidelines for Adolescent Preventive Services* (GAPS)
  - Developed by the A.M.A.
  - Recommendations emphasize health guidance and the prevention of behavioral and emotional disorders in addition to traditional biomedical conditions.
  - Gadomski A, Bennett S, Young M, Wissow LS (2003)

Screens Embedded in SHQ

Include:

- Depression (Mood & Mood-related items) and Sleep
- Suicidality, Safety, Violence, Abuse
- Substance Abuse: CRAFFT
- School: learning/performance; skipping/suspension
- Supervision
- Relationships: Family, Friends/Peers
- Other Psychosocial Stressors: moves; work
- Sex: STD and Pregnancy Risk
- Sexual Orientation
- Health Hx: eating problems, weight, exercise, tobacco
- Medical Hx: e.g. Diabetes, Asthma, Seizures

Successive, brief screens identify *moire'* risk factors (indicate need for assessment & treatment) **!!**



Patient Health Questionnaire-9 (PHQ-9)

- Well-validated and respected tool used to assess adult depression in primary care.
  - Kroenke K, Spitzer RL, Williams JB (2001), The PHQ-9: validity of a brief depression severity measure.

    Journal of General Internal Medicine 16(9):606-13
  - Forms available for downloading @ http://www.phqscreeners.com/overview.aspx

PHQ-9 Evolution

- Background: based on the **Prim**ary Care **E**valuation of **M**ental **D**isorders (**PRIME-MD**)
  - diagnostic instrument containing modules on 12 different mental health disorders
  - developed mid-1990s by Robert Spitzer, MD, Kurt Kroenke, MD, et al. at Columbia University in collaboration with researchers at the Regenstrief Institute, Indiana University, supported by an educational grant from Pfizer Inc.
  - **During development of PRIME-MD,** Drs. Spitzer and Kroenke along with Janet B.W. Williams, DSW, at Columbia University, **created the PHQ screeners**.
  - http://www.phqscreeners.com/overview.aspx

PHQ-9 Evolution, cont.

PHQ:

- self-administered version of the PRIME-MD
- contains only the mood, anxiety, and some of the sleep disorder modules from the original PRIME-MD.
- assesses the 15 most common physical symptoms in primary care.
- "Brief PHQ:" shorter, alternative version of the PHQ, assesses depression, anxiety, psychological stressors, and women's reproductive health.
- **PHQ-9**, instrument **for depression**, simply scores each of the **9 DSM-IV criteria** (Major Depressive Episode) based on the mood module from the original PRIME-MD.
  - http://www.phqscreeners.com/overview.aspx

PHQ-9

- Over the last 2 weeks, how often have you been bothered by any of the following problems?
  1. **Little interest or pleasure in doing things** {*hypo/anhedonia*
  2. **Feeling down, depressed, or hopeless** {*dysphoria/FoH*
  3. Trouble falling or staying asleep, or sleeping too much {*hyper/insomnia*
  4. Feeling tired or having little energy {*hypo/anergy*
  5. Poor appetite or overeating
  6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
  7. Trouble concentrating on things, such as reading the newspaper or watching television
  8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual {*psychomotor agitation/slowing*
  9. Thoughts that you would be better off dead or of hurting yourself in some way {*suicidal/self-harm ideations; death wishes*

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PHQ-9

- **For initial diagnosis** (per instructions)**:**

1. Items (9) checked: [0] Not at all; [1] Several days; [2] More than half the days; [3] Nearly every day

2. If 4/> items checked either [2] or [3] (including items #1 and #2), consider a depressive disorder. Add score to determine severity.

3. ***Consider Major Depressive Disorder*** if 5/> items checked either [2] or [3] (including items #1or #2). {DSM-IV MDEpsd criteria}

Consider Other *(Minor)* ***Depressive Disorder*** if 2 to 4 items checked either [2] or [3] (including items #1or #2).

- Depressive Disorder diagnosis also requires impairment of social, occupational, or other important areas of functioning.
  Additional impairment of functioning item: If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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PHQ-9

- **PHQ-9 SCORING FOR SEVERITY DETERMINATION**

Interpretation of **Total Score** [added #s]	**Depression Severity**
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

- Note: all responses (self-report) should be verified by the clinician, and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
- **Subsequent PHQ-9 use:** to monitor severity over time for newly diagnosed patients or patients in current treatment for depression.

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Modified PHQ-9

- For adolescent depression, GLAD-PC modified the PHQ-9 (with permission) to better represent DSM-IV adolescent depression and added questions about suicide attempts and adolescent dysthymia. These modifications have never been validated in a research setting.
- GLAD-PC calls 13-item Modified PHQ-9 a "diagnostic aid" {assessment instrument vs. screening tool}
- Modified PHQ-9 available in Spanish
- *from* **G**uide**l**ines for **A**dolescent **D**epression in **P**rimary **C**are. Version 1, 2007. pp.57; 62-64

PHQ-9 Modifications

- **Modified:** How often have you been bothered by each of the following symptoms during the past 2 weeks?

Item 2. Feeling down, depressed, **irritable**, or hopeless?

3. Trouble falling asleep, staying asleep, or sleeping too much?

5. Poor appetite, **weight loss**, or overeating?

7. Trouble concentrating on things like school work, reading, watching TV?

{other 6 items, including impairment of functioning, ~unchanged}

- **Added items** (1 re. dysthymia; 2 re. suicidality)**:**
  - In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? Y/N
  - Has there been a time in the **past month** when you have had serious thoughts about ending your life? Y/N
  - Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? Y/N

***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 ER or call 911.*

- Same PHQ-9 severity scoring w/o "Consider Depressive Disorder" guidelines

Patient Health Questionnaire-2 (PHQ-2)

- 2-item version of PHQ-9
- Desirable screen for busy clinical settings {brief better!
- Useful part of multiphasic, comprehensive health screening questionnaires (e.g. SHQ).
- Asks about dysphoria & anhedonia frequency as initial screening test for major depressive episode.
- DSM-IV-TR correlation: dysphoria -&/or- anhedonia (loss of interest/pleasure), for 2 or more weeks, key diagnostic criteria for Major Depressive Episode

PHQ-2

- Over the past two weeks, how often have you been bothered by any of the following problems?
  - Little interest or pleasure in doing things.
    - 0 = Not at all
    - 1 = Several days
    - 2 = More than half the days
    - 3 = Nearly every day
  - Feeling down, depressed, *irritable*, or hopeless.
    - 0 = Not at all
    - 1 = Several days
    - 2 = More than half the days
    - 3 = Nearly every day
- Total point score: _____

Modified for youth

PHQ-2

- Score interpretation:

PHQ-2 score	Probability of *major depressive disorder* (%)	Probability of <u>any</u> depressive disorder (%)
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

PHQ-2 Validity

- PHQ-2 completed by 6000 patients in 8 primary care clinics and 7 ob-gyn clinics.
- PHQ-2 score > or =3 had a sensitivity of 83% and a specificity of 92% for major depression. PHQ-2 score of 3 identified as the optimal cutpoint for screening purposes. Results were similar in the primary care and ob-gyn samples.
- Conclusion: construct and criterion validity make PHQ-2 attractive measure for depression screening.
  - Kroenke K, Spitzer RL, Williams JB (2003), The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care* 41(11):1284-92

PHQ-2

PRIME-MD PHQ (2 Question Screen)
Scoring Instructions

- If the response is "yes" to either question, consider administering the PHQ-9 questionnaire or asking the patient more questions about possible depression (or referral to another clinician to do so).
- If the response to both questions is "no", the screen is negative.

PHQ-2

- Whooley et al. (1997) compared the 2-question screen to the Quick Diagnostic Interview Schedule (QDIS-III) and reported a sensitivity and specificity of 96% and 57% respectively.

- From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ).

http://health.utah.gov/rhp/pdf/PHQ9%20two%20question.pdf

PHQ-2

PRIME-MD PHQ (2 Question Screen)

Name_____Date_____

Over the past two weeks, have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless? Yes / No

2. Little interest or pleasure in doing things? Yes / No

*Modified for Youth in next slide [version]…….

PHQ-2

PRIME-MD PHQ (2 Question Screen)*

Name_____Date_____

Over the past two weeks, have you noticed any of these?

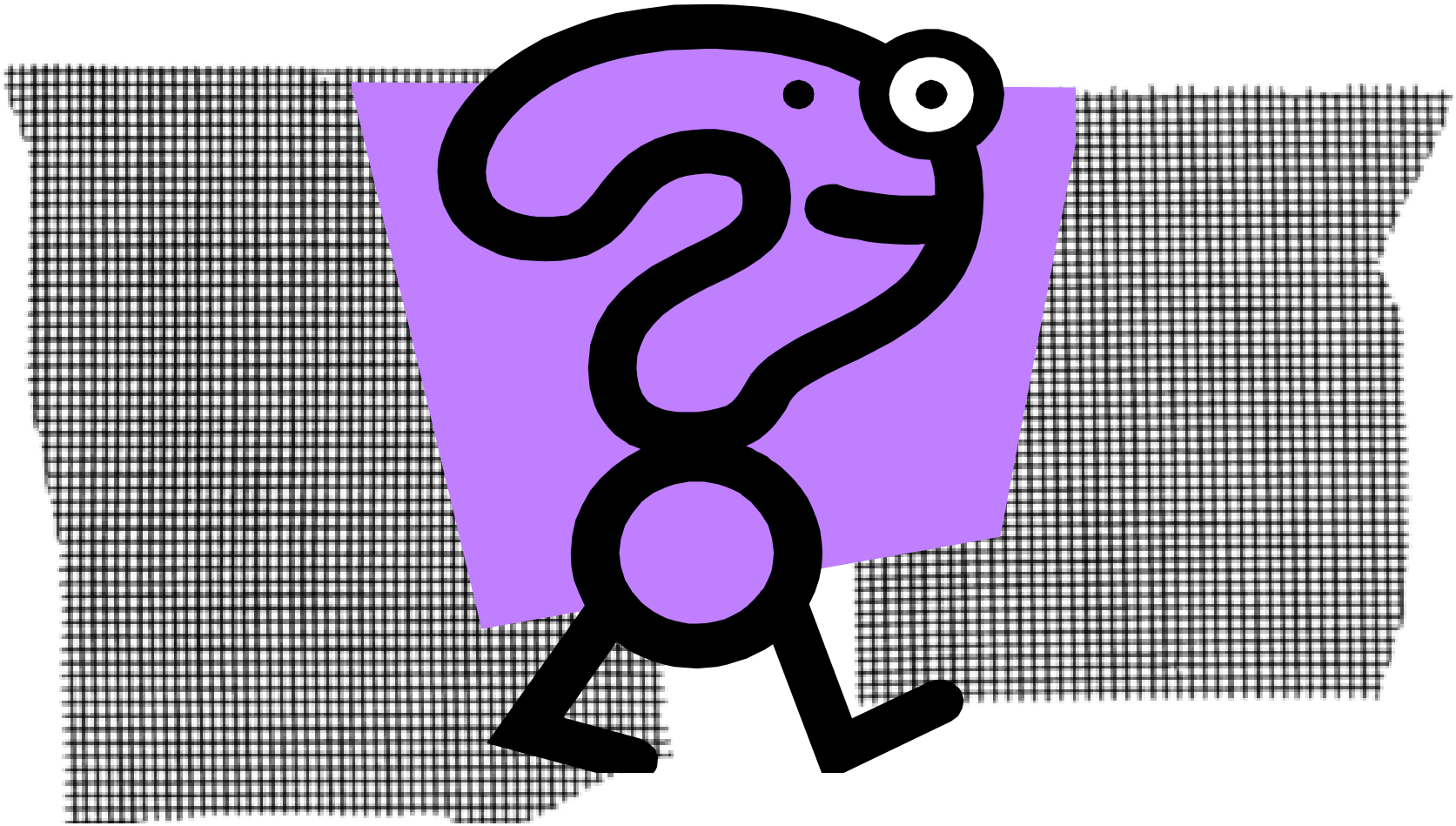
1. Feeling down, depressed, irritable* or hopeless? Yes / No

2. Little interest or pleasure in doing things? Yes / No

*Modified for Youth

Your Questions??

Concerns, Comments, Protests



Screening Implementation in SBHCs / Schools

- When to screen?
- Who administers the screen?
- Who interprets the screen -and- reviews it with the student?
- What to do about a positive screen?
  - Assess or Refer for Assessment & Treatment!
  - Address relevant consent & confidentiality issues
- Hazards of Rx antidepressant therapy based on a positive screen…

Using the CRAFFT

- Massachusetts Department of Public Health Bureau of Substance Abuse Services Provider Guide – Using the CRAFFT
  - http://www.mass.gov/Eeohhs2/docs/dph/substance_abuse/sbirt/crafft_provider_guide.pdf
- Page 6 - Provider Guide

2009 Task Force Guidelines

teen depression screening

- Routine (annual) depression screening for all teens
  {vs.other groups advise screening only high-risk youth}
- U.S. Preventive Services Task Force: independent panel of experts convened by the federal government to establish guidelines for treatment in primary-care
- Recommendations published in *Pediatrics* (April, 2009)
- "When followed by [assessment &] treatment, including psychotherapy, screening can help improve [potentially debilitating] symptoms: persistent sadness, social isolation, school problems; even suicide."

Task Force Recommendations

- "**Screen adolescents** (**12–18 years** of age) for major depressive disorder **when systems are in place** to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up."
- "Evidence is insufficient to warrant a recommendation to screen children (7–11 yrs of age) for major depressive disorder."
  - ***Pediatrics*** 123(4):1223-1228 (April, 2009)

Task Force Guidelines Critique

(+) Applaud the task force for recommending annual depression screening for all adolescents

?? sufficient evidence to not screen children??

- Task Force found "inadequate evidence to support the benefits of treatment in children"
- Needn't obstruct early risk factor identification→ prevention/early intervention (e.g. psychosocial support)

(-) Recommends "assessment instruments" instead of "screening tools"

- Screening for risk factors vs. DSM-IV dx

(+/-) "when systems are in place to ensure accurate diagnosis, psychotherapy (treatment), and follow-up"

- Misconstrued, potentially, as impediment vs. opportunity

Depression Screening in Adolescents– How are Providers doing?

- Primary Care Providers often have overlooked mental health problems in the adolescent population.
- Fortunately, SBHC PCPs often screen!
- Next 4 slides by Mary Ramos, MD, MPH
  - April, 2010 NM School & Adolescent Health Conference

Depression Screening in Adolescents– How are Providers doing?

- Survey of pediatricians and family physicians in MD
  - 47% encountered 1 or more adolescents who attempted suicide in the past year
  - Only 23% frequently or always screened adolescent patients for suicide risk factors

(*Arch Pediatr Adolesc Med* 2000:154:162-168)

Depression Screening in Adolescents– How are Providers doing?

- Survey of pediatricians within HMO in CA
  - 17% reported they screened for depression at all adolescent prevention services visits
  - 15% reported they screened for suicide risk factors at all adolescent prevention services visits

(*Arch Pediatr Adolesc Med* 2000:154:173-179)

Depression Screening in Adolescents– How are Providers doing?

- Survey of providers working at community health centers in multiple states
  - 64% reported they usually screened for depression at adolescent prevention services visits
  - 53% reported they usually screened for suicidal thoughts at adolescent prevention services visits

(*Pediatrics* 2001:107(2):318-327)

Depression Screening in Adolescents– Why is this important for PCPs?

- Half of adolescents making suicide attempts receive medical care in the month prior to the attempt.
- One quarter seek care in the week preceding the attempt.
- It is an error of omission not to screen.

(*Ann Emerg Med* 1997;29:141-145)

Screening Implementation
Envision NM SBHC BH-QI Initiative

1) Screen w/ SHQ: SBHCs administer the Student Health Questionnaire (SHQ) on the first student visit; by the third visit if the student is acutely ill or in crisis during the initial visit (OSAH, NM-DOH, Std.16.2).
2) Assess +screens w/ PHQ-9 or other depression assessment if indicated by results of the SHQ.
3) Team conferencing about further assessment & treatment plan development.

Summary: Quiz revisited

Depression screening involves:

A) Early identification of risk factors
B) Assessment / Diagnosis
C) Treatment
D) B & C
E) All of the above

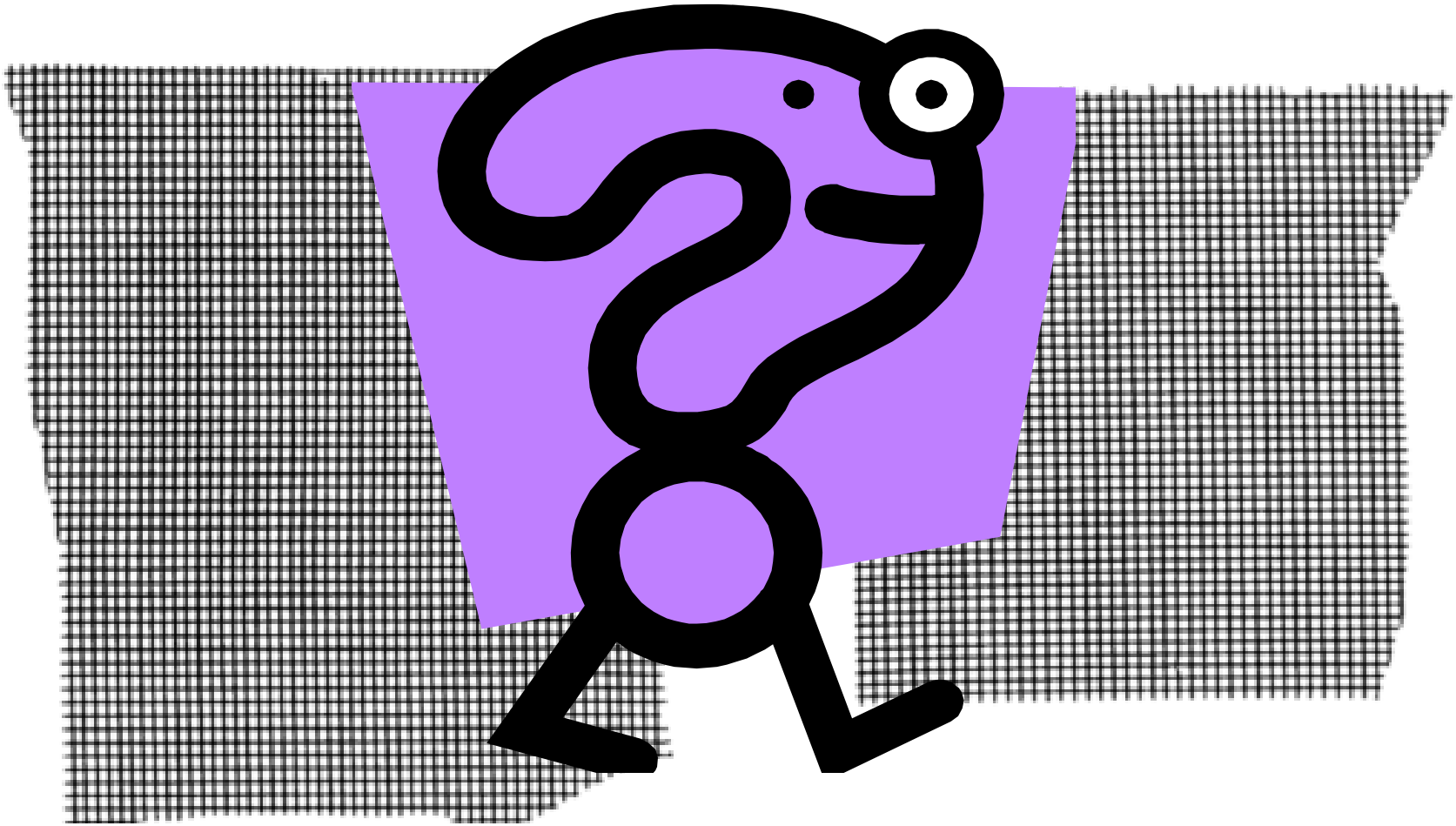
Answer: A

Summary: Student Screening

- Screening identifies risk factors
  {does not assess/diagnose}
- Early screening is important!
- Less is more; brief is better!
  - 3-6 item substance abuse screen (CRAFFT)
  - Dysphoria &/or anhedonia identification constitutes a positive depression screen (PHQ-2)
  - Screen for Suicidality/Harmfulness too--important!
- Positive screen needs subsequent Assmnt & Tx.
  - by itself, neither makes Dx nor indicates Tx!
- Hazardous (potentially) to Dx and Tx, especially Rx antidepressant, on basis of (+)screen (alone) !!

Your Questions??

Concerns, Comments, Protests



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