

UCSF BENIOFF CHILDREN'S HOSPITALS

Mental Health Clinical Guidelines

Depression in Children and Adolescents



UCSF Benioff Children's Hospitals
Oakland | San Francisco

Shelly Nakaishi, CPNP, and
Petra Steinbuchel, MD, Medical Director, Division of Mental Health & Child Development

General Clinical Guidance

Pediatric primary care providers are on the front lines for preventing, screening, assessing, treating, and monitoring pediatric mental health concerns.

The American Academy of Pediatrics (AAP) has recommended that the first step for addressing depression and other common pediatric mental health concerns be to develop standard office procedures.

These procedures should include:

- Screening tools
- Treatment protocols
- Resource and referral guides
- Criteria for consultation
- Psychiatric and social emergencies

See the readiness inventory in attachments.

Overview

Studies have shown that up to 9 percent of teenagers meet criteria for depression at any one time, with as many as one in five teens having a history of depression at some point during adolescence. Major depressive disorder (MDD) in youth is under-identified and undertreated in primary care (PC) settings.

Barriers to specialized mental health services have led primary care to become the de facto mental health clinic, with opportunities to provide early prevention and treatment.

These guidelines will cover screening, assessment, treatment, and referral criteria. These guidelines will not cover how to make specific referrals for specialty care or therapy.

For More Information

Oakland Campus

Phone: 510-428-8428

San Francisco Campus

Phone: 415-476-7000

Pediatric Depression

It is not unusual for young people to experience “the blues” or feel “down in the dumps” occasionally in response to stressful life events. Adolescence is often an unsettling time, considering the many physical, emotional, psychological, and social changes that accompany this stage of life. Teen depression is associated with drug and alcohol abuse, low self-esteem and self-mutilation, pregnancy, violence, and even suicide.

The following symptoms of depression are more common in teenagers than in adults:

- Irritable or angry mood: Irritability, rather than sadness, can be the more predominant mood in depressed teens. A depressed teenager may be bored, grumpy, hostile, easily frustrated, or prone to angry outbursts in a way that is markedly different than his or her baseline.
- Frequent, unexplained aches and pains.
- Extreme emotional sensitivity: Feelings of worthlessness, making him or her extremely vulnerable to criticism, rejection, and failure. This is a particular problem for “over-achievers.”
- Withdrawing from some, but not all people: Adults tend to isolate themselves when depressed; teenagers usually keep up with at least some friendships. However, teens with depression may socialize less than before, pull away from their parents, or start hanging out with a different crowd.
- For more information, go to www.helpguide.org/articles/depression/teen-depression-signs-help.htm.

Subjective

- Complete a history: Use the HEEADSSS mnemonic (Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/self-harming/depression, and Safety from injury and violence).
- Obtain a history of the presenting illness:
 - ▶ Prior evaluations and prior treatments.
 - ▶ Current treatments, including alternative/complementary treatments such as acupuncture, herbs, or yoga.
 - ▶ Rule out any mania symptoms.
- Obtain a family history of mental illness, with special emphasis on depression, bipolar disorder, history of violence/aggression, substance abuse, suicide attempts, or completed suicides.
- Obtain a sleep history.
- Obtain an adverse childhood experiences history and a trauma history.

Objective

- Physical examination:
 - ▶ Assess for other possible comorbid medical conditions, including anemia, allergy, thyroid disease, sleep disorder, Crohn’s disease, lupus, celiac disease, Addison’s disease, and/or cancer.
 - » CBC with Differential, Serology-Electrolytes, Ca, Mg, ESR, Bun/Cr, Glucose, LFTs, Serum B12, Folate, and Thyroid Function Tests (TSH and FT4) may be appropriate baseline labs.
 - » Pregnancy test.
- Questionnaires for depression include PHQ-2 and PHQ 9 Modified for Adolescents (PHQ-9 Adolescent);
 - ▶ Since 2009, the U.S. Preventive Task Force (USPTF) has recommended screening for major depressive disorder (MDD) for 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.
 - ▶ The AAP and USPTF recommend that depression screening be conducted annually.
 - ▶ For children aged 11 years or younger: The USPTF concludes that the current evidence is insufficient to assess the balance between benefits and harms of screening for MDD.
 - ▶ For pediatric primary care, a general depression screen can be used for all adolescents aged 12 to 18 with the PHQ-2. The PHQ-2 does not establish a diagnosis or monitor depression severity, but it screens for depression as a “first step” approach. See the Appendix (page 10) for more information on the PHQ-2.
 - ▶ For patients that score positive on the questionnaire, evaluate if the depression symptoms endorsed are significant and causing impairment. Complete the PHQ-9 if the PHQ-2 is positive.
 - ▶ For patients who score negative on the PHQ-9 Adolescent, it is recommended that the primary care provider briefly review the symptoms marked as “more than half days” and “nearly every day” with the patient. See Appendix (page 10) for PHQ-9 Adolescent.

Pediatric Depression (cont.)

- Suicide screen:
 - ▶ If a youth is being treated for a behavioral or emotional problem, The Joint Commission of Accredited Health Organizations now mandates screening for suicide risk. The PHQ-9 Adolescent provides a screening mechanism for suicide risk.
 - ▶ Clinic protocols should be in place to evaluate and manage psychiatric emergency evaluation for 5150 (involuntary psychiatric hospitalization) evaluation.
 - ▶ If the patient has suicidal ideation with a suicidal plan, complete and document a suicide assessment. Identify and document the following:
 - » Risk factors, protective factors, suicide inquiry (thought, plan, behaviors, intent), risk-level assessment, treatment plan to reduce risk, rationale for interventions, and a follow-up plan.
 - » Document a safety plan, including removal of firearms and lethal medications, substance abuse counseling; identification of support person(s), role of parent/caregiver, SI hotline number, 911/ER info, and other contact information.
 - » Risk factors: mnemonic SADPERSONS (Sex, Age, Depression/affective disorder, Previous attempts, Ethanol/drug abuse, Rational thinking loss, Social supports lacking, Organized plan, Negligent parenting, Stressors: significant family stressors, self-harming behaviors, suicidal modeling by parents/siblings/friends, school problems).
 - ▶ One of the highest risk factors is a previous suicide attempt. One of the highest risk times is after a psychiatric hospitalization. One of the key interventions in primary care is to make sure a recently psychiatrically hospitalized patient has follow-up care, either with their behavioral health provider or with their primary care physician if none has been established.
 - ▶ Protective factors include strong familial/social ties, forward thinking, and faith/spiritual practice.
 - ▶ It is highly recommended to consult/collaborate with a colleague or supervisor and to include this as part of your documentation.
 - ▶ For further reading, See <http://pediatrics.aappublications.org/content/105/4/871.long>.
 - ▶ For additional screening of suicide, the Ask Suicide-Screening Questionnaire (ASQ) can be used. See the Appendix (page 11).
- Screen for co-occurring mental health conditions such as anxiety (30–80 percent), attention deficit hyperactivity disorder (10–80 percent), substance use (20–30 percent), eating disorders (10 percent), bipolar and psychosis.
 - ▶ For anxiety, you can use the SCARED anxiety rating scale or RCADS anxiety rating scale.
 - ▶ If there are bipolar diagnosis concerns, consult with a psychiatrist. Starting a selective serotonin reuptake inhibitor could induce a manic episode.
 - ▶ Significant alcohol or benzodiazepine substance abuse increases risks of seizures.
 - ▶ For co-occurring mental and complicated medical conditions, or for multiple comorbid psychiatric conditions, consider a referral to psychiatry.
- Screen for substances (if appropriate).
 - ▶ Perform toxicology screen, if appropriate.
 - ▶ Long-term use of marijuana increases risk of depression.
 - ▶ Recommend using the CRAFFT screening tool. 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. See the Appendix (page 11) for the CRAFFT.
 - ▶ 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.
 - ▶ Substance use increases the risk of suicide attempts.
 - ▶ Alcohol use and SSRI treatment can increase the risk of seizures.

Assessment

- It is important to interview the youth separately and to gather history for the parent/caregiver and collateral (therapist, school, and other health providers).
- Confirm that the patient meets the criteria for major depressive disorder.

Pediatric Depression (cont.)

To make the diagnosis of major depressive disorder, the DSM 5 criteria is as follows:

- A. Five or more of the following symptoms present during the same two-week time period and represent a change from previous function. At least one symptom is (1) depressed mood or (2) loss of interest/pleasure.

Nearly every day the youth experiences:

1. Depressed mood most of the day (note that irritable and bored feelings are common for teens).
 2. Markedly diminished interest/pleasure in all/almost all activities for most of the day.
 3. Significant weight loss, decrease in appetite, or failure to gain weight as expected (for children).
 4. Insomnia or hypersomnia.
 5. Psychomotor agitation or retardation.
 6. Fatigue or loss of energy.
 7. Feelings of worthlessness or inappropriate guilt.
 8. Diminished ability to concentrate or indecisiveness.
 9. Recurrent thoughts of death, suicidal ideation, or suicide attempt.
- B. Symptoms cause clinically significant distress or impairment.
- C. The episode is not attributable to physiological effects of a substance or another medical condition.

Plan and treatment for major depressive disorder

Mild depression

- First-line treatment:
 - ▶ Psychoeducation: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/depression.aspx.
 - ▶ Use motivational interviewing to identify wellness goals for healthy sleep, healthy activities, healthy eating, healthy supports, and enhanced problem solving.
 - ▶ Create a treatment plan to monitor symptoms and goals (from the Adolescent Health Working Group Behavioral Health Tool Kit, www.ahwg.net/resources-for-providers.html).
 - ▶ Follow up every week to bi-weekly: Short, quality contact with providers can greatly decrease symptoms in mild/moderate depression—“knowing someone cares.”
 - ▶ Continue to monitor for suicidal ideation, self-harming behaviors, and substance use.

- ▶ After four to six weeks of support, or based on patient request, refer for therapy.

» Evidenced-based therapy for adolescent depression

» Cognitive-Based Therapy (CBT)

- » The main principle of CBT is that thoughts influence behaviors and feelings, and vice versa.
- » Treatment targets a 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.

» Interpersonal Therapy for Adolescents (IPT-A)

- » The main principle of IPT-A is that interpersonal problems may cause or exacerbate depression and that depression, in turn, may exacerbate interpersonal problems. Treatment will target a 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.

Moderate to severe depression

- First-line treatment (see above).
- Consider referring for therapy immediately, before the four to six weeks of active support/monitoring.
- If there is continued partial response and functional impairment after two to eight weeks, consider starting medication treatment.

Medication Treatment

When to prescribe medication in primary care:

- Uncomplicated mild to moderate depression that persists after a failed response to first-line treatment and therapy.
- Significant functional impairment.
- The patient and family are not new to the clinic. We recommend not prescribing medication for a patient if they are new. Treatment follow-up is critical. Risk of side effects—including activation or suicidal thinking—is greatest in the first three months of treatment, when follow-up is most critical. Intermittent adherence can cause mood worsening, rather than improvement. This is why anti-depressants are not prescribed upon presentation to the Emergency Room.
- Parent-informed consent obtained if the youth is under 18 years old and not emancipated. Informed consent for psychotropic medication includes:
 - ▶ Diagnosis.
 - ▶ Risks of not treating with medication.
 - ▶ Discussion of alternative or additional treatments.
 - ▶ Discussion of adverse effects (short- and long-term).
 - ▶ Discussion of pharmacokinetic issues (laboratory monitoring if needed, dosing plan, drug–drug interactions).
 - ▶ Treatment adherence risks.
 - ▶ If off-label, documentation of reasons.
 - ▶ Review of FDA warning:

In May 2007, the FDA issued a revised medication guide that no longer includes specific mandates for monitoring Selective Serotonin Reuptake Inhibitors (SSRIs). Instead, it focuses on information parents need to know regarding suicidality and antidepressants. The boxed warning is a warning and not a restriction.

Antidepressant-induced suicidality is rare. The original FDA estimate, based solely on data from more than 4,300 research participants in 23 studies, was 2 percent of children and adolescents receiving a placebo and 4 percent receiving an antidepressant developed suicidal thoughts or attempted suicide. Thus, the risk difference was 2 percent. A subsequent analysis, based on data from 27 randomized controlled trials involving more than 5,300 participants, found a significant

risk difference of just 0.7 percent. The most recent estimate, which was based on data from 35 randomized controlled trials involving more than 6,000 participants, found a risk difference of 0.9 percent—just missing statistical significance. The most recent and, presumably best analyses suggest that there may be a very slight increased risk of suicidality with antidepressants in children and adolescents, but not actual increased risk of completed suicide. Since the time of this black box warning, PCPs have prescribed fewer SSRIs, and the rates of suicide in youth have increased.

Clinical prudence indicates the need to educate patients and parents about suicidality and to provide careful monitoring for suicidality and other adverse effects during the initial phase of treatment and throughout treatment.

- If the youth is in the foster care system, a court authorization (JV-220) is required to prescribe psychotropic medications.

Engaging and Informing Parents

For the purposes of this document, parents are defined as the legal guardian for the patient.

- Inform parents of confidentiality rules for the patient.
- Inform parents about the PHQ-9 screening results, treatment recommendations, follow-up plan, and referrals.
- Obtain written permission from parents to allow collaboration between the primary care physician and the behavioral health specialist.

Starting Medication Treatment

- Per the American Academy of Pediatrics (AAP) and American Academy of Child and Adolescent Psychiatry (AACAP), Selective Serotonin Reuptake Inhibitors (SSRIs) are first-line medication treatment for child and adolescent depression. No guidance regarding which SSRI is indicated.
- The selection may depend on FDA approval, insurance coverage, cost, patient and family preference, history of positive response from family members, medication adherence concerns, or other current medications prescribed (drug–drug interaction concerns).
- The initial dose (in the table below) is recommended. In general, the younger the patient, the smaller the recommended initial dose. Prepubertal children are particularly sensitive to hyperkinesia, insomnia, and restlessness (activation).
- Onset of effect generally occurs after two to four weeks at an effective dose, but some patients start to respond within a week.
- For all SSRIs, monitor the patient’s height and weight. No specific laboratory studies are recommended.

Contraindications include:

- ▶ Known hypersensitivity (escitalopram and sertraline only).
- ▶ Serotonin syndrome and monoamine oxidase inhibitors (MAOIs) for all SSRIs.
 - » Do not use SSRIs and MAOIs concomitantly.
 - » Do not start SSRIs within 14 days of stopping MAOIs (escitalopram, fluvoxamine, sertraline).
 - » Do not start fluoxetine within five weeks of stopping MAOI.
 - » Do not use pimozide concomitantly with SSRIs.
 - » Do not use thioridazine concomitantly with fluoxetine and fluvoxamine.
- Avoid administering—or monitor carefully when co-administering—other serotonergic agents, including triptans, tricyclic antidepressants, fentanyl, lithium, tramadol, tryptophan, buspirone, and St. John’s wort.

Selective Serotonin Reuptake Inhibitors (SSRIs)							
GENERIC NAME	BRAND	US FDA	INITIAL DOSE, MG	MAX DAILY DOSE, MG	DOSING FREQUENCY	AVAILABLE UNIT DOSAGE FORMS	CLINICAL PEARLS
Fluoxetine	Prozac	MDD 8-17, OCD 7-17	10–20 mg	60 mg	Daily	Capsules: 10, 20, and 40 mg. Weekly capsules: 90 mg	Long half-life, no tapering required. Good when medication adherence is a concern.
Escitalopram	Lexapro	MDD 12-17	10 mg	20 mg	Daily	Tablets: 5, 10 (scored), and 20 (scored). Oral solution 1 mg/mL.	Good if there are concerns about drug–drug interactions; less effect on CYP450.
Sertraline	Zoloft	OCD 6-17	12.5–25 mg Over age 13, 50 mg	200 mg	Daily	Scored tablets: 25, 50, and 100 mg. Oral solution 20 mg/mL.	
Fluvoxamine	Luvox	OC 8-17	25 mg	8–11 yr 200 mg, 12–17 yr 300 mg	BID	Tablets: 25, 50, and 100 mg.	

In general, we do not recommend Paxil as a first-line agent due to increased side effects compared with other SSRIs, and slightly increased risk of suicidal ideation.

Starting Medication Treatment (cont.)

Monitoring therapeutic response or dose adjustment, or switching SSRIs

- Dosage adjustment for SSRIs requires balancing the desire to reach a therapeutic dose as quickly as possible with the reality that the effect of a dose change may not be observable for one to four weeks. One practical approach is to increase the dose every seven days to the maximum dose if there are no adverse effects and there is minimal response. Ensure medication adherence before adjusting doses.
- During dose adjustment, a weekly phone check-in or face-to-face appointment is preferred.
- Monitor the patient weekly the first month, then bi-weekly the next month, then monthly for three months, then every one to three months depending on how stable the patient is. During the first month, you may consider a telephone check-in and face-to-face appointments every two weeks.
- If one SSRI fails or causes a partial response at the optimal dose or has adverse effects, switch to an alternate SSRI. Switching from one SSRI to another can be staggered and overlapping, as long as the combined total daily dose remains equivalent and comparable over a couple of weeks. If fluoxetine is discontinued abruptly, dose escalation of the new SSRI can be based on an approximate half-life of fluoxetine of one to two weeks.
- Discontinuation of treatment (escitalopram, sertraline, fluvoxamine) is recommended by 25 percent each week. Fluoxetine, self-tapers due to a long half-life.

Monitoring for adverse reactions

- Common initial (first one to three weeks, or with dose adjustment) adverse reactions include headaches and gastrointestinal reactions (nausea, diarrhea, and/or constipation). To help prevent these, encourage taking medication with meals. If the headaches and GI effects persist, consider BID dosing, changing from qam to qhs dosing if sedating (most common with sertraline) or changing to an alternative SSRI.
- Other common adverse effects include changes in appetite or weight, sexual dysfunction, or diaphoresis.
- Often with sertraline and fluvoxamine, sedation occurs; however, these medications may also cause difficulties with falling asleep and, if these difficulties occur, medication should be changed to qam dosing.
- Less common reactions include abnormal bleeding, angle-closure glaucoma, hyponatremia, seizure, and QTC prolongation (fluoxetine).
- Other concerning side effects to monitor are restlessness (activation); hypomania or mania; suicide risk; and serotonin syndrome.
- Parents and youth are provided with information about when and whom to call for different situations (e.g., emergency, immediate call, or next-day call).

Maintenance

Once an optimal dose is determined, maintenance treatment begins. Frequency of monitoring can be reduced to follow-up every one to three months depending on the patient's needs.

If the patient has mild to moderate depression, consider tapering and stopping after nine months, or during a period when there is less stress for the patient.

If the patient has moderate to severe depression, consider collaborating with the patient's therapist and family to determine if a slow taper toward stopping medication treatment is indicated after a year of medication treatment and at least six months of consistent therapy—preferably during a period of minimal stress or change.

When to refer the patient to Child Psychiatry

1. Complexity or lack of clarity regarding a diagnosis.
2. Safety threat to the patient or to others.
3. Significant change in emotion/behavior with no obvious precipitant.
4. Moderate to severe substance abuse.
5. Primary caregiver has serious mental health problems (including substance abuse).
6. Psychosis or mania.
7. History of psychiatric hospitalization.
8. Partial response to two different SSRI treatments after six to eight weeks, or after more than two psychotropic medications.
9. Family psychiatric history suggests poor response to SSRI treatment.
10. Patient is 6 years old or younger.
11. A chronic medical condition and the patient's behavior seriously interferes with medical treatment.

For more information, please see www.aacap.org/aacap/Member_Resources/Practice_Information/When_to_Seek_Referral_or_Consultation_with_a_CAP.aspx

Appendix

Patient Health Questionnaire-2 (PHQ-2)				
Over the past two 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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

A score of 3 or higher indicates a positive screen, and with a positive screen, further screening is recommended via the PHQ-9 Modified for Adolescents.

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

- The PHQ-9 Modified for Adolescent indicates the likelihood that a youth is at risk for depression or suicide; its results are neither a diagnosis nor a substitute for a clinical evaluation.
- Free download of PHQ-9 Modified for Adolescents:
[http://www.integration.samhsa.gov/images/res/8.3.4%20Patient%20Health%20Questionnaire%20\(PHQ-9\)%20Adolescents.pdf](http://www.integration.samhsa.gov/images/res/8.3.4%20Patient%20Health%20Questionnaire%20(PHQ-9)%20Adolescents.pdf)

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) PCPHQ-9 Mod/6.4.10/1000

PHQ-9 Modified for Adolescents

- Can be administered and scored by a nurse, medical assistant, physician, or other staff.
- Patients should be left alone to complete the PHQ-9 in a private area.
- Patients should be informed of their confidentiality rights before the screen is administered.
- Scoring:
 - ▶ ≥11 is a positive screen
 - ▶ 1–4 Minimal depression
 - ▶ 5–9 Mild depression
 - ▶ 10–14 Moderate depression
 - ▶ 15–19 Moderately severe depression
 - ▶ 20–27 Severe depression
- Suicidality: Regardless of a PHQ-9 score, endorsement of a serious suicidal ideation or a past suicide attempt (questions 12 and 13) should be considered positive screen.

Appendix (cont.)

Ask Suicide Questionnaire (ASQ)

The ASQ has high sensitivity and negative predictive value, and it has been used to identify the risk of suicide in patients presenting to pediatric emergency departments. *Arch Pediatr Adolesc Med.* 2012;166(12):1170-1176. Published online October 1, 2012. doi:10.1001/archpediatrics.2012.1276.

Ask Suicide Questionnaire screening questions

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? If yes, how? When?
Positive responses to one or more of these questions may indicate a risk factor for suicide in youth.

CRAFFT—adolescent substance use screening

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?

CRAFFT scoring: Each “yes” response scores 1 point. A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

References

- Cheung, A.H., Zuckerbrot, R.A., Jensen, P.S., Ghalib, K., Laraque, D., and Stein, R.E. (2007). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management. *Pediatrics.* 120(5). doi:10.1542/peds.2006-1395.
- Riddle, M.A., and Foy, J.M. (n.d.). Pediatric psychopharmacology for primary care.
- Suicide and Suicide Attempts in Adolescents (2000). *Pediatrics.* 105(4), 871-874. doi:10.1542/peds. 105.4.871
- Zuckerbrot, R.A., Cheung, A.H., Jensen, P.S., Stein, R.E., and Laraque, D. (2007). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, Assessment, and Initial Management. *Pediatrics.* 120(5). doi:10.1542/peds. 2007-1144.



UCSF Benioff Children's Hospitals
Oakland | San Francisco

747 52nd Street, Oakland, CA 94609