**Initial Pediatric New Patient Screens Scoring:**

## *Ages 12-18:*

***PHQ-2:***

- **Score ranges from 0-6**
- **If score is 3 or higher further evaluation of depressive symptoms is needed and Phreesia will push a PHQ-9**

***PHQ-9 and PHQ Modified for Teens- used to screen for depression and severity***

- **10 and over is a positive screen**
- **To assess major depression a 2 or a 3 must be scored on one of the first 2 questions-**
    - **If a 2 or 3 is not indicated the patient may still be depressed (depression NOS or another depressive disorder), but it is not major depression.**

| PHQ-9 Score | Provisional Diagnosis | Treatment Recommendation (Patient preferences should be considered) |
|---|---|---|
| **5-9** | **Minimal Symptoms*** | **Support, educate to call if worse, return in one month/monitor.** |
| **10-14** | **Minor depression ++ Dysthymia*, Major Depression, mild** | **Support, watchful waiting, antidepressant or psychotherapy.** |
| **15-19** | **Major Depression, moderately severe** | **Antidepressants or psychotherapy.** |
| **>20** | **Major Depression, severe** | **Antidepressants and psychotherapy.** |

***Generalized Anxiety Disorder (GAD-7)- used to screen for severity of anxiety***

- **10 and over is a positive screen**
- GAD-7 total score for the seven items ranges from 0 to 21.

| GAD-7 Score | Provisional Diagnosis | Treatment Recommendation (Patient preferences should be considered) |
|---|---|---|
| **5-9** | Mild Anxiety | Support, educate to call if worse, return in one month/monitor. |
| **10-14** | Moderate Anxiety | Continue to monitor, refer to mental health treatment. An appointment should occur within five (5) working days of a client's request for mental health services. |
| **15-21** | Severe Anxiety | Refer to mental health treatment for intake within 72 hours. Create safety plan and monitor. |

**Pediatric symptom checklist (PSC-Y)- Patient Report**

| | |
|---|---|
| **Scoring and Interpreting:** | The PSC-17 total score is calculated by adding together the score for each of the 17 items. If 4 or more items are left blank, the questionnaire is considered invalid. A PSC-17 score of ≥15 suggests the presence of significant behavioral or emotional problems. Below are the items contained within the internalizing, conduct, and attention subscales and their cutoff scores:<br>**The PSC-17 Internalizing Subscale (Cutoff ≥5):**<br>1. Feels sad, unhappy<br>2. Feels hopeless<br>3. Is down on self<br>4. Worries a lot<br>5. Seems to be having less fun<br>**The PSC-17 Attention Subscale (Cutoff ≥7):**<br>6. Fidgety, unable to sit still<br>7. Daydreams too much<br>8. Distracted easily<br>9. Has trouble concentrating<br>10. Acts as if driven by a motor<br>**The PSC-17 Externalizing Subscale (Cutoff ≥7):**<br>11. Fights with other children<br>12. Does not listen to rules<br>13. Does not understand other people's feelings<br>14. Teases others<br>15. Blames others for his/her troubles<br>16. Refuses to share<br>17. Takes things that do not belong to him/her |

- **Scoring is easier based on shapes next to the question on the screener**
  - ◆ **Attention Subscale**
  - ❑ **Externalizing subscale**
  - ❇ **Internalizing Subscale**

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Total ◆ _____ Total ❑ _____ Total ❇ _____ Grand Total ◆+❑+❇ _____

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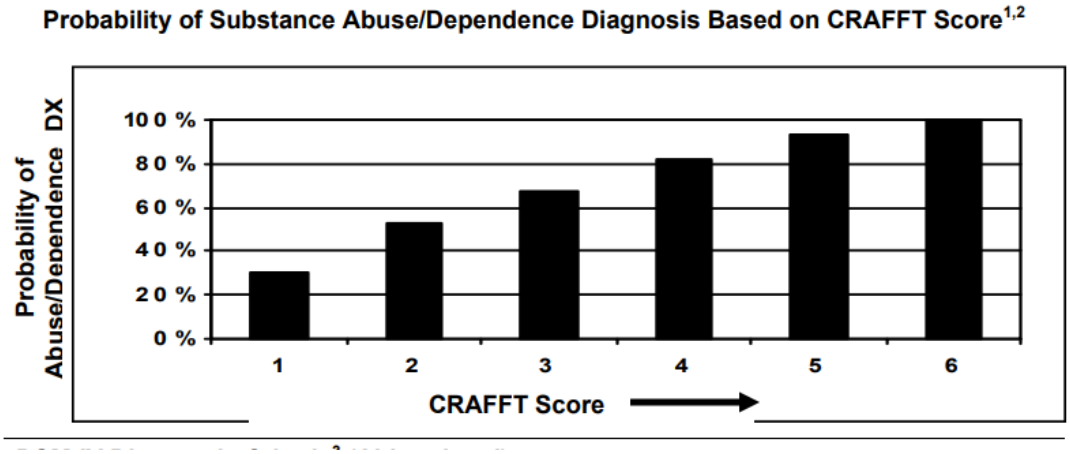
***The CRAFFT- used to assess for substance use/risky behaviors***

- **If patient answered "yes" to ANY of the questions in part A then ask all 6 CRAFFT questions in part B**
- **If patient answered "no" to all of the questions in part A, Ask CAR question only then stop**
- **Part B: Each "yes" question in part B is 1 point**
- **A total score of 2 or higher is a positive screen, indicating a need for additional assessments**




**PEARLS adolescent tool for ages 12-19 to be completed by parent/caregiver**

**& PEARLS for adolescent self-report tool, for ages 12-19, to be completed by the adolescent:**

- PEARLS does not have a given scoring system for each question, but rather:
  - **a higher number of adverse childhood experiences** (part 1)
  - **and a higher number of additional adversities** (part 2) results in a higher risk of experiencing toxic stress.
  - For example, a score of 0 indicates a child or adolescent is at a low risk of experiencing toxic stress, while a score of 4 or more puts the child or adolescent at high risk for experiencing toxic stress.
- Scoring does not differ based on informant but its important to look at and compare results

*****See Below for more information on ACEs, age range guide, and helpful links*****

## *Ages 11 and younger:*

**Pediatric Symptom Checklist (PSC-35): Parent Report**

- The PSC consists of 35 items that are rated as "Never," "Sometimes, " or "Often" present. A value of 0 is assigned to "Never", 1 to "Sometimes," and 2 to "Often".

- The total score is calculated by adding together the score for each of the 35 items. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.
- **For children ages 4 and 5,** the PSC score of 24 or higher suggests the presence of significant behavioral or emotional problems.
- **For children ages 6 through 16,** the cutoff score is 28 or higher. Meaning she/he has more problems than most others their age.
- **Subscales:** To determine what kinds of mental health problems are present, determine the three factor scores on the PSC:
    - The PSC Attention Subscale consists of 5 items: ***cutoff is score of 7 or higher***
        - 4. Fidgety, unable to sit
        - 7. Acts as if driven by a motor
        - 8. Daydreams too much
        - 9. Distracted easily
        - 14. Has trouble concentrating
    - The PSC Internalizing Subscale consists of 5 items: (anxiety/depression) ***cutoff is score of 5 or higher***
        - 11. Feels Sad
        - 13. Feels Hopeless
        - 19. Is down on self
        - 22. Worries a lot
        - 27. Seems to have less fun
    - The PSC Externalizing Subscale consists of 7 items: (conduct and behavioral concerns) ***cutoff is score of 7 or higher***
        - 16. Fights with other children
        - 29. Does not listen to rules
        - 31. Does not understand others feelings
        - 32. Teases others
        - 33. Blames others for his troubles
        - 34. Takes things that do not belong to him
        - 35. Refuses to share

**Pediatric ACEs and Related-Life Events Screener (PEARLS) (Pediatric ACEs):**

- **12-18: Teen ACEs**
    - **Teen (Parent-Caregiver Report) – Identified (English)**
    - **Teen (Self-Report) – Identified (English)**
- **11 and under: Parent-caregiver ACEs**
    - **Child (Parent-Caregiver Report) – Identified (English)**

- 10 questions that screen for a history of abuse, neglect, and household dysfunction (Figure 1). The ACE score refers to the total number of ACE categories experienced, rather than the severity or frequency of any one category. The total score ranges between 0 and 10.
- You should be able to inform your patients of the potential significance of an ACEs score and "WHY" we do this. (See Below)
- **Scoring: any affirmative answer is "significant" and should be discussed with the patient.**

***What are ACEs?***

The term *Adverse Childhood Experiences* (ACEs) refers to a range of events that a child can experience, which leads to stress and can result in trauma and chronic stress responses. Multiple, chronic or persistent stress can impact a child's developing brain and has been linked in numerous studies to a variety of high-risk behaviors, chronic diseases and negative health outcomes in adulthood such as smoking, diabetes and heart disease. For example, having an ACE score of 4 increases a person's risk of emphysema or chronic bronchitis by 400 percent and suicide by 1200 percent.[i] [ii] [iii] [iv]

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**More on ACEs:**

- https://www.acesaware.org/wp-content/uploads/2020/05/Provider-Toolkit-Screening-Tools-Overview.pdf
- https://www.acesaware.org/learn-about-screening/screening-tools/screening-tools-additional-languages/
- https://acestoohigh.com/got-your-ace-score/