Youth Depression Screening, Brief Intervention, and Referral to Treatment

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Why Screening Matters

New GPRA Depression Screening Measure
Youth Ages 12-17

Numerator	Denominator
Patients screened for depression or diagnosed with a mood disorder or suicide ideation at any time during the report period.	Active clinical patients, age 12-17.

Why Screening Matters

Behavioral Health Disorders
Most Likely to Appear During Adolescence (Ages 10 to 25)

- Mood disorders (depression, bipolar disorder).
- Substance abuse disorders (alcohol or drug dependence).
- Most anxiety disorders (generalized anxiety disorder, panic disorder).
- Obsessive-compulsive disorder.
- Most impulse control disorders (conduct disorder, oppositional defiant disorder).
- Eating disorders (anorexia, bulimia).
- Schizophrenia.

"Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," ***Archives of General Psychiatry 62*****, no.6 (2005).**

Youth Depression In Words and Pictures

Isabel, age 12

Youth Depression In Words and Pictures

Isabel, age 12

Youth Depression In Words and Pictures

DSM-V Diagnostic Criteria, Major Depressive Disorder

Criterion A, #1: Depressed mood, most of the day, nearly every day, as indicated by subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful)….

“I feel scared, hopeless, and confused.”
“I don’t know what’s going to happen to me.”
“I don’t even remember what it feels like to be happy.”

Youth Depression In Words and Pictures

DSM-V Diagnostic Criteria, Major Depressive Disorder

Criterion A, #1 (continued): … Note: In children and adolescents, can be irritable mood.

“I cut myself because I’m angry at myself.”
“I’m angry all the time.”
“Everybody irritates me.”
“My whole life is about rage.”

Youth Depression In Words and Pictures

DSM-V Diagnostic Criteria, Major Depressive Disorder

Criterion A, #7: Feelings of worthlessness or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

“I am disgusted and unhappy with myself.”
“I deserve to suffer because of the person I am.”
“I deserve to hurt because I disappoint my parents.”

Youth Depression In Words and Pictures

DSM-V Diagnostic Criteria, Major Depressive Disorder

Criterion A, #9: Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

"I want to kill myself because I'm not good enough."
"Life is hopeless. There is no point in trying anymore."
"I just want to get out of here."
"There is nothing anyone can do to help me."

National Evaluation Project

Tribal/Federal Sites Evaluated (10 States)

Catawba Indian Nation	South Carolina	Tribal
Cherokee Nation (Eastern Band)	North Carolina	Tribal
Cherokee Nation – Nowata	Oklahoma	Tribal
Cherokee Nation – Muskogee	Oklahoma	Tribal
Chitimacha Tribe of Louisiana	Louisiana	Tribal
Choctaw Nation – Stigler	Oklahoma	Tribal
Choctaw Nation – Idabel	Oklahoma	Tribal
Belcourt PHS Indian Hospital	North Dakota	Federal
Colorado Service Unit	Arizona	Federal
Colville Service Unit	Washington	Federal
Fort Hall Service Unit	Idaho	Federal
Gallup Service Unit (Navajo)	New Mexico	Federal
Mescalero Service Unit	New Mexico	Federal
Rosebud Service Unit	South Dakota	Federal

National Evaluation Project

Reported Barriers to Screening

- There isn't enough time to screen everyone.
- Staff don't receive adequate training in screening tools, procedures, and interventions.
- The organization doesn't use standardized tools or consistent screening methods.
- The medical and behavioral health departments don't work together.
- Patients don't understand that depression, substance abuse, and domestic violence aren't normal.
- Patients resist being screened because they don't believe they have a problem.
- Some patients don't answer the screening questions truthfully.
- Patients don't understand why they are being screened during some visits and not others.
- Shame and stigma prohibit identification and treatment.
- Many people don't come in for services annually.
- There aren't enough behavioral health staff to provide treatment.
- Referral resources are limited or are too far away.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Screen regardless of age, gender, race, ethnicity, or IHS eligibility status. • Disregard the GPRA definitions in regards to screening specific populations. • Screen all patients, whether they are included in the GPRA populations or not.	• Screening patients because they are Indian reinforces stigma. • Screening patients in specific age groups decreases patient trust. • Frequent screenings can help the patient begin to realize that these problems are not normal.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Screen all patients at all visits. • Integrate behavioral screenings into the usual and customary triage process.	• Reduce stigma. • Reduce resistance to screenings. • Identify problems earlier (situational depression, new DV situation). • Evidence suggests that patients with behavioral health issues utilize primary care more frequently than other patients.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Make behavioral health screenings a priority.	• Develop screening policies and procedures. • Verbally reinforce them. • Provide performance feedback. • It's easier to screen everyone. • Screenings become a normal and natural part of each patient visit. • All staff understand their roles and responsibilities.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Train the staff in screening and brief intervention methods. • Choose high quality, evidence-based screening tools. • Train staff on behavioral health screening best practices, and brief intervention techniques. • Training should emphasize consistency in tools and methods across all staff and departments. • Help the staff become more comfortable and efficient. • Even more crucial at sites with few behavioral health resources.	• Staff know screening is an expected routine. • Staff become more comfortable talking about behavioral health problems. • Staff understand how to deal with problems when they arise. • Staff become more efficient in delivering interventions. • In areas with few behavioral health providers, this may be the only intervention the patient will receive.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Screen even if there are no referral resources available.	• Reported screening even without any referral resources available. • Screenings are interventions. • Screenings are educational. • Patients, especially patients involved in domestic violence, will seek out primary care services when they believe their providers could help them.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Create an "open door" between departments. • Integrate behavioral health and medical providers as much as possible. • Integrate primary care and data entry staff as much as possible. • Create collaborative working environment.	• Better care coordination. • Better follow-up on referrals. • Better documentation in the system.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Provide patient education. • Handouts for safety planning. • Contact information for DV shelters. • Place patient education materials in discreet locations (bathroom stalls). • Educational materials on bulletin boards. • Handouts for adolescents during sports physicals.	• Providers will be intimately knowledgeable about referral resources in the area, and comfortable providing those referrals. • Knowing that options are available can help the patients make the choice to make changes in their lives.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Deliver brief interventions. • Talk to patients about positive screening results at every visit. • Focus on developing awareness about the issues and motivation to change. • Can be as little as one or two minutes. • Don't worry if the patient doesn't change.	• Patients learn that their providers want to help, and are able to help. • Providers begin to instill the idea that these problems aren't "normal." • Over time, with many patient interactions, the health organization is delivering a targeted, community-level intervention.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Train the staff on documentation. • Screenings primarily documented in the system fields picked up by IHS for GPRA reporting. • Screening result data in notes is secondary, not primary location for documentation.	• Information is documented consistently in the EHR. • Information is accurately reported to IHS for GPRA reporting. • Documentation becomes more efficient and more accurate. • Screening report results is a way to measure and track performance and improvement.

National Evaluation Project

Reported Best Practices

Best Practice	Benefits
Implement quality control measures. • Audit data regularly. • Provide feedback to staff to improve competency. • Retrain as needed.	• Data is more accurate. • Prevalence data and community-level data can be used to obtain a true picture of actual community needs. • Providers will receive feedback on their performance. • Areas of improvement will be identified.

National Evaluation Project

Reported Best Practices

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Screening Methods

PHQ-2

Questions	Answers				
During the past TWO (2) WEEKS, how much (or how often) have you been bothered by any of the following:	None Not at all	Slight Rare, less than a day or two	Mild Several Days	Moderate More than half the days	Severe Nearly every day
• Little interest or pleasure in doing things?	0	1	2	3	4
• Feeling down, depressed, or hopeless?	0	1	2	3	4

Screening Methods

PHQ-9

Questions	Answers				
During the past TWO (2) WEEKS, how much (or how often) have you:	None Not at all	Slight Rare, less than a day or two	Mild Several Days	Moderate More than half the days	Severe Nearly every day
Little interest or pleasure in doing things?	0	1	2	3	4
Feeling down, depressed, or hopeless?	0	1	2	3	4
Trouble falling or staying asleep, or sleeping too much?	0	1	2	3	4
Feeling tired or having little energy?	0	1	2	3	4
Poor appetite or overeating?	0	1	2	3	4
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	0	1	2	3	4
Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3	4
Moving or speaking so slowly that other people have noticed? Or the opposite, being so fidgety or restless that you've been moving around a lot more than usual?	0	1	2	3	4
Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3	4

Screening Methods

PHQ-9 Scores and Proposed Treatment Actions

PHQ 9 Score	Depression Severity	Proposed Treatment Actions
0-4	None-minimal	None
5-9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10-14	Moderate	Treatment plan, consider counseling, follow-up and/or pharmacotherapy
15-19	Moderately severe	Active treatment with pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management.

Screening and Intervention in Practice

Integrated Care Project with the Riverside-San Bernardino County Indian Health

Year 1 – Soboba, Morongo, San Manuel

About Riverside San Bernardino County Indian Health	
9 Federally-Recognized Reservations	8,604 Medical Patients (Per Year)
2 Counties (Riverside and San Bernardino)	27,903 Medical Visits (Per Year)
7 Health Centers	1,322 Behavioral Health Patients (Per Year)
31,908 Registered Patients	6,797 Behavioral Health Visits (Per Year)
14,019 Active Indian Users	

Screening and Intervention in Practice

Integrated Care Project with the Riverside-San Bernardino County Indian Health

Year 1 – Soboba, Morongo, San Manuel

Project Objectives	
Universally screen patients in the medical department	
Integrate behavioral health staff in the medical department	
Deliver 3 brief interventions in medical to patients with low/mild behavioral health problems	
Make referral/warm handoff to behavioral health department for patients with moderate to severe problems. Patients who do not accept the referral are offered 3 brief interventions in medical.	
Track patient appointment attendance and follow-up with patients who miss their appointments	
Develop policy and procedures for: • Screening process • Suicide risk evaluation • Brief intervention • Referral to behavioral health department	• Suicide intervention • Suicide attempt follow-up • Suicide postvention (patients exposed to suicide) • Domestic/intimate partner violence • Case management/follow-up

Screening and Intervention in Practice

Integrated Care Project with the Riverside-San Bernardino County Indian Health

Year 1 – Soboba, Morongo, San Manuel

Screening Goal		
All medical department patients, 10 years of age and older, regardless of gender identity, sexual orientation, race or ethnicity, insurance coverage, purpose of the visit, or physical/mental disability will be screened for behavioral health problems, according to the following pre-established parameters and settings, at every visit, during the vital routine:		
Tobacco Exposure	Annually	IHS
Tobacco Use	Annually	IHS
Alcohol Use	Quarterly	CAGE
Depression	Every Visit	PHQ2 (+) then PHQ9
Suicide Ideation	Every Visit	PHQ2 (+) then PHQ9
D/IP Violence	Every Visit	HITS
Non-Medical Drug Use	Quarterly	DAST-10 (Need to add)

Screening and Intervention in Practice

Integrated Care Project with the Riverside-San Bernardino County Indian Health

Year 1 – Soboba, Morongo, San Manuel

September 30, 2016 to May 10, 2017 (7.5 Months)

Depression Screening Results / PHQ 9

	10-17	18-25	26-54	55 or Older	
Mild	30	69	281	197	**577**
Moderate	16	36	159	81	**292**
Moderate-Severe	8	18	77	47	**150**
Severe	1	7	55	18	**81**
Total	**55**	**130**	**572**	**343**	

Total 1,100 positive reports of 4,677 reports

Screening and Intervention in Practice

Integrated Care Project with the Riverside-San Bernardino County Indian Health

Year 1 – Soboba, Morongo, San Manuel

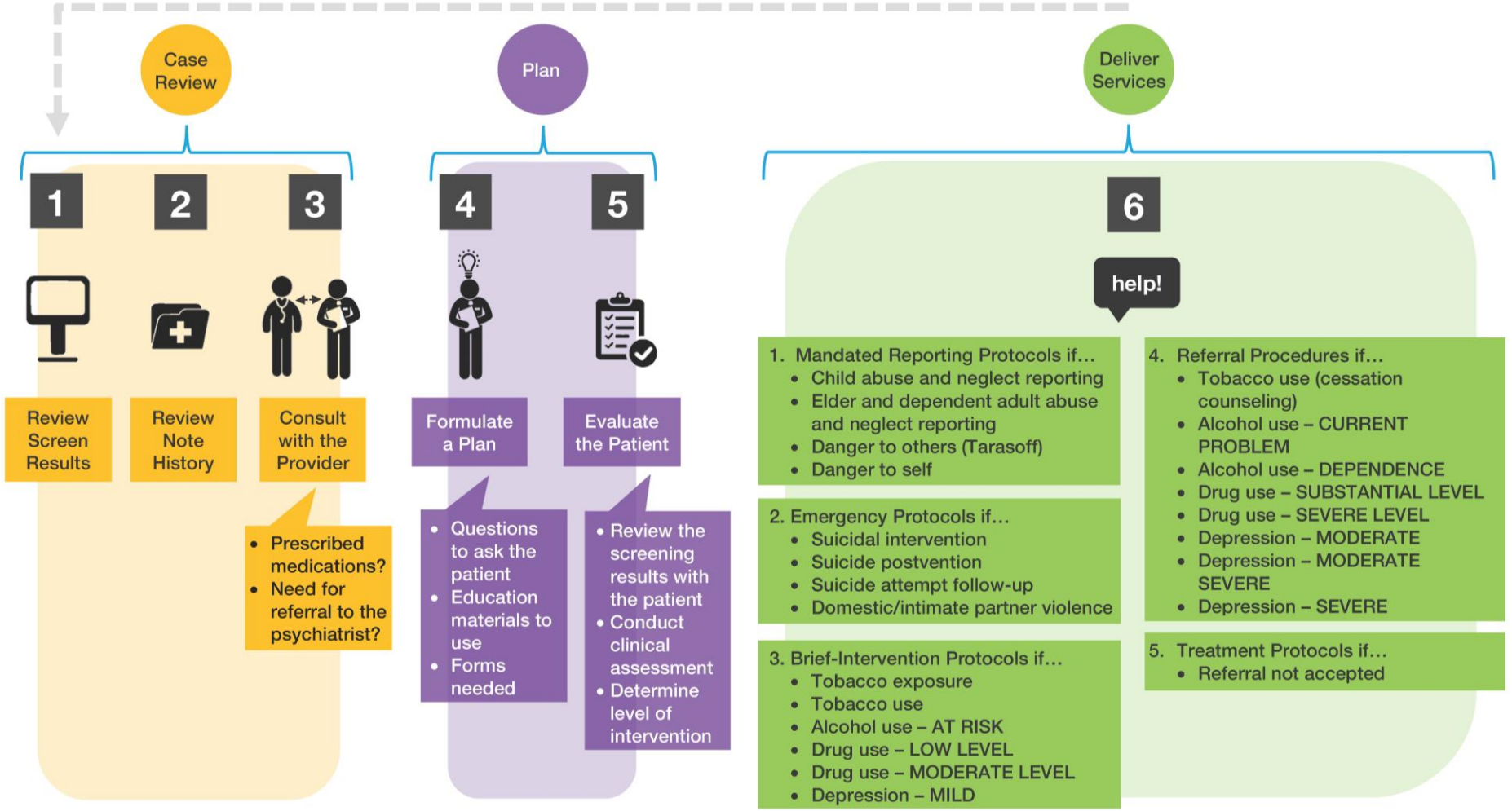
September 30, 2016 to May 10, 2017 (7.5 Months)

Suicide Ideation Results / PHQ 9

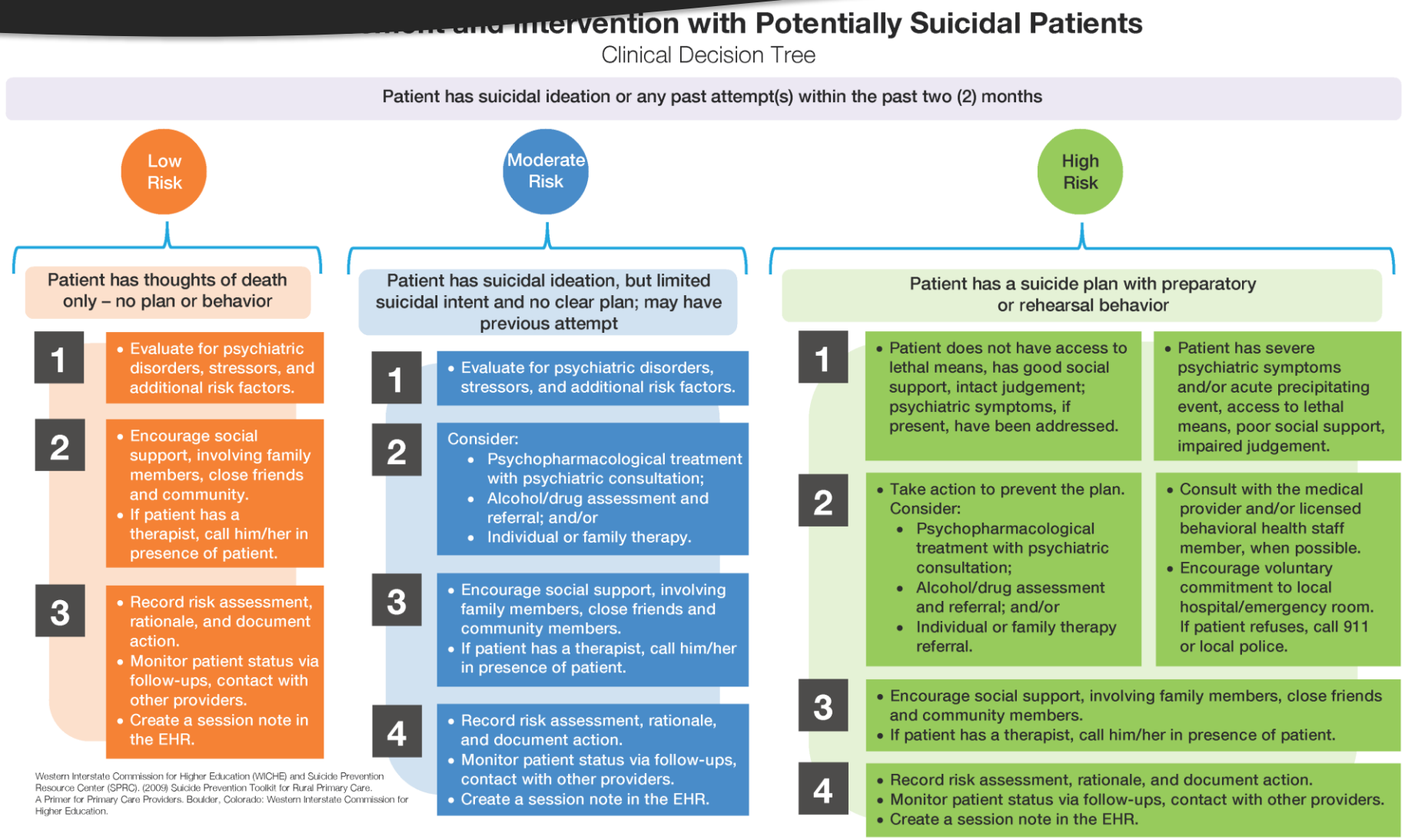
	10-17	18-25	26-54	55 or Older	
Several Days	14	13	47	32	**106**
More than Half the Days	3	10	17	12	**42**
Nearly Every Day	1	0	14	0	**15**
Total	**18**	**23**	**78**	**44**	

Total 163 positive reports of 1,505 screens

Screening and Intervention in Practice



Screening and Intervention in Practice



Western Interstate Commission for Higher Education (WICHE) and Suicide Prevention Resource Center (SPRC). (2009) Suicide Prevention Toolkit for Rural Primary Care. A Primer for Primary Care Providers. Boulder, Colorado: Western Interstate Commission for Higher Education.

Screening and Intervention in Practice

Integrated Care Project with the Riverside-San Bernardino County Indian Health

Year 1 – Soboba, Morongo, San Manuel

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Behavioral Health Screening Best Practices

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