Title: Depression and Suicide Risk Assessment in the Emergency Department	
Process Owner: Sara Goodwin, Hailey Sessions, Matthew Ackerman, Kiyora Nelson, Becca Wirthlin, Cecily Roberts, and Maddy van den Eikhof	**Date Approved**:
Approver(s): Sister DeMordaunt and Kevin McEwan	**Effective Date**:
Department(s): Emergency Department	**Next Review Date**:

Purpose/Summary:

Purpose: Provide efficient and effective screening for each patient in the emergency department for suicide and depression.
Summary: The policy outlines the assessment of patients in the emergency department for depression and suicide. Health care providers will evaluate patients on an individual basis to determine the need for further evaluation and treatment.

Definitions:

- **Adolescent Patients** - Unless otherwise specified, patients who are between 12 to 21 years of age (Hardin et al., 2017)
- **ASQ Ask Suicide-Screening Questions** - A suicide risk screening tool that includes four items to assess suicidal ideation (Mournet et al., 2021)
- **C-SSRS Colombia-Suicide Severity Rating Scale, Triage Vertion** - Brief suicide screening tool that can assess patients for suicide risk (The Joint Commision, 2019)
- **Depression** - A unipolar and disabling mental health problem noted by decreased interest in life and energy (Molebatsi et al., 2020)
- **EHR Electronic Health Record**
- **ED Emergency Department**
- **GDS Geriatric Depression Scale** - A depression screening form that has 15 questions geared toward the older adult population (Shin et al., 2019)

- **GSIS Geriatric Suicide Ideation Scale**- A self-reporting scale used to detect suicide ideation in the older adult population (Heisel & Flett, 2020)
- **MMH Madison Memorial Hospital**
- **MFQ Mood and Feelings Questionnaire -** Questionnaire that is designed to detect depressive signs and symptoms in pediatric and adolescent patients (Eg et al. 2018)
- **Pediatric Patients** - Unless otherwise specified, patients who are between 2 to 12 years of age (Hardin et al., 2017)
- **PHQ-9 Patient Health Questionnaire-9**- A depression screening tool to assess symptoms of depression in the past two weeks on a four point Likert scale (Mournet et al., 2021)
- **Screening** - A tool used to identify risks in patients (Mournet et al., 2021)
- **Suicidal Ideation** - Thoughts and behaviors a person has that are harmful to oneself (Chang et al., 2015)

Goals and Objectives:

1. Eighty percent compliance of ED nurses to complete the assessment of patients for suicide and depression measured through documentation (Quality, Ensuring Our Future).
2. Timely recognition of risk factors for suicidal ideation and depression in patients upon ED admission measured through documentation (Providing the Exceptional Experience, Ensuring Our Future).
3. Provide the help and resources necessary for those who are at risk before discharge measured through documentation (Quality, Ensuring Our Future).

The goals and objectives of this process interrelate to the hospitals goals and objectives as follows:

Quality: Guiding MMH health care providers to implement an evidence based procedure to ensure the highest quality of patient care.

Providing the Exceptional Experience: Ensures the patient will be assessed according to the most current research and information, ultimately receiving high quality care during their visit to MMH. Ensuring that MMH provides opportunities to further care and treatment for every patient.

Ensuring Our Future: Providing an effective, universal suicide screening to promote optimal mental health care, leading to an increased detection of depression and suicide to ensure the health and safety of individuals in the Madison community.

Equipment and Suitable Environment Needed:

- ASQ questionnaire
- C-SSRS Triage version
- GDS-15 questionnaire
- GSIS questionnaire
- Instructions or list of resources for patients who may be at risk for suicide such as a number of suicide hotline and address of a nearby crisis center
- Internet and computer access
- KADS questionnaire
- MFQ questionnaire
- 7PHQ-9 questionnaire
- Private room to conduct an assessment

Procedure:

Overview	Details
<u>Intro</u> **Assess Every Patient**	Nurses in the emergency department are responsible for deciding whether or not a patient needs hospitalization. Every patient should be assessed. (Betz & Boudreaux, 2016), (Kim & Lee, 2021).
<u>Step 1</u> **Ensure Medical Stability**	Address physical needs of patient Assess patient's ability and willingness to answer questions (Betz & Boudreaux, 2016), (Kim & Lee, 2021)
<u>Step 2</u> **Utilize Suicide Screening Tool**	Utilize C-SSRS Triage version (See Policy Attachments) - For age considerations see step 2.5 (The Joint Commission, 2019)

<u>Step 2.5</u> **Age Considerations for Suicide Screening**	**Geriatric patients:** Only utilize GSIS (See Policy Attachments) **Pediatric patients (<8 years old):** A full mental health evaluation should be done by a physician **Pediatric patients (8+ years old) & Adolescent patients (12+ years old):** Only utilize ASQ (See Policy Attachments) Military personnel, veterans, or those with a history of suicide attempts are considered higher risk. Follow age guidelines as specified above (Heisel & Flett, 2020), (National Institute of Mental Health, n.d.)
<u>Step 3</u> **Utilize Depression Screening Tool**	Utilize PHQ-9 survey (See Policy Attachments) - For age considerations see step 3.5 (Molebatsi et al., 2020)
<u>Step 3.5</u> **Age Considerations for Depression Screening**	**Geriatric patients:** Only utilize GDS-15 (See Policy Attachments) **Pediatric patients (6-10 years old)**: Only utilize MFQ (See Policy Attachments) **Adolescent patients (11-18 years old):** Only utilize KADS (See Policy Attachments) Military personnel and veterans are considered higher risk. Follow age guidelines above. (Eg et al., 2018), (Lowe et al., 2018), (Shin et al., 2019)
<u>Step 4</u> **Providing Interventions, Ensuring Safety and Conducting**	**<u>Suicide</u>**: Evaluate patient responses based on the screening tool If patient is at risk for suicide: - Notify physician

Further Assessment	- Refer to the MMH's suicide prevention policy **<u>Depression</u>**: Evaluate responses from the patient based on the screening tool If the patient is at risk for depression: - Notify physician - Refer to the MMH depression intervention policy (Molebatsi et al., 2020), (Mournet et al., 2021)
<u>Step 5</u> Monitoring and Measuring	The policy will be monitored and measured through the charge nurse pulling two charts every two weeks and assessing the EHR for the screenings of depression and suicide risk to see if they were completed by the nursing staff in a timely manner depending on the patient. (Sabe et al., 2021)

Internal References:

- Hospital EHR/documentation system
- List of local external resources for depression and suicide such as therapist, rehab centers, and hotline numbers

External References:

Betz, M. E., & Boudreaux, E. D. (2016). Managing suicidal patients in the emergency department. *Annals of emergency medicine*, *67*(2), 276–282. https://doi.org/10.1016/j.annemergmed.2015.09.001

Bryan, C. J., Allen, M. H., Thomsen, C. J., May, A. M., Baker, J. C., Harris, J. A., Bryan, A. O., & Russell, W. A. (2019). The PRImary care screening methods (PRISM) study: Rationale

and design considerations. *Contemporary Clinical Trials, 84*. https://doi.org/10.1016/j.cct.2019.105823

Chang, B. P., & Tan, T. M. (2015). Suicide screening tools and their association with near-term adverse events in the ED. *American Journal of Emergency Medicine*, *33*(11), 1680-1683. https://doi.org/10.1016/j.ajem.2015.08.013

Eg, J., Bilenberg, N., Costello, E. J., & Wesselhoeft, R. (2018). Self- and parent-reported depressive symptoms rated by the mood and feelings questionnaire. *Psychiatry Research*, *268*, 419–425. https://doi.org/10.1016/j.psychres.2018.07.016

Hardin, A.P., Hackell, J.M., & Committee on Practice and Ambulatory Medicine. (2017). Age limit of pediatrics. *Official Journal of the American Academy of Pediatrics*. *140*(3). https://doi.org/10.1542/peds.2017-2151

Heisel, M. J., & Flett, G. L. (2020). Screening for suicide risk among older adults: Asessing for preliminary psychometric properties of the brief geritatric suicide ideation scale (BGSIS) and the GSIS-screen. *Aging and Mental Health.* https://doi.org/10.1080/13607863.2020.1857690

Idaho Department of Health and Welfare. (2020). *Adult Mental Health Services* (16.07.33). https://adminrules.idaho.gov/rules/current/16/160733.pdf

The Joint Commision. (2019). *Suicide Prevention.* https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/

The Joint Commission. (2021). *Hospital: 2021 National patient safety goals.* https://www.jointcommission.org/standards/national-patient-safety-goals/hospital-national-patient-safety-goals/

Kim, H. J., & Lee, D. H. (2021). Predictive factors for the medical hospitalisation of patients who visited the emergency department with suicide attempt. *BMC Psychiatry*, *21*(1), 1-12. https://doi.org/10.1186/s12888-021-03089-2

Lowe, G. A., Lipps, G. E., Gibson, R. C., Jules, M. A., & Kutcher, S. (2018). Validation of the kutcher adolescent depression scale in a caribbean student sample. *CMAJ Open*, *6*(3), E248–E253. https://doi.org/10.9778/cmajo.20170035

Molebatsi, K., Motlhatlhedi, K. & Wambua, G.N. (2020). The validity and reliability of the patient health questionnaire-9 for screening depression in primary health care patients in Botswana. *BMC Psychiatry, 20*(1), 1-10. https://doi.org/10.1186/s12888-020-02719-5

Mournet, A. M., Smith, J. T., Bridge, J. A., Boudreaux, E. D., Snyder, D. J., Claassen, C. A., Jobes, D. A., Pao, M., & Horowitz, L. M. (2021). Limitations of screening for depression as a proxy for suicide risk in adult medical inpatients. *Journal of the Academy of Consultation-Liaison Psychiatry,* https://doi.org/10.1016/j.jaclp.2021.02.002

National Institute of Mental Health (n.d.). *Ask suicide-screening questions (ASQ) toolkit.* https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml

Sabe, M., Kaiser, S., & Niveau, G. (2021). Suicide in psychiatry and medical liability: A case series. *International Journal of Law and Psychiatry*, *74*. https://doi.org/10.1016/j.ijlp.2020.101671

Shahidullah, J. D., Forman, S. G., & Lekwa, A. J. (2020). Assessment and management of depression and suicidality: Pediatric resident perspectives on training and practice. *Families, Systems & Health*, *38*(2), 172-183. http://doi.org/10.1037/fsh0000484

Shin, C., Park, M. H., Lee, S.-H., Ko, Y.-H., Kim, Y.-K., Han, K.-M., Jeong, H.-G., & Han, C. (2019). Usefulness of the 15-item geriatric depression scale (GDS-15) for classifying minor and major depressive disorders among community-dwelling elders. *Journal of Affective Disorders*, *259*, 370–375. https://doi.org/10.1016/j.jad.2019.08.053

Requirements:

- "Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors." (The Joint Commission, 2021)
- "If an applicant meets the eligibility criteria, they may be eligible for adult mental health services through the Department. If an applicant does not meet the eligibility criteria, they may be referred to other appropriate services. All applicants are required to complete an Application for Mental Health Services. If an applicant refuses to complete the Application for Mental Health Services, the Department reserves the right to discontinue the screening process for eligibility. The eligibility screening must be directly related to the applicant's mental illness and level of functioning…" (Idaho Department of Health and Welfare, 2020)

Quality Assurance and Sustainability:

Upon hiring, there will be orientation training in depression and suicide care in MMH's ED for nurses to increase awareness for patients experiencing suicidal ideations or depression (Shahidullah et al., 2020). This will be a simulation experience taught by a qualified personnel

who teach appropriate signs to watch for in patients that are admitted in the ED. Once the staff member passes the training, they will need to be retrained and reevaluated each year.

Both physicians and nurses should have the same predictability in identifying patients suffering from depression or suicidal thoughts. Each year, healthcare providers in MMH's ED will be tested for their consistency in predicting signs and symptoms of depression and suicidal ideation to ensure a standardized approach to depression and suicide screening in the ED (Chang, 2015). This will include an online test and a group training to remind staff what to look for and how to address patients who are at risk for suicide. The signs and symptoms of depression should be acknowledged and brought to the attention of the psychiatrist or physician in the ED, so that the patient can be further evaluated and receive proper care.

The ASQ, C-SSR, GDS-15, GSIS, KADS, MFQ, and PHQ-9 screening tests at MMH need to be reevaluated for effectiveness, efficiency, and best evidence based practice each year to ensure that best practice is being used in the ED (Bryan, 2019). This can be done using tools such as accredited research databases to search for relevant data that provides the best suicide screening tools in that current year. These can include, but are not limited to CINAHL, MEDLINE, and EMBASE. This will be done by nurses at MMH who are designated by management.

Disclaimer:

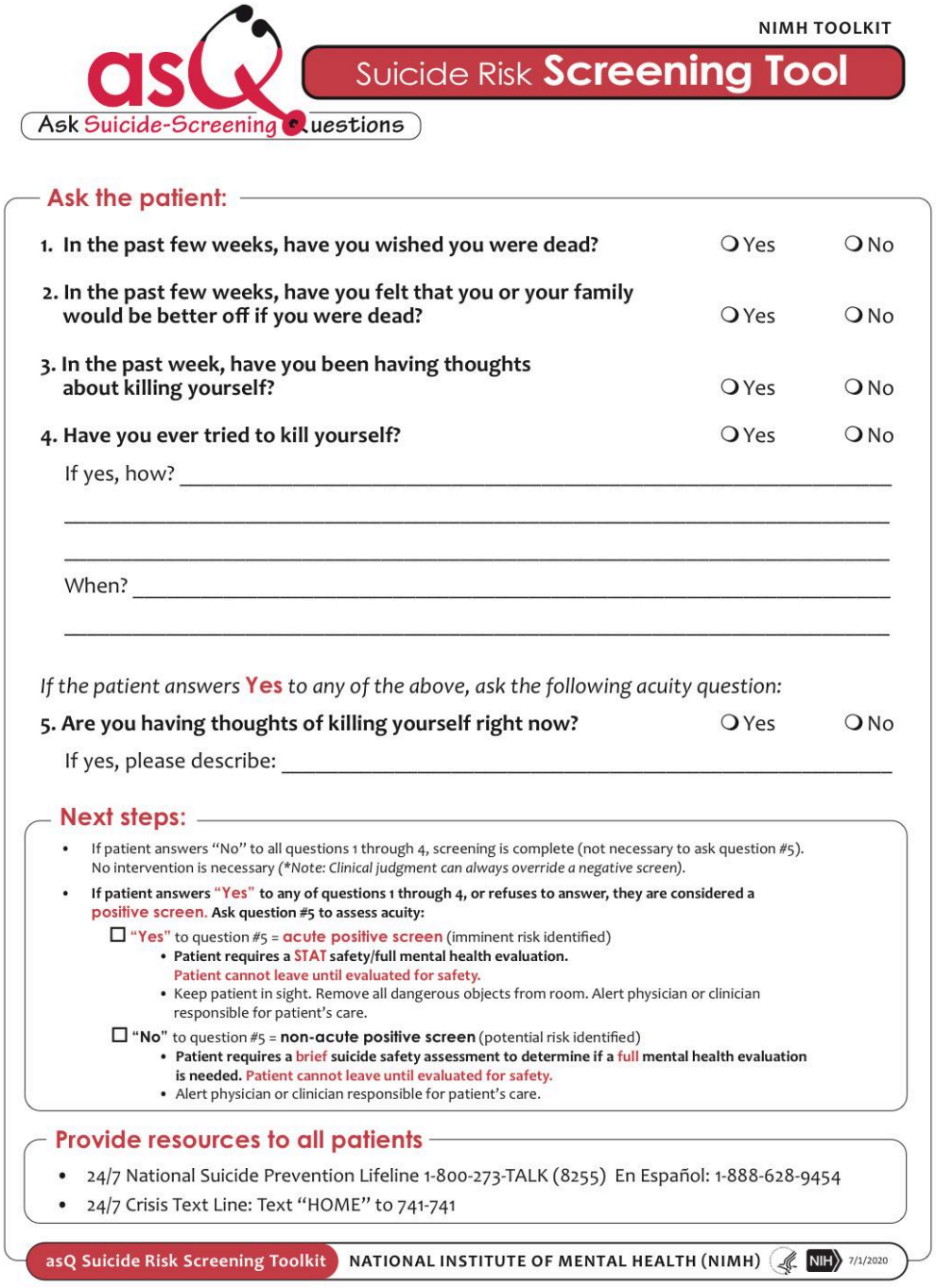
This policy is a resource to assist staff and not all circumstances may apply. The policy does not guarantee safety. Clinical situations may warrant adaption. Extenuating circumstances may apply.

Additional Resources:

Korczak, D. J., Finkelstein, Y., Barwick, M., Chaim, G., Cleverley, K., Henderson, J., Monga, S., Moretti, M. E., Willan, A., & Szatmari, P. (2020). A suicide prevention strategy for youth presenting to the emergency department with suicide related behaviour: Protocol for a randomized controlled trial. *BMC Psychiatry, 20*(1). https://doi.org/10.1186/s12888-019-2422-y

Attachments:

- ASQ survey-



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_155867.pdf

- C-SSRS triage version-

COLUMBIA-SUICIDE SEVERITY RATING SCALE
*Screen with Triage Points for **Emergency Department***

Ask questions that are bolded and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***	**Lifetime** **Past 3 Months**	

Item 1 Behavioral Health Referral at Discharge

Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

https://cssrs.columbia.edu/documents/screener-triage-emergency-departments/

- GDS-15 questionnaire -

try this:®
general assessment series
Best Practices in Nursing Care to Older Adults
From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing

Issue Number 4, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC
New York University College of Nursing

The Geriatric Depression Scale (GDS)

By: Sherry A. Greenberg, PhD(c), MSN, GNP-BC,
Hartford Institute for Geriatric Nursing, NYU College of Nursing

WHY: Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older with clinically significant depressive symptoms reaching 13% in older adults aged 80 and older (Blazer, 2009). Major depression is reported in 8-16% of community dwelling older adults, 5-10% of older medical outpatients seeing a primary care provider, 10-12% of medical-surgical hospitalized older adults with 23% more experiencing significant depressive symptoms (Blazer, 2009). Recognition in long-term care facilities is poor and not consistent amongst studies (Blazer, 2009).

Depression is not a natural part of aging. Depression is often reversible with prompt recognition and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive, functional, and social impairment, as well as decreased quality of life, delayed recovery from medical illness and surgery, increased health care utilization, and suicide.

BEST TOOL: While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage, et al., has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression.

The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued. It takes about 5 to 7 minutes to complete.

TARGET POPULATION: The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

VALIDITY AND RELIABILITY: The GDS was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation ($r = .84$, $p < .001$) (Sheikh & Yesavage, 1986).

STRENGTHS AND LIMITATIONS: The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.

FOLLOW-UP: The presence of depression warrants prompt intervention and treatment. The GDS may be used to monitor depression over time in all clinical settings. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicidality.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGeriRN.org.

The Stanford/VA/NIA Aging Clinical Resource Center (ACRC) website. Retrieved July 2, 2012, from http://www.stanford.edu/~yesavage/ACRC.html. Information on the GDS. Retrieved July 2, 2012, from http://www.stanford.edu/~yesavage/GDS.html.

Blazer, D.G. (2009). Depression in late life: Review and commentary. *FOCUS, 7*(1), 118-136.

Greenberg, S.A. (2007). How to Try This: The Geriatric Depression Scale: Short Form. *AJN, 107*(10), 60-69.

Harvath, T.A., & McKenzie, G. (2012). Depression in Older Adults. In M. Boltz, E. Capezuti, T.T. Fulmer, & D. Zwicker (Eds.), A. O'Meara (Managing Ed.), *Evidence-based geriatric nursing protocols for best practice* (4th ed., pp. 135-162). NY: Springer Publishing Company, LLC.

Koenig, H.G., Meador, K.G., Cohen, J.J., & Blazer, D.G. (1988). Self-rated depression scales and screening for major depression in the older hospitalized patient with medical illness. *JAGS, 36*, 699-706.

Sheikh, J.I., & Yesavage, J.A. (1986). Geriatric Depression Scale (GDS). Recent evidence and development of a shorter version. In T.L. Brink (Ed.), *Clinical Gerontology: A Guide to Assessment and Intervention* (pp. 165-173). NY: The Haworth Press, Inc.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M.B., & Leirer, V.O. (1983). Development and validation of a geriatric depression screening cale: A preliminary report. *Journal of Psychiatric Research, 17*, 37-49.

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.
A score ≥ 10 points is almost always indicative of depression.
A score > 5 points should warrant a follow-up comprehensive assessment.

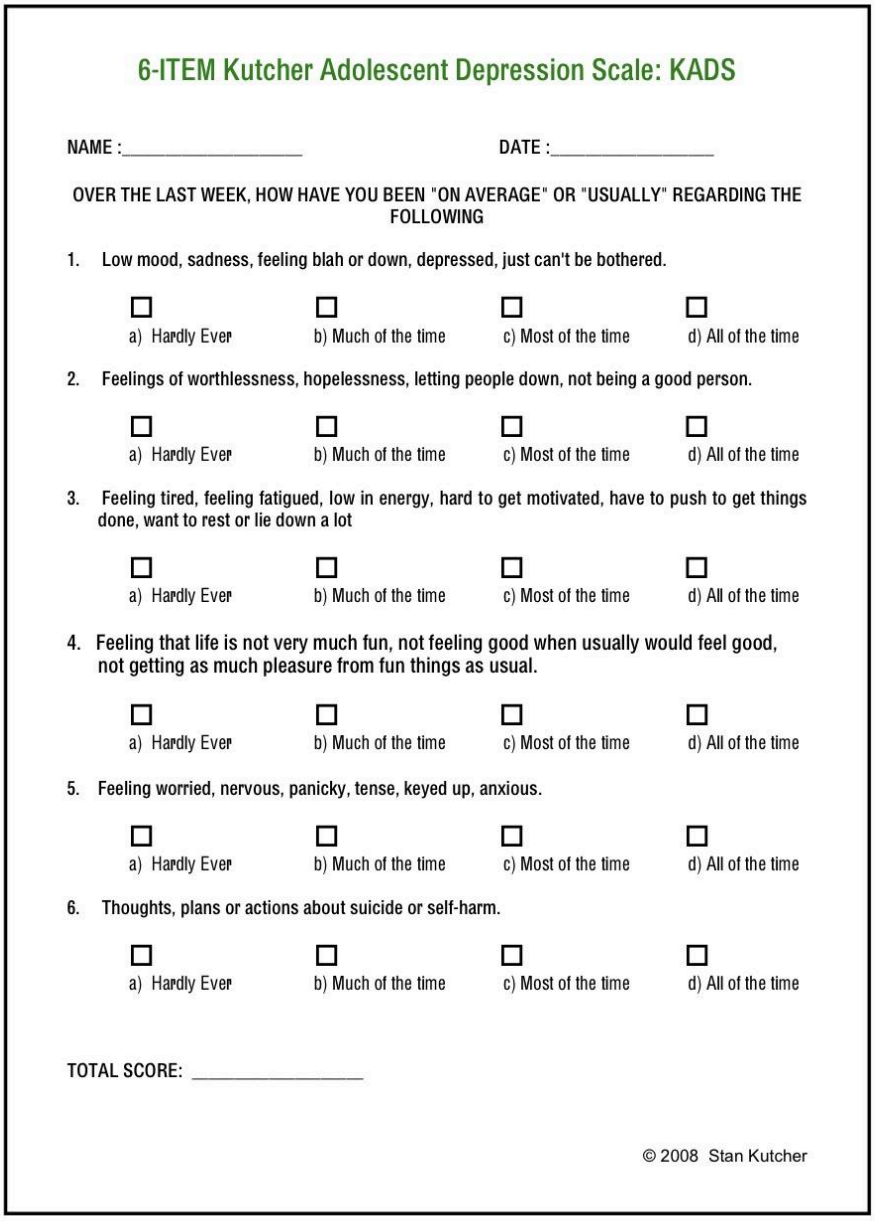
Source: http://www.stanford.edu/~yesavage/GDS.html
This scale is in the public domain.

The Hartford Institute for Geriatric Nursing would like to acknowledge the original author of this Try This, Lenore Kurlowicz, PhD, RN, CS, FAAN, who made significant contributions to the field of geropsychiatric nursing and passed away in 2007.

https://wwwoundcare.ca/Uploads/ContentDocuments/Geriatric%20Depression%20Scale.pdf

- GSIS questionnaire- Available only upon purchase https://www.tandfonline.com/doi/full/10.1080/13607863.2020.1857690

- KADS questionnaire-



6-ITEM Kutcher Adolescent Depression Scale: KADS

NAME :_____ DATE :_____

OVER THE LAST WEEK, HOW HAVE YOU BEEN "ON AVERAGE" OR "USUALLY" REGARDING THE FOLLOWING

1. Low mood, sadness, feeling blah or down, depressed, just can't be bothered.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

2. Feelings of worthlessness, hopelessness, letting people down, not being a good person.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

3. Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

4. Feeling that life is not very much fun, not feeling good when usually would feel good, not getting as much pleasure from fun things as usual.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

5. Feeling worried, nervous, panicky, tense, keyed up, anxious.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

6. Thoughts, plans or actions about suicide or self-harm.

☐ a) Hardly Ever ☐ b) Much of the time ☐ c) Most of the time ☐ d) All of the time

TOTAL SCORE: _____

6 - item KADS scoring:

In every item, score:

a) Hardly Ever = 0
b) Much of the time = 1
c) Most of the time = 2
d) All of the time = 3

then add all 6 item scores to form a single Total Score.

Interpretation of total scores:

Total scores at or above 6	Suggest 'possible depression' (and a need for more thorough assessment).
Total scores below 6	Indicate 'probably not depressed'.

Reference

- LeBlanc JC, Almudevar A, Brooks SJ, Kutcher S: Screening for Adolescent Depression: Comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory, Journal of Child and Adolescent Psychopharmacology, 2002 Summer; 12(2):113-26.

Self-report instruments commonly used to assess depression in adolescents have limited or unknown reliability and validity in this age group. We describe a new self-report scale, the Kutcher Adolescent Depression Scale (KADS), designed specifically to diagnose and assess the severity of adolescent depression. This report compares the diagnostic validity of the full 16-item instrument, brief versions of it, and the Beck Depression Inventory (BDI) against the criteria for major depressive episode (MDE) from the Mini International Neuropsychiatric Interview (MINI). Some 309 of 1,712 grade 7 to grade 12 students who completed the BDI had scores that exceeded 15. All were invited for further assessment, of whom 161 agreed to assessment by the KADS, the BDI again, and a MINI diagnostic interview for MDE. Receiver operating characteristic (ROC) curve analysis was used to determine which KADS items best identified subjects experiencing an MDE.

Further ROC curve analyses established that the overall diagnostic ability of a six-item subscale of the KADS was at least as good as that of the BDI and was better than that of the full-length KADS. Used with a cut-off score of 6, the six-item KADS achieved sensitivity and specificity rates of 92% and 71%, respectively—a combination not achieved by other self-report instruments. The six-item KADS may prove to be an efficient and effective means of ruling out MDE in adolescents.

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https://teenmentalhealth.org/wp-content/uploads/2014/09/6-KADS.pdf

- MFQ questionnaire-

Child Self-Report

MOOD AND FEELINGS QUESTIONNAIRE: Short Version

This form is about how you might have been feeling or acting **recently**.

For each question, please check (✓) how you have been feeling or acting ***in the past two weeks***.

If a sentence was not true about you, check NOT TRUE.
If a sentence was only sometimes true, check SOMETIMES.
If a sentence was true about you most of the time, check TRUE.

Score the MFQ as follows:
NOT TRUE = 0
SOMETIMES = 1
TRUE = 2

To code, please use a checkmark (✓) for each statement.	**NOT TRUE**	**SOME TIMES**	**TRUE**
1. I felt miserable or unhappy.			
2. I didn't enjoy anything at all.			
3. I felt so tired I just sat around and did nothing.			
4. I was very restless.			
5. I felt I was no good anymore.			
6. I cried a lot.			
7. I found it hard to think properly or concentrate.			
8. I hated myself.			
9. I was a bad person.			
10. I felt lonely.			
11. I thought nobody really loved me.			
12. I thought I could never be as good as other kids.			
13. I did everything wrong.			

https://devepi.duhs.duke.edu/files/2018/03/MFQ-Child-Self-Report-Short.pdf

- PHQ-9 survey -

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. 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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https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf