Prescribing Guidelines for Anxiety Disorders and Depression

PARTNERS FOR KIDS®

dayton children's

Prescribing for Anxiety Disorders and Depression

This document was developed by Dayton Children's Hospital in conjunction with Partners For Kids using evidence-informed clinical guidelines and expert opinion, where evidence is lacking, and is generally reflective of FDA approved indications and recommendations when available. It is designed to help primary care practitioners provide timely and effective treatment for children with mental health disorders. This document should not be considered a substitute for sound clinical judgment and clinicians are encouraged to seek additional information if questions arise. If therapeutic response is inadequate, refer to or consult with specialty behavioral health. Additional resources may be found by using the links below:

Dayton Children's Hospital Psychiatry Team	Project ECHO	PFK Quality Improvement
• Community providers may consult with a Dayton Children's Hospital psychiatrist. • To speak with one of the psychiatrists, call (937) 641-4385. The physician connection line facilitates physician-to-physician consults, connecting referring physicians with specialists at Dayton Children's to confer about a patient. • For further psychiatry department information please visit https://www.ChildrensDayton.org/patients-visitors/services/behavioral-health-3/programs-and-services/psychiatry	The Behavioral Health Primary Care ECHO (Extension for Community Healthcare Outcomes) series supports primary care providers through a variety of education sessions including: • Anxiety • Depression • ADHD • Trauma • Substance Use Disorders • And more **Click the link above, or go to:** NationwideChildrens.org/ECHO	Partners For Kids offers two behavioral health in primary care projects. They offer MOC (Part IV) credit and support from subject matter experts. The projects are focused on: • Depression screening and management • Suicide prevention **To learn more, click the link above or submit an email to the PFK QI team** PFKQICoaching@ChildrensDayton.org

Anxiety Disorders and Depression Overview

- Mild cases of anxiety and depression may resolve with lifestyle changes and supportive care (see GLADPC.org). Behavioral intervention is recommended for persistent symptoms or moderate to severe cases.
- Medications may be considered in moderate to severe cases. Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) are common medication classes used for anxiety disorders and depression.
- The medications listed below have FDA indication, or data is sufficient to endorse their use. Other SSRIs may be used effectively, although data is limited.

Screening for Anxiety Disorders

- **Generalized Anxiety Disorder-7 (GAD-7)**
  - The Generalized Anxiety Disorder-7 item scale (GAD-7) is a tool that can assist in identifying cases of generalized anxiety disorder in adolescents ages 12 and older.
  - This tool asks patients or their parents about the symptoms experienced within the past two weeks.
  - Scoring of the questionnaire is a total of numeric values in the GAD-7 grid and reflects the presence of anxiety symptoms, with higher scores reflecting a higher severity.
    - When screening for an anxiety disorder, a score of 10 or more represents the best combination of sensitivity and specificity to identify need for further evaluation of an anxiety disorder.
    - After a diagnosis is made, severity scores may be used to select appropriate treatment options and monitor response to therapy.
  - Providers are encouraged to use this tool to screen, monitor and optimize medication use for anxiety symptoms in children.
  - The GAD-7 questionnaire and scoring instructions can be found here:
    - https://www.phqscreeners.com/images/sites/g/files/g10060481/f/201412/GAD-7_English.pdf

- **Screen for Child Anxiety Related Disorders (SCARED)**
  - The Screen for Child Anxiety Related Disorders (SCARED) is a tool used to screen and monitor patients ages 8 to 18 for anxiety disorders.
  - The tool asks patients or their parents about their symptoms experienced within the past three months.
  - Scoring of the tool can be complex, but the increased complexity provides a greater level of details about the anxiety disorder(s).
  - Instructions for scoring of the tool can be found at the end of each questionnaire.
  - Providers are encouraged to use the tool to screen, monitor, and optimize medication use for anxiety symptoms in children.
  - The SCARED questionnaire can be found at:
    - Child version:
      - www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/ScaredChild.pdf
      - See pages 12-14
    - Parent version:
      - www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/ScaredParent.pdf
      - See pages 15-17

Treating Anxiety Disorders

- Anxiety may present as irritability/agitation or aggression in children depending on their developmental stage and may inadvertently be misdiagnosed as a behavior or other disorder.
- Cognitive Behavioral Therapy (CBT) is recommended for pediatric patients with anxiety disorders.
- Effective behavioral management strategies can be referenced here:
  - https://effectivechildtherapy.org/concerns-symptoms-disorders/disorders/fear-worry-and-anxiety/
- The medication management approach is found in the medication section on pages 6 through 8.

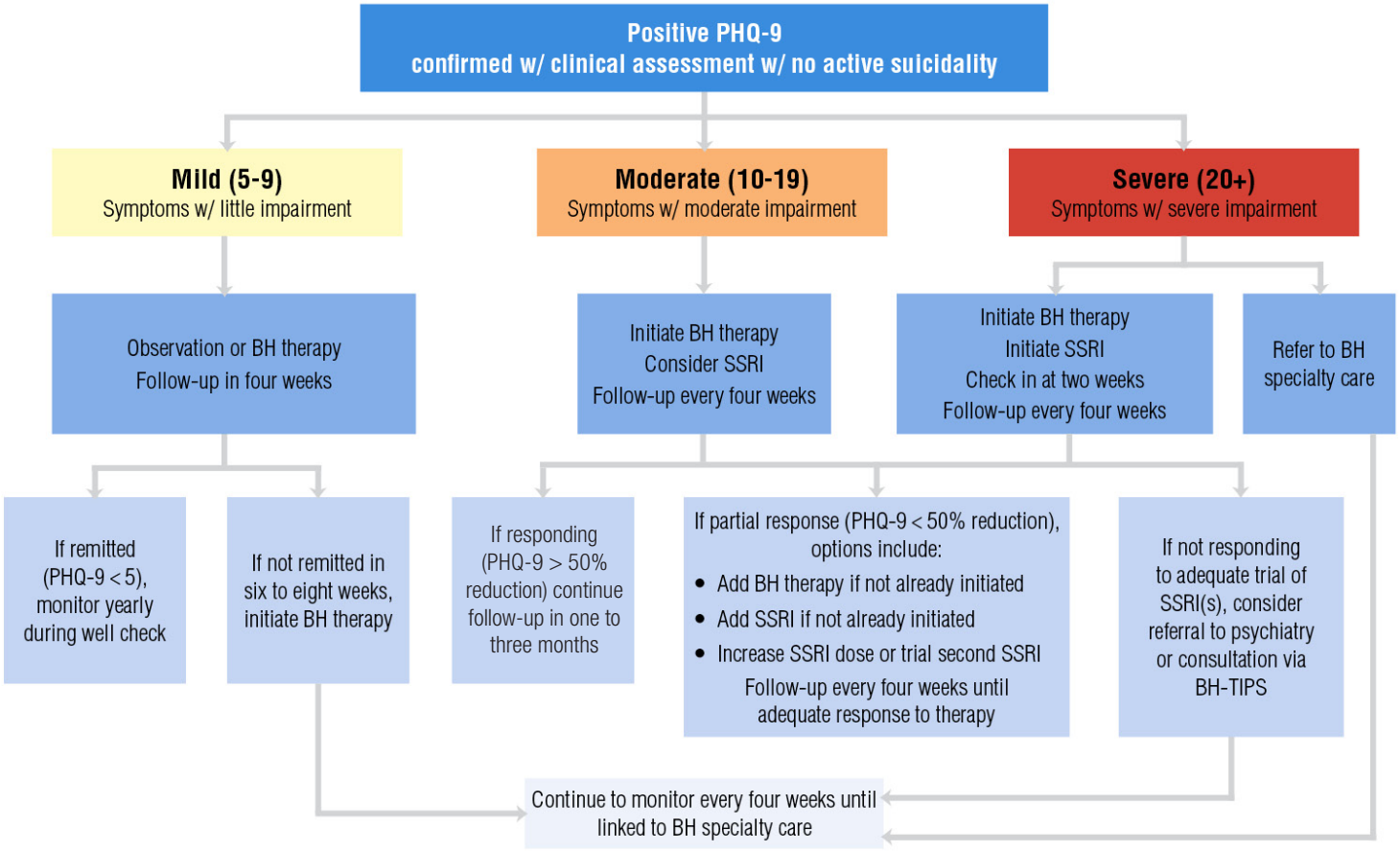
Screening for Depression

- Patient Health Questionnaire (PHQ-9 and PHQ-8)
  - The Patient Health Questionnaire (PHQ-9) modified for teens is a screening and monitoring tool for depression and suicide in adolescents ages 11 to 17.
  - The questionnaire asks patients about their symptoms experienced within the past two weeks.
  - Scoring of the questionnaire is a total of numeric values in the PHQ-9 grid and reflects presence of depressive symptoms, with higher scores reflecting increased symptoms.
  - The PHQ-9 questionnaire can be found at: www.hrsa.gov/behavioral-health/phq-9-modified-teens
  - Providers are encouraged to use this tool to screen, monitor and optimize medication use for depression symptoms and suicidal thoughts in children.
  - The ninth question of the PHQ-9 addresses suicidal ideation. The PHQ-8 can be used if the provider is not comfortable screening for suicide or responding to a positive screen.
  - The PHQ-8 questionnaire can be found at: https://selfmanagementresource.com/wp-content/uploads/2022/06/English_-_PHQ-8-1.pdf
  - Assessing suicide risk and appropriate management is out of scope for this document. Consider contacting Partners For Kids QI using the email on page 3 if interested in a suicide prevention quality improvement project.
    - National Suicide and Crisis Lifeline: Call 988

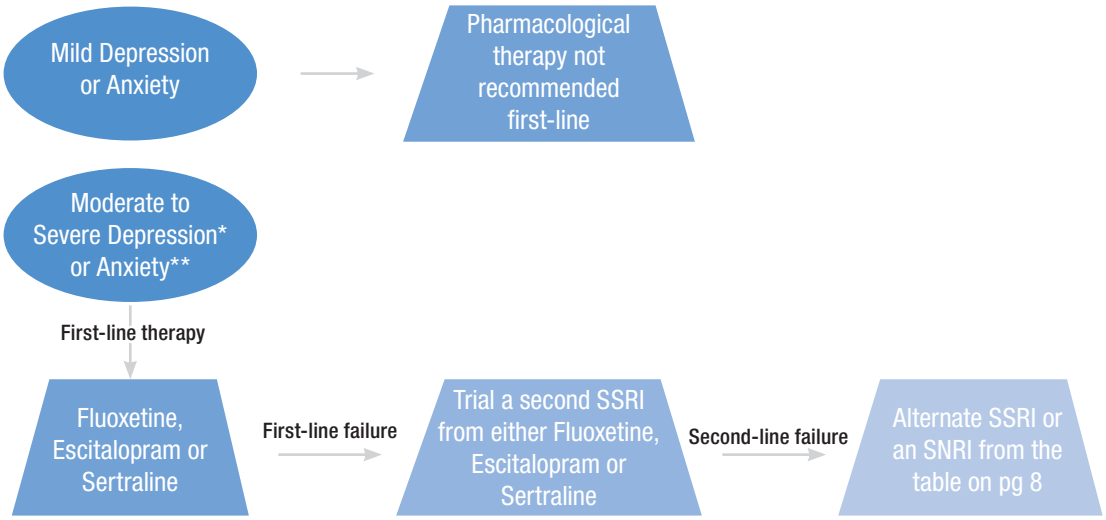
Treating Depression

- Depression may present as irritability/agitation or aggression in children depending on their developmental stage and may inadvertently be misdiagnosed as a behavior or other disorder.
- Symptoms of depression may require therapy with medications in addition to CBT or individual interpersonal psychotherapy (IPT).
- Effective behavioral management strategies can be referenced here:
  - https://effectivechildtherapy.org/concerns-symptoms-disorders/disorders/sadness-hopelessness-and-depression/
- The full medication management approach is found in the medication section on pages 6 through 8.

Depression Management Algorithm



SSRI and SNRI Medications for Treatment of Anxiety Disorders or Depression



*FDA age of approval for SSRIs in depression: Fluoxetine, 8 years | Escitalopram, 12 years | Sertraline, 18 years
**FDA age of approval for SSRIs in anxiety: Sertraline, 7 years | Escitalopram, 12 years | Fluoxetine, 18 years

- Educate patients that the full effect of an antidepressant may take up to six to eight weeks to be seen, but that some positive response should be apparent within two to four weeks.
- An important predictor of medication effect may come from parental or first-degree relative response to a particular medication. If a certain SSRI or SNRI worked well for a relative, it may have an increased chance of success in a related patient.
- Common side effects of antidepressants mentioned below may improve within one to two weeks:

Patient-related Considerations	Recommendations
Diarrhea	Increase hydration and fiber intake
Dry Mouth	Take in the morning Sip water frequently
Insomnia	Take in the morning
Nausea	Take with meals Eat frequent small meals

- Dayton Children's Hospital psychiatry team can assist with medication initiation and dose changes.
- Antidepressants contain a boxed warning indicating a possibility of increased suicidal thoughts and behaviors in adolescents (although no completed suicides have been reported due to SSRI initiation).
  - The risk for increased suicidal thoughts and behaviors is typically highest upon initiation of a new medication or dose change.
  - It is believed this risk is most present early in therapy due to an increase in energy that precedes the improvement in mood. Caregivers and patients should be counseled to be vigilant during the initiation period.
- Regarding serotonin syndrome:
  - Serotonin syndrome is a potentially life-threatening adverse effect that may result from the initiation of serotonergic medications.
  - Typically, serotonin syndrome is not a concern with single agents used within normal dosing limits.
  - The highest risk for serotonin syndrome is upon initiation of a new serotonergic medication in addition to other serotonergic medications a patient is already using.
  - Serotonin syndrome is characterized by the triad of symptoms: mental status changes (alterations of consciousness, confusion, agitation and/or loss of consciousness, etc.), autonomic hyperactivity (sweating, hypertension, tachycardia, etc.) and neuromuscular abnormalities (tremor, hyperreflexia, uncontrolled movements, etc.).
  - Serotonin syndrome should be suspected in the presence of the above symptoms in the setting of a recently started or dose elevated serotonergic agent, particularly in the presence of multiple agents. Serotonin syndrome also typically develops rapidly, usually over the course of 24 hours.
  - When serotonin syndrome is suspected, serotonergic medications should be immediately discontinued, and patients referred to emergency care for further diagnosis and support.

Medication List for Medicaid Plans

Drug*	Initial Daily Dose**	Titration Recommendation	Max Daily Dose	Strengths Available	Taper Recommendation***	Clinical Pearls
Selective Serotonin Reuptake Inhibitors (SSRIs)†						
Escitalopram (Lexapro®)	5-10 mg	5-10 mg every 2-4 weeks	20 mg	5 mg, 10 mg, 20 mg, 5 mg/5 mL	5 mg every 1-2 weeks	Risk of QTc prolongation is present, but less so than citalopram
Fluoxetine (Prozac®)	10-20 mg	10-20 mg every 4 weeks	60 mg	10 mg, 20 mg, 40 mg, 20 mg/5 mL	10 mg every 1-2 weeks	Consider for non-adherent patients due to long half-life. More likely to cause insomnia/agitation
Sertraline (Zoloft®)	25-50 mg	25-50 mg every 2-4 weeks	200 mg	25 mg, 50 mg, 100 mg, 20 mg/mL	25 mg every 1-2 weeks	Oral concentrate must be diluted with specific liquids immediately before use (e.g., water, orange juice, lemonade)
Citalopram (Celexa®)	10-20 mg	10 mg every 2-4 weeks	40 mg	10 mg, 20 mg, 40 mg, 10 mg/5 mL	10 mg every 1-2 weeks	Caution with use of doses >40 mg due to risk of QTc prolongation
Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)†						
Duloxetine (Cymbalta®)	30 mg	30 mg every 2 weeks	120 mg	20 mg, 30 mg, 60 mg	Gradually reduce dose over 2-4 weeks	Monitor for hypertension, dizziness, insomnia
Venlafaxine ER (Effexor ER®)	37.5 -75 mg	37.5 mg every 2-4 weeks	225 mg	37.5 mg, 75 mg, 150 mg, 225 mg	75 mg every week	Increased risk of night sweats. Gradually taper to minimize risk of withdrawal
Dopamine Norepinephrine Reuptake Inhibitors (DNRIs)†						
Bupropion ER (Wellbutrin XL®)	150 mg	Increase to 300mg after at least 2 weeks if adequate response not achieved	300 mg	150 mg, 300 mg	Gradually taper dose as tolerated***	May lower seizure threshold. Use caution in patients with epilepsy. Avoid use in patients with history of, or current diagnosis of, an eating disorder. The generic of Wellbutrin XL® is dosed once daily, Wellbutrin SR® is dosed twice daily

*All medications are preferred on the Ohio Department of Medicaid Unified Preferred Drug List (UPDL)
** Lower starting dose may be used if clinically indicated, or concerns regarding tolerability are present.
*** Taper schedules should be slowed if patients exhibit symptoms of withdrawal which is characterized by flu like symptoms, insomnia, nausea, imbalance, sensory disturbances, and irritability.
†FDA ages of approval for each agent in depression: Fluoxetine, 8 years | Escitalopram, 12 years | Sertraline, 18 years | Duloxetine, 18 years | Venlafaxine, 18 years | Bupropion, 18 years
†FDA minimum age of approval in any diagnosis: Sertraline, 6 years | Fluoxetine, 7 years | Duloxetine, 7 years | Escitalopram, 12 years | Venlafaxine, 18 years | Bupropion, 18 years

- Switching between medications in these classes often depends on several factors and requires individual medication and patient considerations such as half-life of current medication and risk of harm from worsening control during switching.
- The Dayton Children's physician connection line service can be utilized as a resource for provider to provider consult with a psychiatrist to assist with the medication switch approach if questions or concerns arise. The contact information is provided on page 3.

References

- Cheung AH, Zuckerbrot RA, Jensen PS, Laraqie D, Stein REK and the GLAD-PC Steering Group. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management. Pediatrics 2018;141;3.
- Walter HJ, Bukstein OG, Abright AR, et al. Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders. J Am Acad Child Adolesc Psychiatry. 2020 Oct;59(10):1107-1124.
- Detail-Document, Common Oral Medications that May Need Tapering. Pharmacist's Letter/ Prescriber's Letter. March 2016.
- Jensen PS, Cheung AH, Zuckerbrot RA, Levitt A. Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit. Version 3, 2018.
- Tanzi MG. Stopping antidepressants: Clinical considerations. Pharmacy Today. 2016;38.
- Clinical Resource, Choosing and Switching Antidepressants. Pharmacist's Letter/Prescriber's Letter. July 2020.
- Kweon K, Kim HW. Effectiveness and Safety of Bupropion in Children and Adolescents with Depressive Disorders: A Retrospective Chart Review. Clin Psychopharmacol Neurosci. 2019 Nov 20;17(4):537-541.
- Note: Drug information is compiled from data at Lexicomp Online®, online.lexi.com, Micromedex® www.micromedexsolutions.com, package inserts at DailyMed dailymed.nlm.nih.gov and clinical practice guidelines, in combination with psychiatry expert opinion where appropriate. Please refer to the specific medication's package insert for the most up to date information.

Generalized Anxiety Disorder 7-Item (GAD-7) Scale

Name: **Date:**

Over the last 2 weeks, how often have you been bothered by the following problems?	Not At All	Several Days	Over Half the Days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add Scores for Each Column	☐ +	☐ +	☐ +	☐
Total Score (Sum of Column Scores)				

If any of the above problems were identified, how difficult have these 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**

GAD-7 Important Notes and Scoring

The GAD-7 is based on the diagnostic criteria for GAD described in DSM-IV. *However, the GAD-7 is also sensitive to severity of symptoms of social phobia, post-traumatic stress disorder, and panic disorder.*

Please note: This questionnaire is designed for use by a health professional. Since the questionnaires rely on patient self-report, all responses 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 (e.g., presence of DSM-IV GAD symptoms). A diagnosis of Generalized Anxiety Disorder should not be made based on GAD-7 scores alone.

A score of 10 or greater indicates that further evaluation is required.

Scoring Criteria: Total score (adding all the numbers) provides a possible score from 0-21.

GAD-7 Total Score Symptom Range

0-4 Minimal Anxiety
5-9 Mild Anxiety
10-14 Moderate Anxiety
15-21 Severe Anxiety

References:
Dear, B. F., Titov, N., McMillan, D., Anderson, T., Lorian, C., Robinson, E., & Sunderland, M. (2011). Psychometric comparison of the GAD-7 and PSWQ for measuring response during internet treatment for Generalised Anxiety Disorder. *Cognitive Behaviour Therapy, 40(3)*, 216-227.

Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Medical Care, 46,* 266-274.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097. Swinson, R.P. (2006). The GAD-7 scale was accurate for diagnosing generalised anxiety disorder. *Evidence-Based Medicine, 11(6),* 184.

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, check √ the box that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe.				PA/SO
2. I get headaches when I am at school.				SCH
3. I don't like to be with people I don't know well.				SOC
4. I get scared if I sleep away from home.				SEP
5. I worry about other people liking me.				GA
6. When I get frightened, I feel like passing out.				PA/SO
7. I am nervous.				GA
8. I follow my mother or father wherever they go.				SEP
9. People tell me that I look nervous.				PA/SO
10. I feel nervous with people I don't know well.				SOC
11. I get stomachaches at school.				SCH
12. When I get frightened, I feel like I am going crazy.				PA/SO
13. I worry about sleeping alone.				SEP
14. I worry about being as good as other kids.				GA
15. When I get frightened, I feel like things are not real.				PA/SO
16. I have nightmares about something bad happening to my parents.				SEP
17. I worry about going to school.				SCH
18. When I get frightened, my heart beats fast.				PA/SO
19. I get shaky.				PA/SO
20. I have nightmares about something bad happening to me.				SEP

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.				GA
22. When I get frightened, I sweat a lot.				PA/SO
23. I am a worrier.				GA
24. I get really frightened for no reason at all.				PA/SO
25. I am afraid to be alone in the house.				SEP
26. It is hard for me to talk with people I don't know well.				SOC
27. When I get frightened, I feel like I am choking.				PA/SO
28. People tell me that I worry too much.				GA
29. I don't like to be away from my family.				SEP
30. I am afraid of having anxiety (or panic) attacks.				PA/SO
31. I worry that something bad might happen to my parents.				SEP
32. I feel shy with people I don't know well.				SOC
33. I worry about what is going to happen in the future.				GA
34. When I get frightened, I feel like throwing up.				PA/SO
35. I worry about how well I do things.				GA
36. I am scared to go to school.				SCH
37. I worry about things that have already happened.				GA
38. When I get frightened, I feel dizzy.				PA/SO
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).				SOC
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.				SOC
41. I am shy.				SOC

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under resources/instruments.

January 19, 2018

Screen for Child Anxiety Related Disorders (SCARED) CHILD Version

TO BE COMPLETED BY CLINICIAN

Name: _____ Date: _____

SCORING:

A total score of ≥ **25 may** indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. TOTAL=

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 **may** indicate **Panic Disorder** or **Significant Somatic Symptoms**. PA/SO =

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 **may** indicate **Generalized Anxiety Disorder**. GA=

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 **may** indicate **Separation Anxiety Disorder**. SEP=

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 **may** indicate **Social Phobic Disorder**. SOC =

A score of **3** for items 2, 11, 17, 36 **may** indicate **Significant School Avoidance Symptoms**. SCH=

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.,
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

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January 19, 2018

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, check √ the box that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe.				PA/SO
2. My child gets headaches when he/she is at school.				SCH
3. My child doesn't like to be with people he/she doesn't know well.				SOC
4. My child gets scared if he/she sleeps away from home.				SEP
5. My child worries about other people liking him/her.				GA
6. When my child gets frightened, he/she feels like passing out.				PA/SO
7. My child is nervous.				GA
8. My child follows me wherever I go.				SEP
9. People tell me that my child looks nervous.				PA/SO
10. My child feels nervous with people he/she doesn't know well.				SOC
11. My child gets stomachaches at school.				SCH
12. When my child gets frightened, he/she feels like he/she is going crazy.				PA/SO
13. My child worries about sleeping alone.				SEP
14. My child worries about being as good as other kids.				GA
15. When my child gets frightened, he/she feels like things are not real.				PA/SO
16. My child has nightmares about something bad happening to his/her parents.				SEP
17. My child worries about going to school.				SCH
18. When my child gets frightened, his/her heart beats fast.				PA/SO
19. He/she gets shaky.				PA/SO
20. My child has nightmares about something bad happening to him/her.				SEP

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the PARENT)

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23. My child is a worrier.				GA
24. My child gets really frightened for no reason at all.				PA/SO
25. My child is afraid to be alone in the house.				SEP
26. It is hard for my child to talk with people he/she doesn't know well.				SOC
27. When my child gets frightened, he/she feels like he/she is choking.				PA/SO
28. People tell me that my child worries too much.				GA
29. My child doesn't like to be away from his/her family.				SEP
30. My child is afraid of having anxiety (or panic) attacks.				PA/SO
31. My child worries that something bad might happen to his/her parents.				SEP
32. My child feels shy with people he/she doesn't know well.				SOC
33. My child worries about what is going to happen in the future.				GA
34. When my child gets frightened, he/she feels like throwing up.				PA/SO
35. My child worries about how well he/she does things.				GA
36. My child is scared to go to school.				SCH
37. My child worries about things that have already happened.				GA
38. When my child gets frightened, he/she feels dizzy.				PA/SO
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).				SOC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.				SOC
41. My child is shy.				SOC

The SCARED is available at no cost at www.pediatricbipolar.pitt.edu under resources/instruments.

January 19, 2018

Screen for Child Anxiety Related Disorders (SCARED) PARENT Version

TO BE COMPLETED BY CLINICIAN

Name: _____ Date: _____

SCORING:

A total score of ≥ **25 may** indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 **may** indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PA/SO =**

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A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 **may** indicate **Separation Anxiety**. **SEP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 **may** indicate **Social Phobic Disorder**. **SOC =**

A score of **3** for items 2, 11, 17, 36 **may** indicate **Significant School Avoidance**. **SCH =**

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.,
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

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January 19, 2018

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ☐ **Female** ☐ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(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?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Instructions to Clinicians

The Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

$$\frac{(\text{Raw sum} \times 9)}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

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