Children’s Hospital of Pittsburgh
Continuity Clinic Curriculum

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Topic: Improving Mental Health Screening in Pediatric Primary Care

Learning Objectives:

After completing the following educational materials, viewers will be able to:

1. Use the Edinburgh Postnatal Depression Scale (EPDS) to guide counseling and referral for Baby Blues and Postpartum Depression.

2. Use the Pediatric Symptom Checklist (PSC) to guide counseling and referral for behavioral problems in children 4-16 years old.

3. Use the Patient Health Questionnaire (PHQ9) to guide counseling and referral for depression in adolescents 11 years or older.

4. Recognize the availability of more specific screening tools for: anxiety (SCARED), depression (PHQ-9; BDI (Beck Depression Inventory), MFQ (Mood and Feelings Questionnaire), and CDI (Child Depression Inventory)), and substance use disorders (CRAFFT).

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Background

In June 2010, the AAP published an entire supplement to Pediatrics dedicated to enhancing pediatric mental health care.

*Much of the information shared in this module is drawn from this supplement.*

The Task Force that worked on this supplement set 3 goals:

1. Facilitate Systems Change
2. Build Skills
3. Incrementally Change Practice

Among others, this supplement includes articles aimed at enhancing pediatric mental health care, including Strategies for Preparing a Community, Strategies for Preparing a Primary Care Practice, Mental Health Screening and Assessment Tools and Algorithms for Primary Care.

Definition of mental health (AAP supplement)

…”mental” is intended to encompass “behavioral,” “neurodevelopmental”, “psychiatric”, “psychological”, “socio-emotional”, and “substance abuse”, as well as adjustment to stressors such as child abuse and neglect, foster care, separation or divorce of parents, domestic violence, parental or family mental health issues, natural disasters, school crises,…. (Foy JM, AAP Task Force on Mental Health. Introduction. Pediatrics 2010; 125 p S69).

The extent of mental health problems in the US *:

- 9 – 14% of children birth – 5 years old experience social-emotional problems that cause suffering to the child and family and interfere with functioning.
- ~ 21% of children and adolescents meet diagnostic criteria for a mental health disorder and have evidence of at least minimal impairment; approximately half of these children have significant functional impairment (severe emotional disturbance).
- ~ 16% of children and adolescents do not meet criteria for a disorder but have some impairment.
- Half of adults with a mental health disorder had symptoms by 14 years old.
- Based on the Symptom Checklist completed in primary care settings, ~ 13% of school-aged children and 10% of preschool-aged children have parents who present with "concerns" about their children, although their children are functioning reasonably well.
- Unidentified mental health conditions such as anxiety and depression, particularly in children with chronic medical conditions, are a significant force that drives utilization of medical services.

Screening:

To incrementally change clinical practice, we need to implement additional mental health screening tools during preventative care visits. It is important to use screening tools (instruments or measures) that have been shown to have a high degree of reliability, validity, sensitivity and specificity.

This module will present a number of mental health screening tools and their uses in pediatric primary care settings.

Resources:

You should have resources available to address problems that are identified by screenings. Suggested resources can be found at the end of this module.

PART 1: SCREENING FOR MATERNAL and PATERNAL DEPRESSION

It is important to screen for parental depression, as parental mental health impacts children. Some forms of parental depression and mental health concerns are described below.

Maternal Pregnancy Related Mood Disorders

Baby Blues

- Normal postpartum mood reactivity: experienced by most (50-70%) new mothers
- Begins 3–4 days after delivery; resolves by 10–14 days postpartum
- No specific risk factors
- Treatment includes reassurance and validation of experience as well as monitoring for worsening symptoms

Maternal Perinatal Depression is a prevalent condition that affects 1 in 8 women during the postpartum year. This condition negatively impacts child outcomes, and is therefore a pediatric problem. It leads to:

- Increases in health care utilization
- Child sleep problems
- Less secure attachment
- Behavioral problems

Postpartum Depression (PPD):

According to the DSM-V, to be diagnosed with postpartum depression, women must meet the criteria for both major depressive episode and the criteria for the postpartum onset (i.e., when symptom onset appears within 4 weeks of delivery). Note: the term has been used for women with symptoms up to 6–12 months postpartum.

- Criteria for major depressive episode: ≥ 5 of 9 symptoms below (at least one symptom must be item 1 or 2 in the list)
1. Depressed mood most of the day, nearly every day
2. Marked loss of interest or pleasure (anhedonia)
3. Appetite disturbance or significant weight loss or gain
4. Sleep disturbance
5. Physical agitation or psychomotor slowing
6. Fatigue, diminished energy
7. Feeling of worthlessness, excessive guilt
8. Reduced ability to think, concentrate, make decision
9. Recurrent thoughts of death or suicide

Also, these symptoms must negatively affect daily functioning and cannot be accounted for due to illness, substance use or bereavement

- If untreated, mean duration ~ 7 months
- Those at higher risk include women with:
  - Young age, low SES, poor social support
  - Family history of mood disorder
  - Past depression: 25 – 40% risk of PPD
  - Prior PPD: 30 – 50% risk of recurrence

Postpartum Psychosis:
- Risk for infanticide & suicide
- Rare: ~ 1% of worldwide population
- Begins within 4 weeks of delivery
- Can’t tell by appearance, dress, behavior
- Most commonly a manifestation of bipolar disorder
  - Includes symptoms of depression plus ≥ 1 episode of mania

Screening Questions for Psychosis:
- “Do you have thoughts that other people might consider unusual?”
- To elicit thoughts of paranoia (“Do you feel in danger or that anyone is trying to harm you?”).

Paternal Perinatal Depression
- Depression is more common in men in the postpartum year with rates of 10-15% as compared to men in the general population with rate of 5%.
- There is a correlation between maternal and paternal perinatal depression, and paternal perinatal depression appears in 24–50% of men whose partners are experiencing postpartum depression.
- The highest rates of paternal perinatal depression are 3-6 months postpartum.
- Based on statistical data, males are more likely to commit suicide.
- Children of fathers who have depression during the postnatal period are at increased risk of behavioral problems at age 3–5 years old, even after maternal depression and other factors had been controlled for.
Note: In Children’s Hospital of Pittsburgh’s (CHP) primary care (PCC) sites (Oakland and Turtle Creek), we screen mothers for perinatal depression with the Edinburgh Postnatal Depression Scale (EPDS) (presented below) at newborn, 2, and 6 months WCC visits.

If you are working in a setting other than the PCC, please check with your preceptor about the screening tools that are being used in your practice.

SCREENING TOOLS

The Edinburgh Depression Scale (EPDS)

Open the link to review the instructions and scale: [The Edinburgh Depression Scale (EPDS)](link).

Open the attached PDF, [EPDS Maternal includes CHP Questions](pdf) to view the scale with points assigned to each response choice. It includes the additional 2 questions used at CHP PCCs because of the increased risk associated with past history of mood disorders:

- Have you ever had depression, bipolar disorder or schizophrenia? NO YES
- IF YES, are you currently getting help or treatment? NO YES

Scoring the EPDS

- Add the numbers associated with each answer to obtain the total score: min score = 0; max score = 30.
- Higher score indicates higher quantity of symptoms.
- Possible Depression: Score of 10 or greater.
- Always look at item #10 (suicidal ideation).

**Key Point: If item 10 is anything other than zero, ask additional questions.**

- If your questions confirm suicidal ideation, call a crisis center.
- In Allegheny County, call [re:solve Crisis Network](phone): 1.888.7.YOUCAN (1-888-796-8226) before the family leaves your office.

A depression screening decision tool is available to guide you in making decisions regarding next steps if a screen suggests a problem. **For the following two cases, use the Depression Screening Decision Tool* to help you develop a plan.** (*From: Keyser D (Ed) Building bridges: lessons from a Pittsburgh partnership to strengthen systems of care for material depression.)

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**Case 1:**

**Age of infant: 5 days**

Interpret the mother’s [completed EPDS](completed). Then, review the [Depression Screening Decision Tool](tool).

**Question:** How do you interpret this EPDS and what will you do?
Answer:

- Total score = 13 and #10 = 0. Mother does not have a PMH of depression or other mental health illnesses
- Mother is only 5 days postpartum
- Follow algorithm – mother likely has Baby Blues
- Plan
  - Discuss Baby Blues with mother – explain that it is a normal reaction to birth (50-70% of women experience some symptoms of Baby Blues)
  - Counsel that symptoms should improve by 2 weeks postpartum and that if symptoms worsen or don’t get better, she should return to clinic and further evaluation should be considered
  - Administer the EPDS again at the next scheduled visit (either 1 month infant weight check or 2 month well visit)

Case 2

Age of Infant: 6 MONTHS

Interpret the mother’s completed EPDS. Then, review the Maternal Depression Screening Decision Tool.

Question: How do you interpret this EPDS and what will you do?
Answer:
- Total score = 17 and #10 = 2.
- Mother has a PMH of depression or other mental health illnesses
- Mother is 6 months postpartum
- Follow algorithm – mother must be assessed for suicidal ideation
- Plan at CHP PCC (in other practices, please check with your preceptor)
  - Ask the mother more about her situation – including any plans she may have for hurting herself (suicidal ideation, SI) or others.
  - Ask about access to weapons, especially firearms.
  - If confirmed SI, get verbal consent from the mother to call a local crisis network and arrange an evaluation. (In Allegheny County, PA this is re:solve Crisis Network). The mother must consent to this evaluation.
  - The re:solve evaluation can be conducted either in the office or the mother’s home (mother’s home only if the counselor, after talking directly with the mother via phone, feels this is a safe option).
  - If the mother does not give verbal consent and you feel she is a flight risk or in imminent danger – Call re:solve Crisis Network and CHP Security for guidance. Note: CHP security can ONLY detain the mother if you have a 302 (involuntary commitment) or if she is a danger to others (i.e., unable to adequately care for her infant).
  - Please note that if the mother has SI with a plan, you can also call the Western Psychiatric Institute and Clinic Emergency Room (the Diagnostic Evaluation Center, DEC) at 412-647-9380 for guidance and assistance.
  - Make any arrangements necessary for any children with the mother.
PART 2: SCREENING SCHOOL AGED CHILDREN FOR BEHAVIORAL CONCERNS

Screening Tool: The Pediatric Symptom Checklist (PSC) (authors: Jellinick MJ, Murphy JM, Bishop SJ, Pagano M)

- Psychosocial screen to facilitate recognition and treatment of cognitive, emotional and behavior problems in children
- Validated in children ages 4–16 years old
- Created by Michael Jellinick et al for use during primary care visits
  - Parent version (parent completes for their child)
  - Youth version (completed by children 11–16 years old)
  - Available in various languages: [http://www2.massgeneral.org/allpsych/psc/psc_forms.htm](http://www2.massgeneral.org/allpsych/psc/psc_forms.htm)

**Scoring**

- Responses are: NEVER (0); SOMETIMES (1); and OFTEN (2)
- Score by adding the points of responses for all items (max score 70)
  - Skipped items are counted as 0
  - If 4 or more items are skipped, the questionnaire is not valid
- Positive score suggests the need for further evaluation.
  - Ages 4–5 cutoff: 24 or higher (parent version) (scores on school-related questions 5, 6, 17 & 18 omitted)
  - Ages 6–18 cutoff: 28 or higher (parent version)
  - Youth version cutoff: 30 or higher
- Scores above the cut-off are seen in 5–20% of most populations. This range reflects how economic and cultural factors impact psychosocial functioning and reporting. As an example, poverty is a major stressor with a higher burden of psychosocial dysfunction. Thus, it increases the percentage of children with a positive score.
- The recommended cutoff score of 28+ is based upon large samples of patients in the U.S and identifies ~12% of at risk children.

**Additional Features**

- Screen characteristics: 2 of 3 children screened will be correctly identified with moderate to serious impairment of psychosocial functioning. The 1 child “incorrectly” identified usually has at least mild impairment or an overanxious parent. Data suggests a negative screen has 95% accuracy. The possibility for false positives and negatives emphasizes the need for an experienced clinician to interpret the PSC scores.
- The PSC does not provide a diagnosis but screens for impairment of psychosocial functioning. It also does not suggest whether specific treatment is needed. These are important points to keep in mind when using this screen and talking with families.
• Screening for impairment can lead to providing intervention earlier in the course of a disease. Extent of functional impairment or severity of symptoms is a key component for determining treatment options.

• Positive screens should be referred to a qualified behavioral health specialist for further screening and determination of psychosocial functioning. If parents are not ready to accept the referral, these children should be re-screened at a later date to see if impaired functioning persists.

Case 3:

A mother and father bring their 11 year old daughter, Amanda, to see you for WCC. They have some concerns that Amanda is getting into trouble at school lately. She got into a fight and was suspended. She also fights a lot with her younger and older siblings. When pushed, the parents say she had similar problems since she was younger, but the symptoms seem to be worse lately. She also has frequent complaints about belly pain. The parents completed the following PSC together.

Question: How do you interpret this screen, and what do you do next?

[Click here to open the PSC Screen completed by Amanda’s parents.]
**Answer:**

This child's PSC screen score (32) clearly is above the threshold for Amanda's age and warrants a discussion with the parents regarding your concerns about her psychosocial functioning.

- A referral to a behavioral health specialist is appropriate to determine the extent of any impairment, provide a possible diagnosis and define the appropriate treatment options.

- A secondary screen may be appropriate, depending on the availability of on-site behavioral health resources. You may refer to a behavioral health specialist for additional screening, or if you are experienced with other Behavioral Health screening tools, you might use the SCARED screen if the child appears anxious. If the child appears depressed, you might use the Beck Depression Inventory (BDI), Patient Health Questionnaire (PHQ-9) or the Mood and Feelings Questionnaire (MFQ). Brief mention of these screens follows.

**Secondary Screens**

As a pediatric clinician, you can administer a more specific secondary screen to better define what the problem is, especially if the parents or child are not ready for referral to a mental health provider. Examples of these screens are mentioned briefly below. They all take 5–10 minutes to administer and seconds to score. You will receive some practice with the PHQ-9 in this module. (In the PCC, copies of these secondary screens are located in the wall bins in the exam rooms.)

- **SCARED** - screen developed to detect anxiety disorders in children 8+ years old. [Parent version](#). [Child version](#). (Developed by Bermaher et al in 1995)
- **Beck Depression Inventory (BDI)** - another screen for depression in children with two different screens in ages 7–14 and 13+ years old (tests must be purchased).
- **Mood and Feelings Questionnaire (MFQ)** (long versions) - specific screens for depression in children and adolescents 7 – 18 years-old. [Parent version](#). [Child version](#). (Developed by Angold & Costello in 1987). [Article on validity and scoring](#).
- **Patient Health Questionnaire (PHQ - 9)** (see Part 3 in this module) - screen for depression in children and adolescents 11-17 years old.
PART 3: DEPRESSION SCREENING FOR TEENS

The **PHQ-9**, developed in 1999 and modified for adolescents in 2002, is currently being used in many private pediatric practices to screen for depression in teens ages 11–17. The PHQ-9 is being used in all CHP-affiliated primary care practices (PCC and CCP) to assess symptoms of depression and functional impairment during well visits for teens 15-17 years of age. Check with your practice site to learn about teen screening tools used there.

Click here to view the **PHQ-9 for Adolescents**

The PHQ-9 for Adolescents with scoring instructions can be found here: http://www.med.umich.edu/1info/FHP/practiceguides/depress/score.pdf

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**Case 4:**

John Sample, age 15, presents with complaints of fatigue and low energy. Both John and his mother are concerned that he has mono, since his friends have had it. He denies any symptoms other than fatigue. His mother voices a concern that he stays in his room more these days and is always on his computer instead of being with friends. There has been a slow decline in his grades this year, which his mother thinks may be due to a heavy load of basketball practice and his apathy. He hands you his clip board with his review of symptoms and his PHQ-9.

Click here to view John's completed **PHQ-9 form**.

**Interpretation:**

To make a tentative depression diagnosis using this screen, **three criteria** need to be met:

1. There needs to be a score of “2” or greater for questions 1 and/or 2.
2. An answer of “2” or “3” to 5 or more questions needs to be endorsed to arrive at a total symptom count.
3. Functional impairment of “somewhat difficult” or greater needs to be endorsed on question 10.

John’s **total score** on his PHQ9 is as follows:

1. 2 x 1 = 2
2. 5 x 2 = 10
3. 1 x 3 = 3

Total = **15** with “somewhat difficult” endorsed on question 10

Click here to assess severity score: http://www.med.umich.edu/1info/FHP/practiceguides/depress/score.pdf

As you can see, John’s total symptom count (15) places him in the moderately severe scoring range. You can make a provisional diagnosis of major depression. At this time, you need to discuss the signs and symptoms of major depression with the teen and his mother and why you believe this might be a possible diagnosis.
Question: How will you explain this provisional diagnosis to John and his mother?
Answer:

Key points to include in explaining the provisional diagnosis of depression:

- Depression is common: ~11% of adolescents have a depressive disorder by age 18 according to the National Institute of Mental Health and the National Comorbidity Study-Adolescent Supplement (NCS-A). The risk for depression increases as a child ages.

- Depression is no one’s fault (neither the child, nor the parents). It can have a genetic component similar to diabetes and asthma and/or be reactionary (i.e., to a significant loss, stressor or trauma, such as a break up with a boy/girl friend) and/or be a comorbidity of another condition such as ADHD or anxiety.

- Children with ADHD, ODD and/or conduct, learning or anxiety disorders are at higher risk for depression.

- Depression can be treated in a variety of ways, including psychotherapy, medications and other alternative options (e.g., yoga, exercise).

A 'Depression Resource Center' on the American Academy of Child and Adolescent Psychiatry (AACAP) website includes useful information for patients and families, including the handout 'The Depressed Child'.

Question: Are there additional concerns that you should screen for prior to discussion of treatment/referral?
Answer:

Critical screening questions:

Suicidal/Homicidal Ideation

- It is always important to speak with the teen privately to screen for safety! Ask if he or she has any suicidal or homicidal thoughts, a history of suicide attempts or has engaged in self-injurious behavior (e.g., cutting).

- It is also important to assess for a passive death wish. For example, does the teen wish not to be alive or not to wake up in the morning or believe he/she would be better off dead?

Firearms

- Ask about the availability of firearms. According to the National Alliance of Mental Illness, suicide is the 3rd leading cause of death for youth aged 15-24. Having a gun in the home increases the risk of suicide three-fold and the risk of homicide two-fold. Gun suicide attempts are 2.5 times more fatal than hanging attempts and 220 times more fatal than poisoning.

- Parents are more likely to accept a pediatrician’s recommendation to remove guns from the home if their child had a previous suicide attempt and if the counseling is done directly to the gun owner. Many parents are more likely to follow advice to lock up their guns rather than remove them. Dr. David Brent, University of Pittsburgh Endowed Chair in Suicide Studies, advises that counseling about firearms be more of a negotiation with parents about safe storage than gun ownership.

Abuse/Bullying

- Other factors may be impacting the teen’s condition, including recent/remote trauma/abuse or bullying (including cyber bullying).

Substance Abuse

- Substance use in children under the age of 21 can be screened using the CRAFFT questionnaire. This tool is recommended by the American Academy of Pediatrics’ Committee on Substance Abuse for use in adolescents. It consists of a short series of questions and is an effective screening tool meant to assess whether a longer conversation about substance use is warranted.

- Also ask specifically about alcohol use and the availability of alcohol in the home. A case-control study from Allegheny County showed that suicide victims who use firearms were nearly 5 times more likely to have been drinking than those who used other methods.

Question: What are potential treatment options for John?
Answer:

Treatment options for John at this point might include one (or more) of the options below:

1. Refer to your on-site behavioral health therapist, if available, for a full assessment and treatment plan.

2. Refer to a provider in the community (there is a Resource Guide for Allegheny County in Resources Section below). The AAP supplement includes a table that summarizes the evidence-based treatment programs for the common behavioral health issues encountered by pediatric providers (Appendix S2: Evidence-Based Child and Adolescent Psychosocial Interventions).
   - For depression in teens, the treatments with the best evidence from the literature include: Cognitive Behavioral Therapy (CBT), CBT with medication, CBT with parents, and Family Therapy.
   - There is also good support for Client-centered therapy, Expressive writing/journaling/diary, Interpersonal therapy, and Relaxation.

3. Antidepressant medications may be an option – discuss the approach used at your training setting and with your preceptor.
Summary of Mental Health Screening at CHP PCC – Oakland and Turtle Creek

In other practices, check with your preceptor there to ascertain mental health screening procedures.

Summary: Mental Health Screening at CHP PCC – Oakland & Turtle Creek

<table>
<thead>
<tr>
<th>WCC Visit</th>
<th>Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn, 2 and 6 months</td>
<td>Mothers: Edinburgh Postnatal Depression Scale (EPDS) Fathers: EPDS</td>
</tr>
<tr>
<td>9, 18, 24-30 months</td>
<td>PEDS (developmental screening)*</td>
</tr>
<tr>
<td>18 and 24 months</td>
<td>MCHAT (autism screening)*</td>
</tr>
<tr>
<td>4, 6, 8, 10, 12, 14 years</td>
<td>Pediatric Symptom Checklist – Parent (PSC)</td>
</tr>
<tr>
<td>12 and 14 years</td>
<td>Pediatric Symptom Checklist – Parent and Youth (PSC and PSC-Y)</td>
</tr>
<tr>
<td>15-17 years</td>
<td>PHQ-9</td>
</tr>
</tbody>
</table>

If the initial screen is positive, the following secondary screens may be used to assess for a specific concern:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Instrument</th>
<th>Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Vanderbilt forms*</td>
<td>NICHQ Vanderbilt Assessment Scale (parent and teacher)</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>CRAFFT (adolescents)</td>
<td><a href="http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_English.pdf">http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_English.pdf</a></td>
</tr>
<tr>
<td>Depression</td>
<td>BDI, CDI, MFQ, PHQ-9</td>
<td></td>
</tr>
</tbody>
</table>

*Discussed in other Continuity Clinic modules

Note that all of these forms are available in Spanish.
Resources:

Selected resources in Allegheny County, PA

- **Early Intervention (Alliance for Infants and DART in Allegheny County)**
- **re:solve Crisis Network** (1-888-796-8226 for 24/7 crisis management)
- On-site behavioral therapist – many pediatric practices have on-site social workers through the **CHP Child and Family Counseling Center** (CFCC)
- Family Support Centers across the county – including **Family Care Connections**
- **Every Child** programs (both child directed services and family services)
- Center for Children and Families Triple Board Clinic at WPIC headed by Dr. Viveca Meyer, which evaluates and treats medically complex children and adolescents with co-morbid psychiatric illness. 412-246-5222.
- **The United Way in Pittsburgh**
- **Behavioral Health Resource List for the CHP PCC sites**

Selected National Resources

- **Postpartum Support International** [http://www.postpartum.net/](http://www.postpartum.net/)
  927 N. Kellogg, Santa Barbara, CA 93111
  Telephone: 1-805-967-7636

- **Hopeline Network for phone or online support** National crisis hotline (connects crisis centers across the US) [http://www.hopeline.com/gethelpnow.html](http://www.hopeline.com/)
  (800)442-4673 .....1-800-442-HOPE -- same routing as 1-800-SUICIDE
  (800)784-2432 .....1-800-SUICIDA Spanish speaking suicide hotline
  (877)968-8454 .....1-877-YOUTHLINE teen to teen peer counseling hotline
  (800)773-6667 .....1-800-PPD-MOMS Postpartum depression hotline

  Depressed Child **handout** from The American Academy of Child and Adolescent Psychiatry.

References


12. Massachusetts General Hospital - Pediatric Symptom Checklist http://www2.massgeneral.org/allpsych/psc/psc_home.htm


Please also view the evidence-based child and adolescent psychosocial interventions from the AAP supplement on enhancing pediatric mental health: [http://pediatrics.aappublications.org/cgi/reprint/125/Supplement_3/S128](http://pediatrics.aappublications.org/cgi/reprint/125/Supplement_3/S128)