Banner Plans & Networks

Behavioral Health Toolkit

Revised 1/15/2024

Contents

Introduction Letter

1/15/2024

Dear Providers:

Banner Plans & Networks continue to make strides in providing clinically relevant opportunities that impact the quality of care for our members. The Banner Plans and Networks Behavioral Health Clinical Strategy Committee has devised best practices and a toolkit, geared toward Primary Care Physicians to improve outcomes for patients with behavioral health issues.

Depression contributes to most adult primary care visits, often in the form of somatic symptoms, and is diagnosed and treated most frequently by PCPs[1,2]. However, up to half of all cases of depression remain undetected, and even those patients who are appropriately diagnosed frequently do not receive treatment in accordance with recommended guidelines[3]. Depression is a leading cause of disability. It interferes with treatment adherence and exacerbates the course of chronic diseases such as cardiovascular disease, diabetes, obesity, and immune disorders, resulting in poorer outcomes[4]. Depression frequently leads to physical inactivity, sleep disturbances, smoking, excessive alcohol consumption or other substance use, and poor nutrition, further compromising the physical health of patients.

We encourage you to screen for depression using standardized tools such as the PHQ-2 and/or PHQ-9 at least annually. Screening for anxiety is recommended as well, using the GAD-7.

The resources we've put together for you are based on Evidence Based Practice and the latest clinical guidelines.

Toolkit Items:

- Best Practice for Adult Depression
- Best Practice for Adult Anxiety
- Best Practice for Older Adult Depression
- Best Practice for Pediatric Depression
- Best Practice for Pediatric Anxiety
- Screening Tools
- Behavioral Health Coding Guidelines
- Behavioral Health Billing Guidelines
- Resources for Providers & Patients

We hope these resources assist you in your practice. Thank you for your ongoing work to help Banner Plans and Networks make health care easier, so life can be better.

Sincerely,

Dr. Vicki Knight

Medical Director
Chairperson of Behavioral Health Clinical Strategy Committee
Banner Plans & Networks

Best Practices

Best Practices for Adults with Depression

Why Screen and Treat Adults with Depression?

Depression contributes to most adult primary care visits, often in the form of somatic symptoms, and is diagnosed and treated most frequently by PCPs[1,2]. However, up to half of all cases of depression remain undetected, and even those patients who are appropriately diagnosed frequently do not receive treatment in accordance with recommended guidelines[3]. Depression is a leading cause of disability. It interferes with treatment adherence and exacerbates the course of chronic diseases such as cardiovascular disease, diabetes, obesity, and immune disorders, resulting in poorer outcomes[4]. Depression frequently leads to physical inactivity, sleep disturbances, smoking, excessive alcohol consumption or other substance use, and poor nutrition, further compromising the physical health of patients.

Risk Factors and Screening to Detect Depression in Adults:

Those with significant risks factors should be screened using appropriate tools below:

Adults	Geriatric	Pregnant & Postpartum
PHQ-9	Geriatric Depression Scale	Edinburgh Postpartum Depression Scale
Female gender	Disability	Poor self-esteem
At risk age range (18-29)	Poor physical health status	Child care stressors
Undereducated	Complicated grief	Prenatal anxiety
Previously married	Chronic sleep disturbances	Life stress
Unemployed	Loneliness	Descreased social support
Chronic Illnesses	Hx of depression	Single/unpartnered relationship status
Hx of Depression or Substance Use		Difficult infant temperament
Family Hx of depression		Hx of postpartum depression or depression
Family Hx of psychiatric disorders		Lower Socioeconomic status
		Unintended pregnancy

All Adults ages 18 and over should be screened annually using the PHQ-2 or PHQ-9

How Often to Screen?

- Annually – if no significant risk factors or previous positive screening
- Quarterly – after initial positive screening
- Following reports of depressive symptoms, change in risk factors or significant life events
- In accordance with clinical judgement

Evaluation and Diagnosis of Depressive Disorders:

DSM-5-TR Criteria for Major Depressive Disorder (MDD)

- Five or more of the following symptoms during the same 2-week period, occurring most of the days, nearly every day.

Criteria for Major Depressive Disorder (MDD)	
Depressed Mood (Subjective or Observed)	Psychomotor Agitation or Retardation
Loss of Interest/Pleasure in Activities	Fatigue or Loss of Energy
Significant Unintentional Weight Loss or Gain	Feelings of Worthlessness or Excessive Guilt
Decrease or Increase in Appetite	Decreased Concentration
Insomnia or Hypersomnia	Recurrent Thoughts of Death/Suicide

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

DSM-5-TR Criteria for Major Depressive Disorder (MDD) – Continued

- Symptoms must represent a change from a previous level of functioning.
- Symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Episode must not be attributable to the physiological effects of a substance or another medical condition.
- Episode is not better explained by a schizophrenia spectrum diagnosis.
- No history of manic or hypomanic episodes.

Depression Treatment Guidelines:

Nonpharmaceutical Treatment Interventions for Depression	
Psychotherapy	**Other**
• Behavioral Therapy • Cognitive Behavioral Therapy (CBT) • Interpersonal Therapy • Psychodynamic Therapy • Supportive Therapy • Mindfulness	• Electroconvulsive Therapy (ECT) • Transcranial Magnetic Stimulation (TMS) • Exercise • Sleep • Nutrition

Pharmaceutical Treatment for Depression	Starting Dose	Usual Dose
SSRI's (Selective Serotonin Reuptake Inhibitors)		
Citalopram (Celexa)	20 mg	20-60 mg
Escitalopram (Lexapro)	10 mg	10-20 mg
Fluoxetine (Prozac)	20 mg	20-60 mg
Paroxetine (Paxil)	20 mg	20-60 mg
Paroxetine, extended release (Paxil CR)	12.5 mg	25-75 mg
Sertraline (Zoloft)	50 mg	50-200 mg
DNRI's (Dopamine Norepinephrine Reuptake Inhibitors)		
Bupropion, immediate release (Wellbutrin)	150 mg	300-450 mg
Bupropion, sustained release (Wellbutrin SR)	150 mg	300-450 mg
Bupropion, extended release (Wellbutrin XL)	150 mg	300-450 mg
SNRI's (Serotonin Norepinephrine Reuptake Inhibitors)		
Venlafaxine, immediate release (Effexor)	37.5 mg	75-375 mg
Venlafaxine, extended release (Effexor XR)	37.5 mg	75-375 mg
Desvenlfaxine (Pristiq)	50 mg	50 mg
Duloxetine (Cymbalta)	60 mg	120 mg
Norepinephrine-Serotonin Modulator		
Mirtazepine (Remeron)	15 mg	15-45 mg
TCA's (Tricyclic Antidepressants)		
Amitriptyline (Elavil)	25-50 mg	100-300 mg
Doxepin (Sinequan, Silenor)	25-50 mg	100-300 mg
Imipramine (Tofranil)	25-50 mg	100-300 mg
Nortriptyline (Pamelor)	25 mg	50-200 mg
MAOI's (Monoamine Oxidase Inhibitors)		
Phenelzine (Nardil)	15 mg	45-90 mg
Tranylcypromine (Parnate)	10 mg	30-60 mg
Isocarboxazid (Marplan)	10-20 mg	30-60 mg

Indications for Referral to Psychiatric Providers:

Indications for Specialty Referral	
Patient Preference for Therapy Before Medication	Lack of Response to Trials of Multiple Medications
Suicidality or History of Suicide Attempts	Concerns for Mania or Psychotic Features
Complex Clinical Presentation	Diagnostic Uncertainty
Chronic and Recurrent Depression	Co-occurring Mental Health & Substance Use
History of Significant Trauma	Co-occurring Mental Health & Personality Disorders

Best Practices for Adults with Anxiety

Why Screen and Treat Adults with Anxiety?

Anxiety is the most common psychiatric disorder in the United States, affecting up to one-third of individuals at some time in their lives. Women more commonly are affected than men. Although anxiety is a frequent cause of significant functional impairment in adults, only about 10% of patients with anxiety disorders receive treatment within one year of onset, and fewer than 40% receive any treatment at all for the disorder[6]. Patients are most likely to present initially to a primary care provider with a variety of somatic complaints (such as heart palpitations, an increased heart rate, shortness of breath, chest tightness, feelings of fatigue, headache, GI disturbances, sensations of numbness or tingling, dizziness, difficulty sleeping or muscle weakness), rather than explicit emotional or behavioral health concerns. Up to 60-75% of individuals with depression have a comorbid anxiety disorder.

Common Types of Anxiety Disorders:

Generalized Anxiety Disorder: An excessive, persistent, and unrealistic worry about everyday life events, often accompanied by physical symptoms, that produces a constant feeling of being overwhelmed.
Social Anxiety Disorder: Fear of situations in which an individual may be scrutinized, evaluated, or judged by others.
Panic Disorder: Characterized by sudden episodes of intense fear that trigger severe physical reactions when there is no real danger or apparent cause.
Post-Traumatic Stress Disorder: A condition in which a traumatic event is persistently re-experienced in the form of intrusive recollections, dreams or dissociative flashback episodes.
Obsessive-Compulsive Disorder: Characterized by repeated, persistent, and unwanted thoughts, urges or images that are intrusive and cause distress, accompanied by repetitive, ritualistic behaviors that follow specific rules and patterns to help diminish the feelings of distress.
Phobias: Uncontrollable, irrational, and persistent fears of specific objects, situations, or activities.

Risk Factors and Screening to Detect Anxiety in Adults:

Those with significant risks factors should be screened using appropriate tools:

Risk Factors	
Female gender	Early parental loss
Family history of anxiety/depression	Childhood trauma or sexual abuse
History of self-harm by age 16	Substance Use Disorder before age 21
Stressful environment (home, work, school)	Limited education
Low self esteem	Loneliness
Chronic medical conditions	Socioeconomic & cultural factors
Personality traits such as: introversion, overthinking, perfectionism, resistance to change, empathy	

How Often to Screen?

- Annually – if no significant risk factors or previous positive screening
- Quarterly – after initial positive screening
- Following reports of anxiety symptoms, change in risk or significant life events
- In accordance with clinical judgement

Tools for Screening:

Generalized Anxiety Disorder 2-item or 7-item – GAD 2 or GAD-7

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Evaluation and Diagnosis of Anxiety:

DSM-5-TR Criteria for Generalized Anxiety Disorder (GAD)

Excessive anxiety and worry about numerous events or activities that are difficult to control and occur more days than not for at least 6 months, accompanied by at least 3 of the 6 symptoms:

Criteria for Generalized Anxiety Disorder	
Restlessness	Being easily fatigued
Difficulty concentrating	Irritability
Muscle tension	Sleep disturbances

- Symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The patient's clinical presentation is not better explained by another mental health disorder, the physiological effects of a substance, or another medical condition.

Anxiety Treatment Guidelines:

Nonpharmaceutical Treatment Interventions for Anxiety	
• Education, resources & monitoring • Cognitive Behavioral Therapy (CBT) • Self-help & psychoeducational groups	• Relaxation therapy & techniques • Exercise

Pharmaceutical Treatment for Anxiety		Starting Dose	Usual Dose
SSRI's (Selective Serotonin Reuptake Inhibitors)			
	Citalopram (Celexa)	20 mg	20-60 mg
	Escitalopram (Lexapro)	10 mg	10-20 mg
	Fluoxetine (Prozac)	20 mg	20-60 mg
	Paroxetine (Paxil)	20 mg	20-60 mg
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SNRI's (Serotonin Norepinephrine Reuptake Inhibitors)			
	Venlafaxine, immediate release (Effexor)	37.5 mg	75-375 mg
	Venlafaxine, extended release (Effexor XR)	37.5 mg	75-375 mg
	Desvenlfaxine (Pristiq)	50 mg	50 mg
	Duloxetine (Cymbalta)	60 mg	120 mg
Azapirones	Buspirone (Buspar)	7.5 mg BID	20-30 mg QD Daily Max 60 mg
Antihistamines	Hydroxyzine (Vistaril, Atarax)	50-100 mg up to 4 times daily	
	Diphenhydramine (Benadryl)	25-50 mg up to 4-6 times daily	
Gabapentinoids	Pregabalin (Lyrica)	50 mg TID or 75 mg BID	450 mg daily Daily Max 600 mg
	Gabapentin (Neurontin)	300 mg QD	600-1800 mg Daily Max 3600 mg
Benzodiazepines	**Short term use only (2 weeks), avoid in patients with history of substance use disorders, scheduled doses (not PRN), use agents with longer half-lives)*		
Long Acting -	Clonazepam (Klonopin)	0.5-1 mg BID or TID	Daily Max 20 mg
	Diazepam (Valium)	2-10 mg BID to QID	Daily Max 40 mg
Short Acting -	Lorazepam (Ativan)	0.5-1 mg TID or QID	Daily Max 10 mg
	Alprazolam (Xanax)	0.25-0.5 mg BID/TID	Daily Max 4 mg

Indications for Referral to Psychiatric Providers:

Indications for Specialty Referral	
Patient Preference for Therapy Before Medication	Lack of Response to Trials of Multiple Medications
Severe impairment in daily functioning	Co-occurring Mental Health & Substance Use
Complex Clinical Presentation	Diagnostic Uncertainty

Best Practices for Older Adults with Depression

Why Screen and Treat Older Adults with Depression?

Up to 80% of older adults who are treated for mental health disorders receive care for these conditions from primary care providers[5]. Unfortunately, depression in the elderly is often considered a normal part of the aging process. Depressive disorders therefore are under-recognized, under-diagnosed, and under-treated in this population. Current evidence indicates that older adults are at increased risk for experiencing depression. However, elderly patients with depression tend to report more somatic and cognitive symptoms than affective symptoms. In addition, features of medical comorbidities frequently are present that may complicate the patient's diagnosis and presentation, such as fatigue, weight loss, and insomnia. Depression in older adults is known to be associated with significant negative consequences, including poor quality of life, difficulties with activities of daily living, physical comorbidities, premature mortality, and cognitive impairment. Some of these symptoms are not included in the DSM 5-TR criteria for Major Depressive Disorder but may be categorized as Other Specified Depressive Disorders—Depressive Episode with Insufficient Symptoms or simply Unspecified Depressive Disorder. Depression is a significant predictor of suicide in the elderly, particularly among white males aged 85 and older, who have a suicide rate that is six times higher than the general population[7].

Risk Factors and Screening to Detect Depression in Older Adults:

Risk Factors for Depression in Older Adults	
Chronic Medical Conditions	Chronic Stress
Social isolation and Loneliness	Cognitive Impairment
Bereavement	Functional Limitations/Difficulty Performing ADLs
Sleep Problems	Prior History or Family History of Depression
Lack of Exercise or Physical Activity	Substance Use

Those with significant risks factors should be screened using tools below:

Screening Tools		
PHQ-2	PHQ-9	Geriatric Depression Scale

How Often to Screen?

- Annually – if no significant risk factors or previous positive screening
- Quarterly – after initial positive screening
- Following reports of depressive symptoms, change in risk factors or significant life events
- In accordance with clinical judgement

Evaluation and Diagnosis of Depressive Disorders:

Diagnostic criteria for depression is the same in adults of any age. However, symptoms more commonly present in older adults include:

Diagnostic Criteria for Depression	
Fatigue/feeling tired/lack of energy	Lack of pleasure/enjoyment in usual activities
Difficulty sleeping	Psychomotor retardation
Irritability	Change in weight or appetite
Confusion	Frequent/persistent aches and pains
Difficulty paying attention	Suicidal ideation
Feelings of hopelessness, worthlessness, and guilt	

Physiological Factors, Risks, and Medication Considerations:

Physiological Factors/Conditions Associated with Depression in Older Adults:	
• Inflammation/autoimmune disorders	• Cancer/malignancy (particularly pancreatic)
• Cardiovascular/Cerebrovascular disease	• Viral infections
• Neurodegeneration	• Metabolic disorders/nutritional deficiencies
• Endocrine disorders	
Risks Associated with Antidepressant Use in Older Adults:	
• Falls	• Anticholinergic effects
• Osteoporosis/fractures	• Extrapyramidal symptoms
• Orthostatic hypotension	• Medication interactions/polypharmacy
• Sedation	• Cardiac effects
Medication Considerations:	
• Lower initial doses	• TCAs generally not recommended
• SSRIs preferred over SNRIs as first line treatment	• Consider medications with prior response

Indications for Referral to Psychiatric Providers:

Indications for Specialty Referral	
Suicidal ideation	Lack of Response
Psychosis	Diagnostic complexity/uncertainty
Unable to tolerate initial medications	Possible need for ECT to induce rapid response

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Best Practice for Children or Adolescents with Depression

Why Screen and Treat Children or Adolescents with Depression?

Why is screening so important? Depression is a serious mental health concern. Children and adolescents with depression have a much higher chance of having depression as adults and carry a higher risk of suicide. Treatment of depression in children and adolescents can improve physical and emotional health, leading to healthy and productive lives[9].

Screening to Detect Depression in Adolescents and Children:

Who and When to Screen:		
Age Range	***Frequency of Screening***	***Screening Tools***
12 Years and Older	Annually	PHQ-2 - Prior to office visit PHQ-A or PHQ-9 - During office visit
11 Years and Younger	When depression suspected	Short Mood & Feeling Questionnaire (SMFQ) prior to office visit Long Mood & Feelings Questionnaire (LMFQ) during office visit
Risk Factors for MDD: Females, older age, family history of depression, prior history of depression, comorbid mental health or behavioral problems, chronic medical illness, obesity, ACEs, uncertainty about sexual orientation, low socioeconomic status, poor academic performance.		

Evaluation and Diagnosis of Depressive Disorders:

DSM 5 TR Criteria for Major Depressive Disorder (MDD)

- Discreet episode of at least 2 weeks – of a clear change in mood for the worse (sadness/irritability) and at least 5 of the below criteria must be present for most of the day, nearly every day and must result in significant distress or functional impairment for the child.

Criteria for Major Depressive Disorder (MDD)	
Depressed Mood (Subjective or Observed)	Psychomotor Agitation or Retardation
Loss of Interest/Pleasure in Activities	Fatigue or Loss of Energy
Significant Unintentional Weight Loss or Gain	Feelings of Worthlessness or Excessive Guilt
Decrease or Increase in Appetite	Decreased Concentration
Insomnia or Hypersomnia	Recurrent Thoughts of Death/Suicide

DSM 5 TR Criteria for Persistent Depressive Disorder

- Chronic form of Depression lasting > 1 year
- Symptoms occurring on most days
- Symptoms are similar to MDD, however less severe and less pervasive

DSM 5 TR Criteria for Disruptive Mood Dysregulation Disorder

- Symptoms must be recurrent and present for at least 12 months with no longer than 3 months symptom free
- Persistent irritable or angry mood most days of the week and in at least 2 settings
- Severe temper outbursts (behavioral/verbal) at least 3 times a week that are not in line with the situation or the child's developmental level
- Resulting in significant distress or functional impairment for the child
- Child must be $\geq$ 6 years old. Symptoms are usually present by age of 10

Rule out/Differentials to be considered:

Medical Conditions	Medications	Substances/Toxins	Other Mental Health Conditions
• Hypothyroidism	• Narcotic Analgesics	• Nicotine	• ADHD
• Mononucleosis	• Chemotherapy Agents	• Alcohol	• Disruptive Behavior Disorders
• Anemia	• Cardiovascular Medications	• Cannabis	• Anxiety
• Autoimmune Diseases	• Stimulants	• Opiates	• PTSD
• Chronic Fatigue Syndrome	• Corticosteroids	• Cocaine	• Bipolar Depression
• Migraines	• Immunosuppressants	• Other Stimulants	• Psychotic Disorders
• Epilepsy	• Oral Contraceptives	• Sedatives	• Autism Spectrum Disorder
• Asthma		• Anabolic Steroids	• Learning Disorders
• Inflammatory Bowel Disease		• Carbon Monoxide	

Depression Treatment Guidelines:

Nonpharmaceutical Treatment Interventions for Depression:

Psychotherapy		Integrative Approaches
Older Children/Adolescents:	*Younger Children:*	
Individual Psychotherapy	**Individual Psychotherapy**	**Somatic Therapies**
• CBT (Gold Standard)	• CBT (Gold Standard)	• Biofeedback/Integrative Physical Therapy
• Interpersonal Therapy	• Interpersonal Therapy	• Somatic Experiencing
• Modified CBT	• Play Therapy	**Supplementation**
• Psychoanalytic		• Omega-3 (Fish Oil), St. John's Wort, Many Others
+ many other options	**Family Therapy**	**Other**
	• Attachment Based	• Eletroconvulsive Therapy
Family Therapy	• Parent-Child Interaction Therapy	• Transcranial Magnetic Stimulation
		• Sleep Hygiene
Group Therapy	**Group Therapy**	• Nutrition

Pharmaceutical Treatment Interventions for Depression:

SSRIs	SNRIs	MAOs/TCAs	Miscellaneous
Fluoxetine (FDA approved 8+)	Venalafaxine	**Monoamine Oxidase Inhibitors**	**Dopamine Norepinephrine**
Escitalopram (FDA approved 12+)	Venlafaxine XR	Phenelzine	**Reuptake Inhibitors**
Citalopram	Desvenlafaxine	Tranylcypromine	Bupriopion, Buprioprion XR or SR
Sertraline	Duloxetine	Isocarboxazid	**Norepinephrine-Serotonin**
Paroxetine		**Tricyclic Antidepressants**	**Modulator**
Fluvoxamine		Amitriptyline	Mirtazepine
Vilazodone		Doxepin	**Seratonin Antagonist**
		Imipramine	**Reuptake Inhibitors**
		Nortriptyline	Trazodone

Indications for referral to Psychiatric Providers:

Indications for Specialty Referral	
Suicidality or History of Suicide Attempts	Concerns for Mania
Moderate to Severe Depression	Diagnostic Uncertainty
Chronic and Recurrent Depression	Co-occurring Mental Health & Substance Use
MDD with Psychotic Features	Co-occurring Mental Health & Personality Disorders

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Best Practice for Children or Adolescents with Anxiety

Why Screen and Treat Children or Adolescents with Anxiety?

Why is screening so important? Anxiety is a common mental health concern. Per the National Institutes of Mental Health estimation, 25% of youth ages 13-18 years old experience an anxiety disorder, with almost 6% of these youth experiencing severe anxiety. Treatment of anxiety in children and adolescents can improve physical and emotional health, leading to healthy and productive lives[8].

Screening to Detect Anxiety in Adolescents and Children:

- USPSTF recommends screening for anxiety disorders in children and adolescents 8+ years.
- Screening occurs based on either parent or child self-reports symptoms OR based on practitioner observations/clinical history.

Screening Tools	
• Screen for Child Anxiety Related Disorders (SCARED) • Spence Children's Anxiety Scale (SCAS) and Preschool Anxiety Scales • Generalized Anxiety Disorder – 7 (GAD-7)	• Anxiety Pediatric Symptom Checklist • Strengths and Difficulties Questionnaire • American Psychiatric Association's Cross-Cutting Symptom Measures
Risk Factors for Anxiety Disorders in Children and Adolescents: Family history of anxiety disorders, exposure to violence/trauma, ACES, low socioeconomic status, social support, comorbid mental health, or behavioral concerns, etc.	

Evaluation and Diagnosis of Anxiety Disorders:

There are 11 defined anxiety disorders in the DSM 5 TR. All the disorders cause clinically significant distress or impaired functioning for the individual. Some of the more common ones are:

DSM 5 Diagnosis	Symptoms	Time Duration
Generalized Anxiety Disorder	• Excessive anxiety or worry about events/activities • ***1 or more of the following:*** Restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance	• Occurring more days than not for at least 6 months
Panic Disorder	• Recurrent, unexpected panic attacks • 1 or more attacks followed by maladaptive behavior changes or worry related to panic attacks • Intense fear or discomfort peaking withing minutes with ***4 or more of the following:*** Palpitations, sweating, trembling, shortness of breath, choking, chest pain, nausea, feeling faint or dizzy, chills and/or hot flashes, paresthesia, derealization/depersonalization, fear of losing control/dying	• At least 1 month of persistent worry or maladaptive behavior changes related to panic attacks
Social Anxiety Disorder	• Excessive anxiety or worry about events/activities • ***1 or more of the following:*** Restlessness, fatigue, difficulty concentrating, irritability, muscle tension, sleep disturbance	• Persistent, lasting for at least 6 months
Separation Anxiety Disorder	• Developmentally inappropriate anxiety/fear of separation from attachment figure • ***3 or more of the following:*** Recurrent excessive distress when anticipating or experiencing separation; persistent and excessive worry about loss and harm; persistent and excessive worry about an event causing separation; persistent reluctance or refusal to go out because of separation fear; persistent and excessive fear or reluctance to be alone or without attachment figure; persistent reluctance or refusal to sleep away from home or be away from attachment figure; repeated separation nightmares; repeated complaints of physical symptoms when separation occurs or is anticipated	• Lasting at least 4 weeks

Rule out/Differentials to be considered:

Medical Conditions	Medications	Substances/toxins	Mental Health Disorders
• Hyperthyroidism • Caffeinism • Migraines • Asthma • Diabetes • Chronic pain/illness • Hypoglycemic episodes • Hypoxia • Pheochromocytoma • Central Nervous Systems Disorders • Cardiac arrhythmias • Cardiac valvular disease • Systemic lupus erythematosus • Allergic reactions • Dysmenorrhea	• Bronchodilators • Nasal decongestants and other sympathomimetics • Antihistamines • Steroids • Dietary supplements • Antidepressants • Antipsychotics • Stimulants • Withdrawal from benzodiazepines (esp. short-acting)	• Cannabis • Cocaine • Anabolic Steroids • Hallucinogens • Phencyclidine • Withdrawal from nicotine, alcohol, or caffeine • Exposure to organophosphates • Ingestion of metals (lead, arsenic, etc.)	• ADHD • Obsessive-Compulsive disorder • Psychotic disorder • Autism Spectrum disorder • Learning disorders

Anxiety Treatment Guidelines:

Nonpharmaceutical Treatment Interventions for Anxiety:

Psychotherapy		Integrative Approaches
Older Children/Adolescents:	*Younger Children:*	
Individual Psychotherapy • CBT (Gold Standard) • Interpersonal Therapy • Modified CBT • Psychoanalytic + many other options **Family Therapy** **Group Therapy**	**Individual Psychotherapy** • CBT (Gold Standard) • Interpersonal Therapy • Play Therapy **Family Therapy** • Attachment Based • Parent-Child Interaction Therapy **Group Therapy**	**Somatic Therapies** • Biofeedback/Integrative Physical Therapy • Somatic Experiencing **Supplementation** • Omega-3 (Fish Oil), St. John's Wort, Many Others **Other** • Eletroconvulsive Therapy • Transcranial Magnetic Stimulation • Sleep Hygiene • Nutrition

Pharmaceutical Treatment Interventions for Anxiety:

SSRIs	SNRIs	Miscellaneous
Fluoxetine Escitalopram Citalopram Sertraline Paroxetine Fluvoxamine Vilazodone	Venlafaxine Venlafaxine XR Desvenlafaxine Duloxetine ***(FDA approved 7+)***	**Unknown Mechanism of action** Buspirone Hydroxyzine **Benzodiazepines** Alprazolam Lorazepam Diazepam Clonazepam **Antihistamines** Diphenhydramine **Beta blockers** Propranolol

Indications for Specialty Referral	
Suicidality or History of Suicide Attempts	Moderate to Severe Symptoms
Chronic or Recurrent Symptoms	Diagnostic Uncertainty
Co-occurring Mental Health and Personality Disorders	Co-occurring Mental Health and Substance Use Disorders

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Tip Sheets

Depression & Anxiety Screening Tips

Best Practices:

- All patients should be screened for depression at least annually.
- For pre-appointment screening, please use the PHQ-2.
- The PHQ-9 questions regarding suicidality need to be reviewed and acted upon by the provider, so distributing in advance is not advised.
- Printable copies of screening tests in multiple languages are available for download from https://www.phqscreeners.com/select-screener
- Laminate copies of the screening tools for patients to complete with wipe-off marker while in the exam area waiting for their provider.
    - After the patient has completed the questionnaire on the laminated screening tool the laminated tool should be scored and inputted into the patient's chart prior to cleaning for the next patient's use.
- Have a tablet with screening tools for patient to use.
- As with all tools, clinical judgement should be used when interpreting results.

Documenting Follow-ups

How to Document Follow-ups?

Follow-Up Plan: Documented follow-up for a positive depression screening must include one or more of the following:

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

PHQ-9 Interpretation, Treatment & Determining Remission

PHQ-9 total score	Depression Severity	Actions
0-4	None or minimal depression	• Treatment typically is not needed.
5-9	Mild depression	• Monitor and repeat PHQ-9 in 6-12 months, or sooner if clinically indicated. • Consider possible treatment based on duration and severity of symptoms, as well as patient preferences.
10-14	Moderate depression	• Repeat PHQ-9 in 4-6 weeks to assess symptom progression and/or response to treatment. • Consider counseling referral and possible medication treatment based on severity and duration of symptoms, as well as patient preferences. • Symptoms that are present for 2 years or more constitute chronic depression, consider pharmacotherapy. • Active treatment is indicated if symptoms have been present for more than one month and are associated with significant functional impairment.
15-19	Moderately severe depression	• Repeat PHQ-9 in 4-6 weeks to assess treatment response. • Treatment generally is indicated with medication, therapy, or both.
20-27	Severe depression	• Repeat PHQ-9 within 4-6 weeks, or sooner if clinically indicated, to assess treatment response. • Prompt initiation of pharmacotherapy is indicated. • Consider expedited referral to mental health specialists for psychotherapy and collaborative medical management.

PHQ-9 Scoring After 4-6 Weeks of Treatment with an Antidepressant at an Adequate Dose

PHQ 9 Change	Action
Drop of 5 points or more OR 50% Reduction in Score	• Adequate response. No treatment changes needed. • Follow up in 4-6 weeks.
Drop of 2-4 points	• Likely inadequate response. • Consider increase in antidepressant dose. • Follow up in 4-6 weeks.
Drop of 0-1 points or increased score	• Increase dose, add an augmenting agent, or switch to an alternative antidepressant. • Consider counseling, if not already in place. • Consider psychiatric consultation. • Follow up in 4-6 weeks.

Evaluating Treatment Response

Follow Up PHQ 9 Score	Action
Drop of 5 or more points after 3 months of treatment	• Clinically Significant Response • Continue to monitor every 6 months or as clinically indicated
Score of 6-10	• Partial remission • Continue to monitor every 6 months or as clinically indicated
Score of 1-5	• Remission • Continue to monitor every 6-12 months or as clinically indicated

See Behavioral Health Toolkit Main Document for References and Additional Resources

Behavioral Health Coding & Documentation

In 2008, the World Health Organization (WHO) ranked major depressive disorder (MDD) third in causes of long-term disease burdens. They projected that MDD will move to first place by 2030. Therefore, selecting the most specific and appropriate diagnosis for patients is essential for telling the best patient story, identifying patients who may need additional care dollars to manage their disease process, and for making sure our patients don't fall through the proverbial "crack".

Diagnosis Code Selection and Documentation Tips

The provider should include the below qualifiers to the diagnosis code and documentation. If it is unclear, query the provider.

- Type (episode):
  - **Single episode**: First time the patient meets the criteria for MDD and has no history of a prior event. If the patient **never** experiences a break in symptoms and continues to meet the criteria for MDD, then the single episode remains appropriate.
  - **Recurrent episode**: An episode is considered recurrent when there is an interval of at least two consecutive months between separate episodes during which criteria are not met for MDD. Multiple episodes of MDD exist.
- Severity:
  - **Mild**: typically 2 or 3 symptoms are present.
  - **Moderate**: four or more symptoms are present, difficulty with activities of daily living (ADLs).
  - **Severe**: With or without psychotic features. Unable to complete ADLs, thoughts or actions of suicide may be present. Provider documentation is essential.
- Status:
  - **In remission**: Determined by the treatment level of the patient. Is the patient actively being treated for MDD (i.e., receiving counseling and/or taking anti-depressive medication and is "stable").
  - **Partial remission**: Occasional symptoms from a previous major depressive episode without meeting full criteria or hiatus lasting less than two months without any significant symptoms.
  - **Full remission**: No significant signs or symptoms of the disturbance present during the past two months. The patient may still be receiving treatment for prevention of additional episodes.
  - **History of**: The patient is no longer receiving active treatment for the MDD and is stable.
- Specifiers, if applicable, such as:
  - With anxious distress
  - With mixed features
  - With melancholic features
  - With peripartum onset
  - With seasonal pattern

There are significant changes noted in the V28 CMS – HCC risk adjustment model regarding MDD. Most notably is the removal of the risk adjustment factor (RAF) value to MDD diagnoses that are:

- Mild
- In remission

- In partial remission
- In full remission
- Unspecified

Major Depressive Disorder ICD-10s

ICD-10-CM codes	Description	ICD-10-CM codes	Description
F32.0	Major depressive disorder, single episode, mild	F33.0	Major depressive disorder, recurrent, mild
F32.1 *	Major depressive disorder, single episode, moderate	F33.1 *	Major depressive disorder, recurrent, moderate
F32.2 *	Major depressive disorder, single episode, severe without psychotic features	F33.2 *	Major depressive disorder, recurrent, severe without psychotic features
F32.3 *	Major depressive disorder, single episode, severe with psychotic features	F33.3 *	Major depressive disorder, recurrent, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission	F33.40	Major depressive disorder, recurrent, in remission, unspecified
F32.5	Major depressive disorder, single episode, in full remission	F33.41	Major depressive disorder, recurrent, in partial remission
F32.81	Premenstrual dysphoric disorder	F33.42	Major depressive disorder, recurrent, in full remission
F32.89	Other specified depressive episodes	F33.8	Other recurrent depressive episodes
F32.9	Major depressive disorder, single episode, unspecified	F33.9	Major depressive disorder, recurrent, unspecified
F32.A	Depression, unspecified	F34.1	Persistent depressive disorder (Persistent Dysthymic disorder)

"*" = diagnoses that risk adjust in the V28 risk adjustment model.

Appropriate Documentation:

When selecting the best diagnosis for your patient, code what you know, be as specific as possible, and review any notes from the specialist. It is recommended to use the same diagnoses that the specialist uses if the patient meets the criteria. Remember the MEAT (Monitor, Evaluate, Assess/Address, and Treat) mnemonic will help ensure you include the pertinent information in your note. Below is an example of good documentation.

Major depressive disorder, recurrent, moderate (F33.1)

Ms. M is seen for medication management for her MDD. The patient states that she "can't make it through the day" without her escitalopram, and she feels more on edge. PHQ-9 today is a 12 which is lower than the 14 at the last visit. Ms. M appears to be more anxious and restless today, and the GAD-7 score was a 6. She states that work has been very busy, and her children are stressing her out.

Pt has been on escitalopram 10mg for the past year and does not want to add any more medications to her routine. Referral to psychiatry.

Questions regarding Risk Adjustment coding, documentation, and billing – email BPN.RiskAdjustmentLeadershipTeam@bannerhealth.com

Provider & Patient Resources

*Crisis Resources

What is a Behavioral Health Emergency?

- When you think you are having a crisis or any situation where you believe you might hurt yourself or someone else because of your mood or thinking.
- When someone's thinking changes rapidly to the point where the person is not able to recognize reality from fantasy. Sometimes the person does not realize what is happening and may not want help.

If patient has an **IMMEDIATE** need,
please call the appropriate **CRISIS LINE** or **911**:

National 24-Hour Crisis Hotlines

Suicide & Crisis Lifeline: **988**

National Suicide Prevention Lifeline: **800-273-8255**

National Substance Use & Disorder Issues Referral & Treatment Hotline: **800-662-4357**

Teen Lifeline – **Phone or Text: 602-248-8336**

SAMHSA Crisis Text Line: **Text HOME to 741741**

Suicide & Crisis Hotlines by County

Maricopa County: **800-631-1314 or 602-222-9444**

Apache, Gila, Mohave, Navajo & Yavapai: **877-756-4090**

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz & Yuma: **866-495-6735**

Warm Lines by County

A Warm Line is a confidential, free phone service offering mental health support. Unlike a crisis line, they are not intended for emergency situations.

Gila & Maricopa County: **602-347-1100**

Pima County: **520-770-9909**

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz & Yuma: **844-733-9912**

Tribal Warm Line for American Indian Community Members: **855-728-8630**

Banner University Health Plans

2701 E. Elvira Road, Tucson, Arizona 85756
(800) 582-8686 • TTY 711 • Fax (520) 874-5555
www.BannerUHP.com

PCP Referral to Behavioral Health Provider

How can a Behavioral Health (BH) Provider help?
Banner – University Health Plans (BUHP) is committed to coordination of care for patients/members to ensure optimal integrated care to meet their needs. Many of our members have complex behavioral health and physical health conditions that may require multiple providers to communicate their treatment approaches and interventions to improve the member's care.

BH Providers offer a wide array of evidence-based services to help meet each member's needs to promote their overall wellbeing. BH Providers can help support members who are struggling with mental health symptoms and can assist them in making behavioral changes. Members who complete an intake with a BH Provider agency receive a comprehensive assessment that helps identify their unmet needs and treatment objectives, provides an initial diagnosis and identifies potential interventions. A BH Provider Case Manager is assigned to regularly reach out to the patient to re-assess symptom severity and connect them to clinically appropriate services to help the member reach their goals. In addition to formal services, BH Providers help meet cultural needs and empower members by connecting them to community supports to encourage long-term wellness.

Who can benefit from a referral to a BH Provider?
Members may benefit from a referral to a BH Provider if their behavioral health needs require extensive or specialized services beyond the primary care provider's scope. Examples of support that BH providers can offer include the following:

- Counseling, psychotherapy or a specialized therapy
- Support for co-occurring conditions (e.g. physical, behavioral, substance use, and/or developmental)
- Intensive wrap-around services from direct support providers which may support members who have recently attempted to harm self and/or others
- Psychiatric, psychological or neuropsychological testing and implementation of recommendations
- Support for complex trauma
- Care coordination for members at risk of BH hospitalization or BH residential services
- Medication for a diagnosis other than ADHD, Anxiety, Depression and Opioid Use Disorder

How and when to refer to a BH Provider?
If BUHP members require medication for certain limited behavioral health disorders (Anxiety, Depression, Attention Deficit Hyperactive Disorder (ADHD) and Opioid Use Disorder), they may obtain medication from a primary care provider. All other psychiatric diagnoses must be referred to a BUHP contracted BH Provider.

Referrals can be made with the attached PCP Referral to BH Provider form, which includes general information about the member, referring PCP information and the chief complaint/symptoms resulting in the referral. Once the referral is submitted by email, a BUHP Care Manager will follow up on member intake and enrollment with the BH Provider to verify the member is connected to services. The referral is not required if the member would prefer to contact a BH Provider directly or to outreach BUHP Customer Care at (800) 582-8686. The benefit of completing the included referral is that a BUHP Care Manager will be assigned to the member for additional support as needed.

Members suspected as having an autism diagnosis can be managed through this referral process or directly referred to a specialized Autism Spectrum Disorder (ASD) diagnosing provider located at:
https://www.banneruhp.com/resources/autism-spectrum-disorder.

Banner – University Family Care/ACC | Banner – University Family Care/ALTCS
Banner – University Care Advantage HMO SNP

Banner University Health Plans

2701 E. Elvira Road, Tucson, Arizona 85756
(800) 582-8686 • TTY 711 • Fax (520) 874-5555
www.BannerUHP.com

PCP Referral to Behavioral Health Provider

This patient receiving medical care services at our practice is in need of a Behavioral Health Assessment.

Section 1: Member Information	
Urgency of Referral: ☐ Routine (Member must be seen within 7 days) ☐ Urgent (Member must be seen within 24 hours)	
Date:	**AHCCCS ID:**
Member's Name:	**DOB:**
Phone:	**Address:**
Legal Guardian (if applicable): ☐ Parent/Guardianship ☐ Department of Child Safety	**Guardian's Name (if applicable):**
Member's Preferred Language:	**Guardian's Preferred Language (if applicable):**
Payer Source: ☐ Banner–University Family Care (ACC) ☐ Banner–University Family Care (ALTCS) ☐ Banner–University Care Advantage (HMO SNP)	
Section 2: Referring PCP Information	
Primary Care Provider's Name:	**Practice Name:**
Address:	**Phone:**
Fax:	**Email:**
Section 3: Referral Information	
Complaint/Symptoms Resulting in Referral: ☐Anxiety/panic ☐Cognitive decline/dementia ☐Depression ☐Developmental delay ☐Difficulty with attention, hyperactivity or impulsivity ☐Post-traumatic stress/trauma/abuse ☐Eating disorder behavior ☐Substance use type:	☐Obsessions/compulsions ☐Personality disordered behaviors ☐Violence/aggressive/oppositional behavior ☐Other behavioral health symptoms: ☐*Psychosis (auditory/visual hallucinations, delusions)** ☐*Suicidal ideation** ☐*Homicidal ideation** **If patient is a danger to self or others, or otherwise in need of IMMEDIATE support, please call the appropriate CRISIS LINE below.*
Current Diagnoses:	**Current Medications:**
PHQ9, ACES or other screening tool findings (including tool name and score):	
Additional Information:	

If the patient has an IMMEDIATE need, please call the appropriate CRISIS LINE:
Maricopa County: (800) 631-1314 or (602) 222-9444
Gila County: (877) 756-4090
Pima, Pinal, Yuma, La Paz, Cochise, Graham, Greenlee and Santa Cruz Counties: (866) 495-6735

Email routine and urgent referrals to: BUHPCareMgmtBHMailbox@bannerhealth.com

Banner – University Family Care/ACC | Banner – University Family Care/ALTCS
Banner – University Care Advantage HMO SNP

Banner - Aetna Mental Wellbeing Resource Center

Let's make every day better and brighter

Nothing should stand in the way of good mental health. So, if you are in need or caring for someone who is, you can turn to us for information, inspiration, and support when you're ready. Whatever you are facing, you're not in this alone.

Banner | aetna

Go to BannerAetna.com & search mental health or scan the QR Code

Make an appointment with a Behavioral Health Provider

Find educational videos on:

- Attention Deficit Hyperactivity Disorder
- Depression
- Bipolar
- Anxiety
- Relationships
- Substance Misuse
- Suicide
- And More

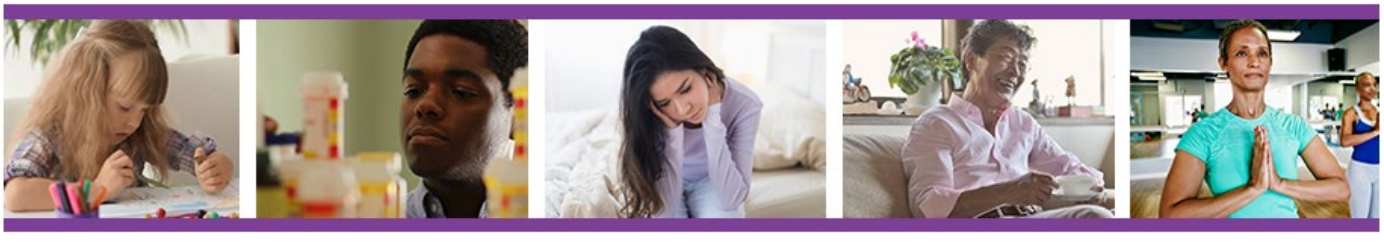
Find Virtual Mental Health Care

Make a video appointment with a provider at MDLIVE includes psychiatrists, social workers, and marriage counselors.

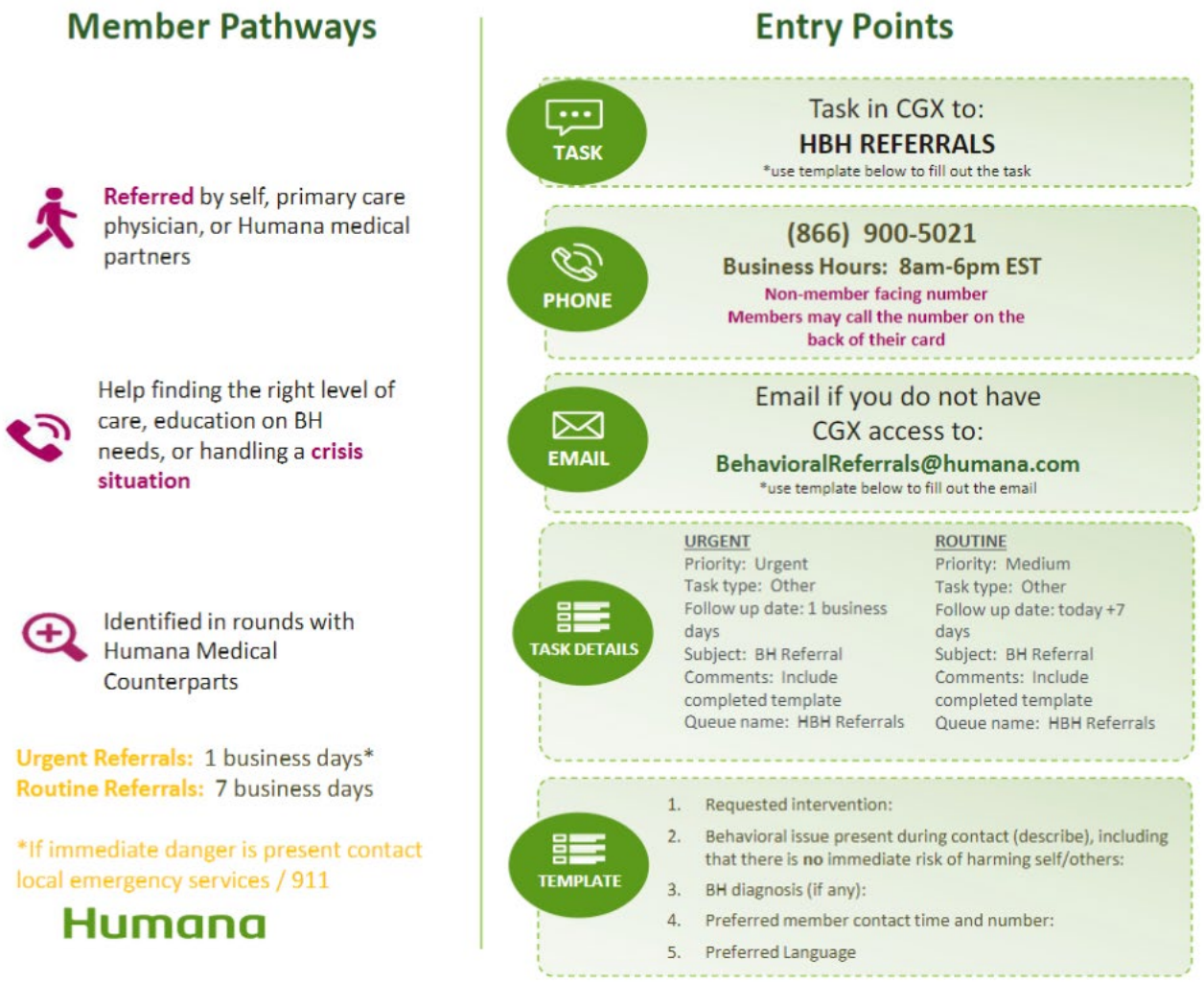
Join a video counseling and coaching program

Check in on yourself – Self assessments for:

- Anxiety
- Depression
- Quick Mind Check



Humana Behavioral Health Consult Team

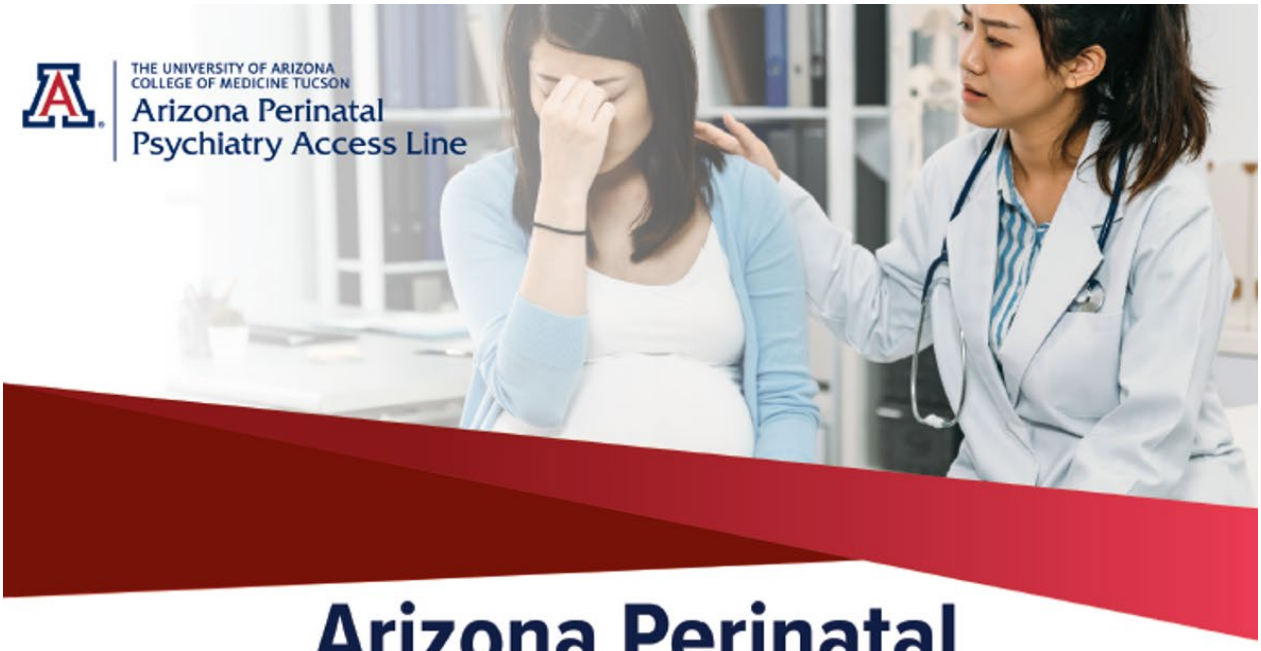


When To Refer

Common referral conditions listed below; from rounds consultation to risk assessment for behavioral needs

Severity and/or Complex BH Needs	
• Addiction or SUD Treatment • Member crisis but no immediate risk • Serious Mental Illness (SMI) • Eating Disorders • Pregnancy or recent birth complicated by BH needs • Consultation on appropriate level of care • BH provider access issues	• Special need population – BH treatment needed • BH symptoms complicating chronic physical health condition • BH symptoms significantly affecting daily life • Psychiatric evaluation needed • Early indicators of BH Symptoms • Other reasons based on clinical judgement

Arizona Perinatal Psychiatry Consult Line



Arizona Perinatal Psychiatry Access Line

Is your patient pregnant or postpartum and struggling with substance use and/or their mental health?

Call 888-290-1336

to consult with perinatal psychiatrists who will provide free clinical guidance, M-F, 12:30 p.m.-4:30 p.m.

APAL is a statewide perinatal psychiatry access line. We assist medical providers in caring for their pregnant and postpartum patients with mental health and substance use disorders. Perinatal psychiatrists are available by phone to answer your questions and review treatment options.

APAL.arizona.edu

team@apal.arizona.edu

Banner Health Network Pyx Health Program

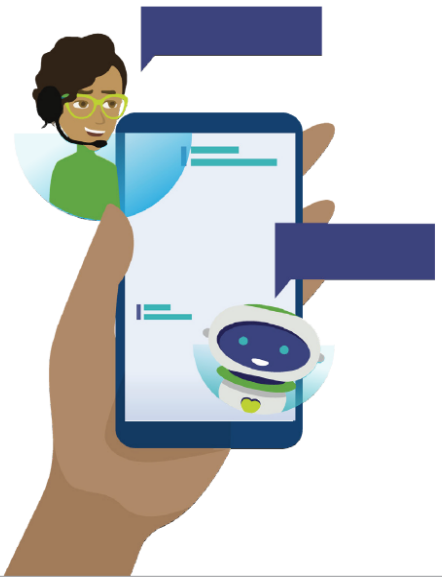
Pyx Health builds connections with each user to bridge the gap between their precise needs and the right resources — all while providing a friend who cares.

Pyx Health is proud to partner with your organization to address loneliness and social isolation, the root cause of myriad physical and behavioral health problems. Through the combination of an engaging mobile experience and friendly humans at the Compassionate Support Center, Pyx Health supports users outside the care setting.

You have no idea how good it felt to answer the phone and have someone ask me, 'How are you feeling today?' It feels like I really do have friends.

Maria, Pyx Health member

- **Access resources, screenings, and SDOH support**
  In addition to providing quick and easy access to your resources, the Pyx Health program also regularly screens for loneliness, depression, anxiety, and SDOH needs (housing, food, childcare, transportation, etc), and offers real-time help to meet users' needs.
- **Chat with Pyxir, the friendly chatbot**
  Pyxir and his best friend Rudy provide 24/7 companionship, humor, and uplifting support with loneliness, anxiety, motivation, and more.
- **Get human support**
  Our Compassionate Support Center staff is ready to assist users over the phone during weekday business hours — making them feel heard, seen, and helped in times of need with a connection to your organization or a community-based organization. There is no limit to the duration or number of calls between users and our trained staff.



Thank you for all your help. I was able to find resources on that site. I actually found MOPS, a support group for moms. I was looking for that too.

Jenny, Pyx Health member

Signing up is easy

The app is available at the App Store and Google Play store, or on the web at pyxhealth.com/store-download. Those without a smartphone can receive services via telephone at 1-855-499-4777.

Banner Health Network

Pyx Health®
Because no one gets better alone™

pyxhealth.com • 1-855-499-4777

Screening Tools

PHQ – 2 Short Depression Screening Tool

Patient Health Questionnaire-2 (PHQ-2)

Instructions:

Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0=Not at all; 1=Several days; 2=More than half the days; 3=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

Instructions

Clinic personnel will follow standard scoring to calculate score based on responses.

Total score: _ _

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-9 Depression Screening Tool

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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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GAD – 7 Anxiety Screening Tool

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than 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 is 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

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

Geriatric Depression Scale (GDS)– Short Form

Patient Version

Geriatric Depression Scale (Short Form)
Self-Rated Version

Patient's Name: _____ Date: _____

***Instructions*: Choose the best answer for how you felt over the past week.**

No.	Question	Answer	Score
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 people?	YES / NO	
11.	Do you think it is wonderful to be alive?	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	
		TOTAL	

(Sheikh & Yesavage, 1986)

GDS Scoring

Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is considered normal. A score greater than 5 suggests depression.

No.	Question	Answer	Score
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 people?	***YES*** / NO	
11.	Do you think it is wonderful to be alive?	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	
		TOTAL	

(Sheikh & Yesavage, 1986)

Edinburgh Postnatal Depression Scale (EPDS)

Patient Version

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

EPDS Scoring

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

PHQ – A (PHQ-9 Modified for Adolescents)

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

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

	(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?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

SMFQ – Short Mood & Feelings Questionnaire

The SMFQ is designed to measure core depressive symptomology in children and adolescents aged 6-17 years old. There are two versions, one for the patient responses and one for parent or caregiver responses. There are no prescribed cut points for the SMFQ; however higher scores (over 12), suggest greater severity in depression symptoms. Providers should use their clinical judgement and discretion.

Self-Reported

Short Mood and Feelings Questionnaire

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

For each question, please check how much you have felt or acted this way *in the past two weeks.*

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

	NOT TRUE	SOMETIMES	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 any more	❑	❑	❑
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	❑	❑	❑

Parent or Caregiver Reported

Parent Report Version — SMFQ

Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks.*

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

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	❑	❑	❑
2. S/he didn't enjoy anything at all	❑	❑	❑
3. S/he felt so tired that s/he just sat around and did nothing	❑	❑	❑
4. S/he was very restless	❑	❑	❑
5. S/he felt s/he was no good any more	❑	❑	❑
6. S/he cried a lot	❑	❑	❑
7. S/he found it hard to think properly or concentrate	❑	❑	❑
8. S/he hated him/herself	❑	❑	❑
9. S/he felt s/he was a bad person	❑	❑	❑
10. S/he felt lonely	❑	❑	❑
11. S/he thought nobody really loved him/her	❑	❑	❑
12. S/he thought s/he could never be as good as other kids	❑	❑	❑
13. S/he felt s/he did everything wrong	❑	❑	❑

SMFQ Scoring

(Short Mood and Feelings Questionnaire)

Scoring the SMFQ

Note: the SMFQ has been validated for use in children age 6 years and up.

The SMFQ should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child's symptom severity and treatment response over time.

Scoring:

Assign a numerical value to each answer as follows:

Not true = 0

Sometimes = 1

True = 2

Add up the assigned values for all 13 questions. Record the total score.

A total score on the child version of the SMFQ of 8 or more is considered significant.

> Sensitivity of 60% and specificity of 85% for major depression at a cut off score of 8 or higher. Source is Angold A, Costello EJ, Messer SC. "Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents." *International Journal of Methods in Psychiatric Research* (1995), 5:237-249.

Sensitivity/specificity statistics of the parent version is not reported in the literature. If your patient does not complete the child version of SMFQ, repeated administration of the parent version over time should still be useful for symptom tracking.

Tool Kit Survey

To help us continuously improve our tool kits, education, and communication with providers, please take this short survey regarding the Behavioral Health Toolkit by scanning the QR code with your mobile devise or visiting https://forms.office.com/r/m6XCEWq9hY

Thank you so much for your feedback!

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