TeenScreen® Primary Care

Post-Screening Interview Resources

For adolescents that score positive on the screening questionnaire.

Patients that score positive on the screening questionnaire should be evaluated by the PCP to determine if the symptoms endorsed on the questionnaire are significant, causing impairment for the patient, and warrant a referral to a mental health specialist or follow-up by the PCP. The interview with the patient should focus on their answers to the questionnaire and the specific symptoms with which they are having difficulties. For patients who score negative, it is recommended that the PCP briefly review the symptoms marked as "sometimes" and "often" with the patient.

Following are resources you may find helpful for conducting the post-screening interview with youth who complete the screening questionnaire.

Before the Interview

The purpose of this document is to provide guidelines for assessing youth who score positive on the screening questionnaire. The protocol provides follow-up questions for the primary care provider (PCP) to probe in the problem areas identified by the adolescent's responses.

The last section of the interview tool provides space to identify suicidal youth, summarize the presenting problems confirmed by the interview, and list next steps for treatment or referral. It is recommended that the completed interview tool be sent to the behavioral health provider upon referral.

In this document, you will find:

1. Post-screening interview checklist
2. Sample symptom-specific questions that may be used to assess for specific problem areas
3. Information on conducting a suicide risk assessment

1. Post-Screening Interview Checklist

The following is a checklist to assist with structuring the post-screening interview.

Identifying Information

PATIENT NAME:________________________________ **PATIENT NO:____________**

DOB:________________ **AGE:____________________** **SEX:____________________**

PARENT/GUARDIAN:__________________ **DATE OF INTERVIEW:______**

SCREEN RESULTS: **_____Positive** **_____Negative** **_____Other**

Beginning the Interview

Rapport-Building Questions	**Comments**
1. How has school been: What grades are you getting?	
2. How are you getting along with people these days? Do you have friends that you can really trust?	
3. How are things at home? How are you getting along with your parents?	
4. What do you like to do for fun?	

Depression

Low Mood: ___ No ___ **Yes →** Details:	**Guilt/ Worthlessness**: ___ No ___ **Yes →** Details:
Irritability: ___ No ___ **Yes →** Details:	**Hopelessness**: ___ No ___ **Yes →** Details:
Lack of Pleasure/ Interest: ___ No ___ **Yes →** Details:	**Fatigue/ Loss of Energy**: ___ No ___ **Yes →** Details:
Sleep Disturbance: ___ No ___ **Yes →** Details:	**Decreased Concentration/ Indecisiveness**: Details: ___ No ___ **Yes →**
Appetite/ Weight Change: ___ No ___ **Yes →** Details:	**Agitation/ Retardation** ___ No ___ **Yes →** Details:

Impairment Details:

Suicidal Ideation

Thoughts of killing self: ___ No ___ **Yes** → Details:	**Onset:** **Frequency**: **Recency:**
Suicide Plan/ Methods associated with thoughts: ___ None ___ Vague ___ Specific Details:	
Method(s) available: ___ No ___ Uncertain ___ Yes→ Details:	**Strength of Intent/ Wish to Die:**
Precipitants/ Triggers of suicidal ideation:	**Deterrents to suicidal actions:**
Passive suicidal ideation (e.g., Wish were dead, never wake up):	**Onset, frequency, recency:**

Suicidal Behavior – Number of attempts in lifetime: _____________

Most RECENT Suicide Attempt	Most SERIOUS Suicide Attempt
Date:	**Date:**
Method: ___ Planned ___ Impulsive Details: **Believed action would result in death** (Intent): ___ No ___ Uncertain ___ Yes **___ Disclosed __ Was Discovered ___ Stopped self** **Details:** **Attempts to conceal**: **Lethality/ Medical attention**: **Stressors/ Mood just prior to attempt**: **Substance use just prior to attempt**:	**Method**: ___ Planned ___ Impulsive Details: **Believed action would result in death** (Intent): ___ No ___ Uncertain ___ Yes **___ Disclosed __ Was Discovered ___ Stopped self** **Details:** **Attempts to conceal**: **Lethality/ Medical attention**: **Stressors/ Mood just prior to attempt**: **Substance use just prior to attempt**:

Summary of Suicide Risk Assessment (see page 20 for additional information):
❒ **Low** ❒ **Moderate** ❒ **High**
Reasons:

Parents should be informed of current active suicidal ideation (thoughts of killing self within the last 3 months) and past suicide attempts.

Anxiety

Panic Attacks: ___ No ___ **Yes** → Details:	**Onset, frequency, recency:**
Persistent anxiety/ worry: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Social Anxiety: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Other Anxiety: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:

Inattention

Difficulty sustaining attention: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Easily distracted or forgetful: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Difficulty organizing tasks or activities: Details: ___ No ___ **Yes** →	**Impairment:** ___ No ___ **Yes** → Details:
Avoids tasks that require sustained mental effort: Details: ___ No ___ **Yes** →	**Impairment:** ___ No ___ **Yes** → Details:

Hyperactivity/ Impulsivity

Difficulty engaging in leisure activities quietly: Details: ___ No ___ **Yes** →	**Onset, frequency, recency:**
Fidgets, squirms, runs about excessively: Details: ___ No ___ **Yes** →	**Impairment:** ___ No ___ **Yes** → Details:
Interrupts or intrudes on others: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Difficulty awaiting turn: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:

Conduct Problems

Aggression to people or animals: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Destruction of property: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Deceitfulness or theft: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Serious violations of rules: ___ No ___ **Yes** → Details:	**Impairment:** ___ No ___ **Yes** → Details:
Argues with adults, defies adults' requests: Details: ___ No ___ **Yes** →	**Impairment:** ___ No ___ **Yes** → Details:
Loses temper, is angry, spiteful, or resentful: Details: ___ No ___ **Yes** →	**Impairment:** ___ No ___ **Yes** → Details:

Substance Use

Alcohol use: ___ No ___ **Yes** → Details: Frequency of use: ________________ Quantity used: ____________	**Impairment:** ___ No ___ **Yes** → Details:
Marijuana use: ___ No ___ **Yes** → Details: Frequency of use: ________________ Quantity used: ____________	**Impairment:** ___ No ___ **Yes** → Details:
Other drug use: ___ No ___ **Yes** → Details: Type of drug(s): ________________ Frequency of use: ________________ Quantity used: ____________	**Impairment:** ___ No ___ **Yes** → Details:

Other Problem Areas:

____

____

Current Stressors:

____

____

Psychiatric History: ❒ No ❒ Yes, describe: ______________________________________

____

____

Screening Impressions: ____

____

____

Currently seeing a mental health professional? ❒ Yes ❒ No **Future appt. scheduled?** ❒Yes ❒ No
If yes, describe contact:

____

____

<u>Visit Disposition:</u>

❒ Crisis/ Emergency care

❒ Youth in treatment, confirm/ discuss with parent

❒ Follow-up with PCP

❒ Referral for Mental Health Evaluation

❒ No referral, inform parent about suicidal behavior

2. Sample Symptom Specific Questions

Additional questions that provide healthcare professionals with examples of questions commonly used to explore specific problem areas uncovered by the screening questionnaire and assess for suicide risk factors are below.

General Questions

- How has school been for you this year? What kind of grades are you getting?
- How have you been feeling lately?
- How are you getting along with other people lately? At home? At school? Do you have some friends or a best friend whom you can really trust and confide in? Can you count on a teacher(s) for support or help? Can you talk to your parent(s) and expect that they will try to support or to help you?
- What do you do for fun? What activities are you involved in at school? At home?
- Are you having a lot of hassles in your life lately? With people at school? With friends? With boy/ girlfriend? With family? Or others?
- How is your health?

Symptom-Specific Questions

Depression Items

1. How has your mood been lately, over the last three months? Have you been feeling sad or blue or depressed? Have you been feeling irritable or grumpy a lot? How often do you feel that way? How long does that feeling last? Have you ever felt that way most of the day for several days in a row? Do those feelings come and go a lot? How recently have you felt that way? What was happening in your life when you felt that way?
2. You mentioned that you enjoy ___ activities. Have you been doing (fill in favorite activities) lately, as much as usual? How often? With whom? Have you enjoyed (activities) as much as usual? Do you feel like you are just going through the motions and things aren't as fun as they used to be? Have you lost interest in the things you usually want to do? Is there anything you still enjoy or spend as much time doing as you have in the past?
3. How has your energy been lately? Do you feel so tired that you have to take naps? How often?
4. How do you sleep at night? What time do you go to bed? What time do you go to sleep? What time do you wake up? Any trouble falling asleep? Waking up in the middle of the night and not being able to go back to sleep? How about waking up too early in the morning and not being able to fall back asleep? Do you worry a lot when you cannot sleep? What about? Are you sleeping a lot more than usual?
5. How is your eating? Has there been a change in how hungry you are? Have you been eating more or less than usual? Have you gained weight or lost any weight without trying to? How much?
6. Have you had any trouble concentrating or making decisions? Have you had trouble reading or paying attention to your schoolwork?
7. How have you been feeling about yourself lately? Have you felt that you are not as smart or as good-looking as other people? Have you been feeling bad about things you have done or not done?
8. How have you been feeling about the future? Have you been feeling that nothing will work out for you?
9. Have you been slowed down, as if you were walking or talking in slow motion? Or were you really restless, always moving, pacing or wringing your hands? Has anyone commented on that?
10. Have you had these experiences (feeling sad, cranky, and tired, trouble sleeping, etc) around the same time? Did that time last at least 2 weeks/ or as long as a year?

11. Distress/ Impairment: Have you wanted to get some help with (feeling depressed and other symptoms reported)? Has (feeling depressed and other symptoms reported) caused problems for you at school (or work)? Has (feeling depressed and other symptoms reported) caused problems for you with your friends or family? What kinds of problems?
12. If you suspect psychosis: At that time, or any other time, have you felt your imagination playing tricks on you? For example, did you believe things you found out later weren't true, like someone was out to get you, or to hurt you? Or that you were a very special person, smarter, more powerful than other people? Or that people on the radio or television were talking about you? Did you hear voices or see things that weren't really there?

General Anxiety Symptoms

1. On the questionnaire, you said that you were nervous or worried. What situations make you nervous? How nervous do you get? What do you worry about?
2. How much of the time are you worried about something? Has being nervous or worried caused problems for you at school? Has being worried or nervous caused any problems for you with your friends or family?
3. Has being worried or nervous caused any other problems for you? Have you wanted to get some help with being so nervous or worried?

Generalized Anxiety Disorder (i.e., anxiety about a number of events and activities)

1. What do you worry about? Do you worry most of the time/ more days than not? Can you stop worrying for awhile if you try?
2. Do you also feel jumpy and restless? Do you get tired easily? Do your muscles hurt from being tight?
3. Do you have trouble concentrating or find that your mind goes blank?
4. Do you get mad easily and often?
5. Have you had any trouble sleeping? What troubles do you have? Falling asleep? Waking up in the middle of the night?
6. Distress/ Impairment: Has being so worried caused problems for you at school? Has worrying a lot caused any problems for you with your friends or family? Has worrying a lot caused any other problems for you? Have you wanted to get some help with being so worried?

Social Phobia (i.e., anxiety in social or performance situations)

1. What situations make you nervous? How nervous do you get? Are you always very nervous before or during (situation)?
2. Does this happen in situations with kids your own age or just with adults?
3. Can you tough it out and get through the situation or do you avoid it even if it means you get marked down in school or get in trouble?
4. If you do (the thing(s) that make you nervous) it, do you start to feel less nervous or are you really upset and anxious the whole time?
5. Distress/ Impairment: Have you wanted to get some help with being so nervous in these situations? Has being so nervous or avoiding these situations caused problems for you at school (or work)? Has being so nervous or avoiding these situations caused problems for you with your friends or family? What kinds of problems? Has being so nervous or avoiding these situations stopped you from doing things you really wanted to do? What kinds of things?

Panic Disorder

1. Have you ever felt suddenly extremely nervous or afraid in a situation that most people would not think of as scary? Of felt like you were having a heart attack? When this happens do you sweat a lot or feel very hot or cold? Do you feel your heart pounding? Do you feel shaky? Did you have trouble breathing or feel like you were choking? Do you have an upset stomach or feel like you want to vomit? Does your chest hurt? Did you feel dizzy or lightheaded like you might faint? Did you have tingling or numbness in your fingers and feet? When this happens do you think that you are going crazy or losing control or that you might die?
2. If you have asthma, did you ever feel this way when you were NOT having an asthma attack?
3. Did these attacks happen only when you were using drugs?
4. How many times have you had attacks like this, with several of those experiences you mentioned coming on very suddenly? After an attack like this, have you ever felt nervous and worried that you might have another attack? Have you worried about why you had the attack and whether it means you are going crazy or are very sick?
5. Have you been avoiding situations or changed your behavior in some way since you began having these attacks?

Obsessive-Compulsive Disorder

Compulsions

1. You mentioned on the questionnaire that you often check things or do things over and over again. What do you do? How often do you do this? How many times a day does this happen?
2. If you can’t (repetitive behaviors reported), how do you feel? Do you try to stop yourself from doing these things?
3. Are there rules you use to repeat them? What are your rules?
4. How much time do you spend doing these things?
5. Why do you do (repetitive behaviors reported)?
6. Distress/ Impairment: Has doing these things over and over caused problems for you at school? Has doing these things over and over caused any problems for you with your friends or family?
7. Has doing these things over and over caused any other problems for you? Have you wanted to get some help with doing these things over and over?

Obsessions

1. You mentioned on the questionnaire that you have thoughts or images that come back to you over and over again. What are the thoughts or images? Are they upsetting to you?
2. Are these thoughts the same as worries that you have?
3. Have you tried to ignore these thoughts or stop yourself form having them? What happens when you try?
4. How much time do you spend having these thoughts?
5. Distress/ Impairment: Have these thoughts caused problems for you at school? Have these thoughts caused any problems for you with your friends or family? Have these thoughts caused any other problems for you? Have you wanted to get some help with these thoughts?

Inattention/ Hyperactivity

1. Do you have difficulty paying close attention to schoolwork or play activities and often make careless mistakes? How does this cause you problems in school, at home, or with your friends?
2. Are you easily distracted or forgetful? Do you often lose things necessary to do your schoolwork or other tasks (books, worksheets)? Does this cause problem for you at home, school, or with friends?
3. Do you have difficulty following instructions or organizing your work? How does this affect your schoolwork or homework?
4. Do you avoid, dislike or express reluctance to do school work that requires a lot of mental effort? Is this a problem at school/home?
5. Do you have difficulty playing quietly? How does this affect you?
6. Do you often fidget, squirm in, or leave your seat? Do you often run about or climb excessive when it is not appropriate? Do you often talk too much? Do these cause problems for you at school or home?
7. Do you interrupt others who are working or playing? How does this cause problem for you?
8. Do you blurt out answers or take your turn before the right time?

Conduct Problems

1. Do you often bully or threaten others or initiate physical fights? Have you ever used a weapon to cause serious harm? Have you been physically cruel to people or animals? Have you stolen directly from a victim (i.e. mugging, purse-snatching)?
2. Have you deliberately started a fire or done something else to destroy property?
3. Have you broken into someone's house or car? Do you often lie to obtain goods or favors? Have you stolen items of value without confronting the victim (i.e., shoplifting, forgery)?
4. Do you often stay out late at night against your parents' wishes? Have you run away from home overnight at least twice? Are you often truant from school and did you start this before age 13 years?
5. Do you often lose your temper or argue with adults? Do you often actively defy adult requests or rules?
6. Do you often deliberately annoy people? Are you touchy or easily annoyed by others? Do you often blame your mistakes on others?

Alcohol and Substance Abuse

1. You mentioned on the questionnaire that you have used (fill in substance or substances indicated and ask questions for each one).
2. When was the last time you used? What was the situation?
3. Were you with family? With friends? Were you alone?
4. How often do you use? How much do you usually use?
5. Did you like the feeling you had when you used? Why, why not?
6. Have you been in situations where you have or could have been hurt or gotten in trouble when you were (drinking/ using drug)? For example, have you had unprotected sex? Missed school? Been suspended or expelled? Driven a car after (drinking/ using drug)? Gotten into fights or arguments after (drinking/ using drug)? Tried to kill yourself after (drinking/ using drug)? Had any problems with the police because of (drinking/ using drug)? Ended up (drinking/ using drug) a lot more than you planned to? Felt depressed or angry or sick while or after (drinking/ using drug)? Any other problem you had while or after (drinking/ using drug)? Wanted help because you were (drinking/ using drug) too much?

RISK FACTORS/ WARNING SIGNS OF SUICIDE

The most common risk factors associated with teen suicide include depression, previous suicide attempts, frequent thought about death, and the use of drugs or alcohol. The following information was accessed from the American Academy of Child and Adolescent Psychiatry (AACAP) Web site to provide you with additional information about identifying and managing potentially suicidal patients.

Many of the signs and symptoms of suicide are similar those of depression:

- Change in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent actions, rebellious behavior, or running away
- Drug and alcohol use
- Unusual neglect of personal appearance
- Marked personality change
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in pleasurable activities
- Not tolerating praise or rewards

A teenager who is planning to commit suicide may also:

- Complain of being a bad person or feeling rotten inside
- Give verbal hints with statements such as: I won't be a problem for you much longer; Nothing matters; It's no use, and I won't see you again
- Put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- Become suddenly cheerful after a period of depression
- Have signs of psychosis (hallucinations or bizarre thoughts)

3. Suicide Risk Assessment[1]

If your patient endorses either of the suicide questions on the questionnaire, or the patient displays common risk factors associated with depression and/ or suicide (see above), we suggest conducting a comprehensive suicide risk assessment to determine the patient's level of risk and the most appropriate next steps. We also recommend that all patients that score positive on the questionnaire be assessed for depression and suicide.

You may want to begin by asking your patient about their feelings about being alive and generally about suicide ideation, using questions such as:

1. Have you ever felt that life is not worth living?
2. Did you ever wish you could go to sleep and just not wake up? How often? Since when?
3. Do you think about dying? Or wish you were dead?

Based on the patient's response, you may then want to proceed to more specific questions, such as:

1. Do you ever imagine that others would be better off without you?

[1] Adapted from Petit J, Cohen G, Lednyak, L. Detecting and treating depression in adults. *City Health Information*. 2007;26(9):59-66 [revised May 2008]. Available at: http://www.nyc.gov/html/doh/downloads/pdf/chi/chi26-9.pdf

2. Do you think about how it would be if you were dead? How often? Since when?
3. Do you think about people who have died? How often? Since when? Do you know someone who ended his or her own life? Do you know someone who tried to kill himself or herself?
4. Have you thought seriously about killing yourself? When was the first time you had those thoughts? When was the most recent time? What was going on with you or in your life that made you think about killing yourself? How often did you think about it?
5. How close have you come to acting on those thoughts, doing something to end your life? What did you do? When was that?

If a patient exhibits suicidal ideation, you may then want to ask if he or she has a suicide plan or if they have previously attempted suicide, such as:

1. Have you thought about how you would end your life? What would you do? When did you think you would do it? Where did you think you would do it? Are (guns/ pills/ other methods) (at home/ easy to get)?

2. Have you ever started to do something to end your life but changed your mind? Have you ever started to do something to end your life but someone stopped you or interrupted you? What happened? When was that? How often did that happen?

3. (Have you ever/ on the questionnaire you mentioned that there was a time when you) tried to end your life. How often did you do that? When was the first time? When was the most recent time? What did you do? What happened after you did that? At the time you did that, how much did you want to die? At the time you did that, how certain were you that you would die? Afterward, did you feel glad or sorry that you were alive?

4. Around the times you (tried to end your life/ thought seriously about ending your life), were you drinking or using drugs? How was your mood? Did you tell anyone about what you did or about how you were feeling? Has anything changed since you (tried to end your life/ thought seriously about ending your life)?

5. What things would make you feel more/ less hopeful about the future? What things would make you more/less likely to want to kill yourself? What things would make you more/ less likely to try to kill yourself? What things make you want to go on living?

Potential Crisis Situations

Before screening begins, it may be helpful to review standard crisis protocols and guidelines that are in place to manage crisis situations and abuse situations that may arise as a result of screening. Crisis situations may involve any or all of the following:

Imminent Danger:

- Currently at high risk for suicidal behavior
- Currently at high risk for homicidal behavior
- Exhibits violent behavior
- Exhibits psychotic symptoms

Current Suicidal Ideation:

- Includes thinking about killing self within the last three months
- Includes transient thoughts of killing self that occurred within the last three months
- Does not include thoughts about suicide as an abstract concept

Past Suicide Attempts:

- Any self-injurious behavior accompanied by evidence (either explicit or implicit) that the person intended to die regardless of lethality of method

- Includes aborted or interrupted attempts: any potentially self-injurious behavior accompanied by evidence (either explicit or implicit) that the person intended to die but stopped or was interrupted before physical damage occurred

Risk Levels[2]

Low Risk	No current thoughts of hurting or harming self and no other major risk factors (thoughts of suicide as an abstract concept) **Action:** Follow-up visits or non-urgent referral to mental health specialist; continue to monitor the patient.
Intermediate Risk	Current thoughts of harming or killing self, but neither plans, previous attempts or other major risk factors. **Action:** Assess suicide risk at subsequent visits, involve family, and refer to a mental health specialist for an urgent mental health assessment.
High Risk	Current thoughts of harming or killing self, with plans, and/ or access to method(s) and/ or other major risk factors or warning signs. **Action:** Emergency management by a mental health specialist. Arrange a safe means for transport to the nearest emergency room.

If a patient is actively thinking of suicide and/ or has made a suicide attempt in the past (and if he or she reports having a plan for committing suicide), arrange an immediate consultation with a psychiatrist or other qualified mental health professional. Actively thinking about suicide constitutes a medical emergency that may necessitate calling 911.

SAFE-T Pocket Card; Suicide Assessment Five-Step Evaluation and Triage

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a SAFE-T Pocket Card that is available free of charge for mental health clinicians and health care providers. This pocket card provides a five-step evaluation and triage protocol to assess patients for suicide risk. Information included on this pocket card drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors.

The SAFE-T Pocket Card can be ordered through SAMSHA's web site at: http://nmhicstore.samhsa.gov/publications/ordering.aspx.

[2] Adapted from Intermountain Health Care. Depression 2006 Update. p.11. Available at: https://kr.ihc.com/ext/Dcmnt?ncid=51061767

WHEN TO REFER TO A MENTAL HEALTH SPECIALIST (AACAP)

The following excerpt was taken from a fact sheet developed by AACAP to provide physicians with information about when to seek a referral to a mental health specialist. This worksheet, and other helpful resources for physicians, can be found in its entirety at:
http://www.aacap.org/page.ww?name=Physicians+and+Allied+Professionals§ion=Physicians+and+Allied+Professionals

Specific Criteria for Referrals
The referring practitioner should consider the following criteria when considering the decision to refer:

1. When an adolescent demonstrates an emotional or behavioral problem that constitutes a threat to the safety of the adolescent or the safety of those around him/her. (e.g. suicidal behavior, severe aggressive behavioral, an eating disorder that is out of control, other self-destructive behavior).

2. When an adolescent demonstrates a significant change in his/her emotional or behavioral functioning for which there is no obvious or recognized precipitant. (e.g. the sudden onset of school avoidance, a suicide attempt or gesture in a previously well functioning individual).

3. When an adolescent demonstrates emotional or behavioral problems (regardless of severity), and the primary caretaker has serious emotional impairment or substance abuse problem. (e.g. an adolescent with emotional withdrawal, whose parent is significantly depressed; an adolescent with behavioral difficulties whose parents are going through a "hostile" divorce).

4. When an adolescent demonstrates an emotional or behavioral problem in which there is evidence of significant disruption in day-to-day functioning or reality contact. (e.g. an adolescent who has repeated severe tantrums with no apparent reason, an adolescent reports hallucinatory experiences without an identifiable physical cause).

5. When an adolescent is hospitalized for the treatment of a psychiatric illness.

6. When an adolescent with behavioral or emotional problems has had a course of treatment intervention for six to eight weeks without meaningful improvement.

7. When adolescent presents with complex diagnostic issues involving cognitive, psychological, and emotional components that may be related to an organic etiology or complex mental health/ legal issues.

8. When an adolescent has a history of abuse, neglect and/or removal from home, with current significant symptoms as a result of these actions.

9. When an adolescent whose symptom picture and family psychiatric history suggests that treatment with psychotropic medication may result in an adverse response. (e.g. the prescription of stimulants for a hyperactive adolescent with a family history of bipolar disorder or schizophrenia).

10. When an adolescent has had only a partial response to a course of psychotropic medication or when any child is being treated with more than two psychotropic medications.

12. When an adolescent with a chronic medical condition demonstrates behavior that seriously interferes with the treatment of that condition.