Integrated Behavioral Health SCREENING TOOLS for Primary Care

IBHP Integrated Behavioral Health Project

CPCA California Primary Care Association

CalMHSA Compassion. Action. Change.

Mental Health Services Act Proposition 63 California

"Despite the high prevalence of mental health and substance use problems, too many Americans go without treatment—in part because their disorders go undiagnosed. Regular screenings in primary care and other healthcare settings enables earlier identification of mental health and substance use disorders, which translates into earlier care. Screenings should be provided to people of all ages, even the young and the elderly."[1] These easy to use tools have been selected because they are appropriate for Community Clinics and Health Centers and recommended by vanguard CCHCs that use them. *Documents and summaries sourced from www.integration.samhsa.gov unless otherwise noted.*

GENERAL RESOURCES

Healthy Living Questionnaire

Please note that the first eight questions are taken from the SF-8 Health Outcomes Questionnaire, and it requires a license to be administered.

Copyright: The Medical Outcomes Trust (MOT), Health Assessment Lab (HAL) and QualityMetric Incorporated, www.qualitymetric.com.

Kessler 6

The Kessler 6, a six-question scale & Kessler 10 (the Kessler 6 modified) are mental health screening tools used with a general adult population. It is a short measure of non-specific psychological distress based on questions about the level of nervousness, agitation, psychological fatigue and depression, used to distinguish psychological distress from serious mental illness. Designed by Professor Ronald C. Kessler, Health Care Policy, Harvard University, the measure was designed as the mental health component at the 'core' of the annual United States National Health Interview Survey. The **Kessler 6** is available in Arabic, Cantonese, Japanese, and Spanish and the **Kessler 10** in Arabic, Mandarin, Japanese, Spanish and Swahili.

More information about use, questionnaires, scales and training as well as additional languages at www.hcp.med.harvard.edu.

Duke Health Profile

The Duke Health Profile (Duke) is a 17-item standardized self-report instrument containing six health measures (physical, mental, social, general, perceived health, and self-esteem), and four dysfunction measures (anxiety, depression, pain, and disability).

Patient Stress Questionnaire

The Patient Stress Questionnaire is a 26-question tool used in primary care settings to screen for behavioral health symptoms. It was adapted from the PHQ-9, GAD-7, PC-PTSD, and AUDIT, and is available in Spanish.

From University of Massachusetts

PHQ 15

The PHQ 15, the Somatic Symptom Severity Scale, is a 15-question scale and is also available in Spanish.

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Quality of Life Scale

The Quality of Life Scale is a 10-question tool ,measures five domains of quality of life: material and physical well-being, relationships with others, social, community and civic activities, personal development and fulfillment and recreation.

The QOLS is copyrighted by Carol Burckhardt. However, it is considered to be in the public domain. For more information about validation http://www.ncbi.nlm.nih.gov/pmc/articles/PMC269997.

GENERAL RESOURCES, continued

Pittsburgh Insomnia Rating Scale

The Pittsburgh Insomnia Rating Scale (PIRS) is a patients' self assessment scale of 52-questions about sleep and rest, and is available in multiple languages that can be accessed from the University of Pittsburgh after completing a user agreement. The complete list of languages is available at www.proqolid.org/instruments/pittsburgh_sleep_quality_index-psqi.

Copyright University of Pittsburgh Medical School; may be used for non-commercial purposes; no modifications without permission, www.sleep.pitt.edu/content.asp.

Insomnia Severity Scale

The Insomnia Severity Scale is a seven-question self assessment scale recommended by the Department of Veteran's Affairs. The Spanish version is validated in Spain and can be purchased at www.sciencedirect.com/science/article/pii.

Brief Pain Inventory

Brief Pain Inventory is a nine-question self assessment scale. Available free to individual clinical practices. Available in 23 languages and linguistically validated in 27.

Recommended by the Department of Veterans Affairs and the Department of Defense. See MD Anderson Cancer Center web site, www.mdanderson.org.

GENERAL RESOURCES - PEDIATRIC

Vanderbilt Assessment Scale-Parent

The Vanderbilt Assessment Scale-Parent is a 52-question ADHD screen for parents and teachers. Vanderbilt scoring instructions. Also available is the 43-question Vanderbilt Assessment Scale-Teacher. The parent form is available in Spanish and a Spanish language parent education page is available at www.addrc.org/category/spanish-language/.

Copyright 2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality.

Modified Checklist for Autism in Toddlers (M-CHAT)

Modified Checklist for Autism in Toddlers (M-CHAT) is a parent/child 23-question assessment tool to be scaled by a professional. Validated for children 16-30 months; recommended by the American Academy of Pediatrics. The tool is being validated in multiple languages including Spanish for Western Hemisphere, Chinese, Korean, Vietnamese. For more information google MCHAT and click on M-CHAT Information.

Robins, D., Fein, D., Barton, M. Green, J. (2001) The Modified Checklist for Autism in Toddlers: an initial study investigating the early detection of autism and pervasive developmental disorders. Journal of Autism and Developmental Disorders, 31 (2), 131-144. In public domain, www.m-chat.org

Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a 35-item evidence based method for detecting and addressing developmental and behavioral problems. Available in multiple languages including English, Spanish, Chinese, Hmong, Japanese, and Khmer. Adolescent versions available in English, Spanish, Chinese and Vietnamese. Pictorial versions in English and Spanish. The 17 item version for parents and youth and other languages can be found on the web site.

For further information www.massgeneral.org/psychiatry/services/psc_forms.aspx. In public domain. Extensive literature review available on the web site.

GENERAL RESOURCES - MOOD AND ANXIETY DISORDERS

Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9) is the most common screening tool to identify depression. Available in Spanish and Adolescent versions.

GENERAL RESOURCES - MOOD AND ANXIETY DISORDERS, cont.

Geriatric Depression Screen (GDS)

The Geriatric Depression Screen (GDS) Short Form is a 15-question tool and is available in Spanish as well as multiple languages at www.stanford.edu, however no validations are listed.

The use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986. May be copied without permission.

Mood Disorder Questionnaire (MDQ)

The Mood Disorder Questionnaire (MDQ) includes 13 questions associated with bipolar disorder symptoms and is available in Spanish. Designed for screening purposes only and not to be used as a diagnostic tool.

Permission for use granted by RMA Hirschfeld, MD.

SAFE-T

The SAFE-T (Suicide Assessment Five-Step Evaluation and Triage) was developed in collaboration with the Suicide Prevention Resource Center and Screening for Mental Health and based upon work supported by SAMHSA. Guides for patients and family members are available in Spanish at www.store.samhsa.gov/facet/treatment-prevention-recover/term/suicide-prevention.

Suicide Behaviors Questionnaire (SBQ-R)

The Suicide Behaviors Questionnaire (SBQ-R) is a four-question scale assesses suicide-related thoughts and behavior.

PC-PTSD

The PC-PTSD is a four-item screen designed for use in primary care and other medical settings to screen for post-traumatic stress disorder. It is currently used by the VA. Public information in Spanish is available at www.ptsd.va.gov/public/pages/what_if_think_have_ptsd_spanish.asp.

GAD-7

The GAD-7 (Generalized Anxiety Disorder) is a seven-question screening tool that identifies whether a complete assessment for anxiety is indicated. It is available in multiple languages including Chinese and Spanish. Additional languages can be viewed by going to www.phqscreeners.com, click screening form and select language.

Pfizer granted permission to reproduce July 22, 2010.

SUBSTANCE USE DISORDERS

AUDIT

The AUDIT (Alcohol Use Disorders Identification Test) is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption. Developed by the World Health Organization (WHO), the test correctly classifies 95% of people into either alcoholics or non-alcoholics. The AUDIT is particularly suitable for use in primary care settings and has been used with a variety of populations and cultural groups. It should be administered by a health professional or paraprofessional. Available in Spanish.

CAGE AID or CAGE Assessment

The CAGE AID or CAGE Assessment is a commonly used, five-question tool used to screen for drug and alcohol use and has been tested in primary care. It is a quick questionnaire to help determine if an alcohol assessment is needed. If a person answers yes to two or more questions, a complete assessment is advised. Tested extensively in primary care and validated for older adults. Available in Spanish. Computerized, self administered takes 30 seconds to complete. Increased responsiveness among youth

AUDIT-C

The AUDIT-C is a simple three-question screen for hazardous or harmful drinking that can stand alone or be incorporated into general health history questionnaires. Tested extensively in primary care and validated for older adults. Self administered; takes two minutes to answer and 15 seconds to score. More info. at www.alcohol/learningcentre.org.uk/topics/browse/briefadvice.

SUBSTANCE USE DISORDERS, continued

DAST 10

The DAST 10 (Drug Abuse Screen Test) is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than eight minutes to complete. Designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth.

"SAMHSA Alcohol Use Among Older Adults Pocket Screening Instruments for Health Care and Social Service Providers"

Brief Pain Inventory 9-question self assessment scale. Available in 23 languages and linguistically validated in 27. Available free to individual clinical practices.

See MD Anderson Cancer Center web site, www.mdanderson.org.

MAST-G

The MAST-G Michigan Alcoholism Screening Test has developed a 10 question geriatric version. Developed by University of Michigan Alcohol Research Center, Michigan Alcohol Screening Test (MAST-G).

Copyright: The Regents of the University of Michigan, 1991. In the public domain.

UNCOPE PLUS

UNCOPE PLUS is a 10-question screen developed by Norman G. Hoffmann, PhD. Also available in Spanish.

More information www.evinceassessment.com. Permission granted to use.

SUBSTANCE USE / MOOD DISORDERS - PERINATAL

TWEAK

TWEAK is a five-question tool from the Fetal Alcohol Syndrome Disorders Center for Excellence, a division of SAMHSA. The tool combines questions from three other tools.

4 Ps

4 Ps is a four-question tool often used as a way to begin discussion about drug and alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment. Adopted by the Contra Costa Department of Health Services Maternal and Child.

Available in public domain.

Edinburgh Postpartum Depression

Edinburgh Postpartum Depression is the most common complication of childbearing. 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, has proven to be an effective screening tool, and is available in Spanish.

In public domain. Can also be downloaded from www.aap.org/practicingsafety/module2.htm.

SUBSTANCE USE DISORDERS - ADOLESCENTS

SBIRT Protocol for Teens

CRAFFT

The CRAFFT Six question alcohol and drug screen and scale is designed for adolescents. Available in multiple languages including Chinese, Japanese, Khmer, Laotian, Russian, Spanish, and Vietnamese.

www.ceasar-boston.org/CRAFFT/screenCRAFFT.php.

It is recommended by the American Academy of Pediatrics Committee on Substance Abuse. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Archives of Pediatrics & Adolescent156(6) 607-614, 2002.

OTHER RESOURCES - GENERAL

SAMHSA and other organizations have produced guides and recommendations for screening and treating behavioral health in primary care. Below you will find a brief description and links to these documents.

Learn more about trauma informed behavioral health care from this publication by the National Council on Behavioral Health: **www.integration.samhsa.gov/clinical-practice/sbirt/NC_Mag_Trauma_Web-Email.pdf**

Behavioral health publications in English and Spanish can be found at **www.samhsa.gov/publications.** The TIPS series offer an large range of topics relevant to integrating behavioral health into primary care. Below in the Substance Use Disorders Section you will find a selected few.

Alameda County CCHN BH Screening Tool list for consideration to add to EHR. Alameda CHCs have collaborated to adopt NextGen and to standardize data and quality measures. This list is under discussion for network wide EHR adoption.

The Integrated Behavioral Health Project's web site **www.ibhp.org** provides an encyclopedia of the Who, What, How and Where of integrated health. Its **"Partners in Health: Mental Health, Primary Care and Substance Use Inter-agency Collaboration Tool Kit"** provides resources, model summaries, MOU's, job descriptions and more.

OTHER RESOURCES - LEGAL

SAMHSA Guide 42cfr

The SAMHSA Guide 42cfr explains confidentiality requirements for storing and sharing sensitive information.

OTHER RESOURCES - MOOD DISORDERS

The MacArthur Foundation Initiative

The MacArthur Foundation Initiative on Depression and Primary Care has created a Depression Tool Kit is intended to help primary care clinicians recognize and manage depression. To download click on www.depressionprimarycare.org/clinicians/toolkit.

The Medicare Learning Network "Screening for Depression Booklet"

The Screening for Depression Booklet is now available in hard copy format. This booklet is designed to provide education on screening for depression. It includes coverage, coding, billing, and payment information.

To access a new or revised product available for order in hard copy format, go to MNL Products and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the web page.

STABLE Resource Toolkit

The STABLE Resource Toolkit provides quality improvement resources to help clinicians identify and manage bipolar disorders.

ACE Adverse Childhood Events

The ACE Study is ongoing collaborative research between the Centers for Disease Control and Prevention in Atlanta, GA, and Kaiser Permanente in San Diego, CA. Over 17,000 Kaiser patients participating in routine health screening volunteered to participate in the study. Data resulting from their participation continues to be analyzed; it reveals staggering proof of the health, social, and economic risks that result from childhood trauma. Ace Calculator in English and in Spanish.

More information at www.acestudy.org.

OTHER RESOURCES - SUBSTANCE USE DISORDERS

SBIRT

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders for use in community settings. The SAMHSA SBIRT page, www.integration.samhsa.gov/clinical-practice/sbirt also includes curricula, online resources, and publications designed to help implement SBIRT initiatives. SBIRT is based on methodology that was developed during the implementation of a comprehensive SBIRT grant program comprised of all the integral components, and supported by research by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

SBIRT: a Resource Toolkit for Behavioral Health Providers to Begin the Conversation with Federally-Qualified Healthcare Centers.

A comprehensive program for assessing substance use and abuse in a primary care setting.

SAMHSA Guide for Substance Abuse Services in Primary Care TIP 42

"SAMHSA Guide for Substance Abuse Services in Primary Care TIP 42" includes summary, diagrams, risk factors, interview approaches, assessment key elements, DSM IV diagnostic criteria, definitions of specialty treatment models and approaches

SAMHSA Quick Guide for Substance Abuse Services in Primary Care TIP 24

"SAMHSA Quick Guide for Substance Abuse Services in Primary Care TIP 24" summarizes guide above into handy reference guide for practitioners.

SAMHSA Substance Abuse Treatment in Older Adults TIP 26

"SAMHSA Substance Abuse Treatment in Older Adults TIP 26" summarizes research, age issues, assessment, guidelines, referrals and treatment approaches, legal and ethical issues and tools. "

SAMHSA Managing Chronic Pain in Adults with or in Recovery for Substance Use Disorders TIP 54

"SAMHSA Managing Chronic Pain in Adults with or in Recovery for Substance Use Disorders TIP 54" is a comprehensive guide that includes introduction to pain and addiction, patient assessment and management, managing addiction risk in patients treated with opiods, patient education and treatment agreements.

SAMHSA Substance Abuse Treatment: Group Therapy TIP 41

"SAMHSA Substance Abuse Treatment: Group Therapy TIP 41" provides overview, types, criteria, development, stages of of treatment, techniques and supervision

SAMHSA A Provider's Introduction to Treatment for LBGT Individuals

"SAMHSA A Provider's Introduction to Treatment for LBGT Individuals" Includes populations overview, cultural and legal issues, treatment issues, "coming out," families, clinical, health and age related issues and a program administration section

SAMHSA Quick Reference Guide for Screening and Assessing Adolescents for Substance Use Disorders

"SAMHSA Quick Reference Guide for Screening and Assessing Adolescents for Substance Use Disorders" is based on TIP 31 & 32. Summarizes screening, assessment, treatment, age related issues, program characteristics, treatment models and special needs.

SAMHSA's Medication Assisted Treatment

Links to SAMHSA's Mediction Assisted Treatment, http://www.samhsa.gov/resources, include overview, principles, treatment of special populations, prescribing Naltrexone, RX data base, clinical guidelines for prescribing Buprenorphrine and treating opioid and alcohol addiction as well as training resources.

OTHER RESOURCES - SUBSTANCE USE DISORDERS, continued

NIAMED

NIAMED is a comprehensive Physicians' Outreach Initiative that gives medical professionals tools and resources to screen their patients for tobacco, alcohol, illicit drug, and non-medical prescription drug use. Developed by the National Institute on Drug Abuse, NIDAMED resources include an online screening tool, a companion quick reference guide, and a comprehensive resource guide for clinicians.

Alcohol Screening and Brief Intervention

Alcohol Screening and Brief Intervention is a guide for public health practitioners.

APHA

OTHER RESOURCES - PERINATAL

SAMHSA Quick Reference Guide Pregnant Women TIP 2

SAMHSA Quick Reference Guide Pregnant Women TIP 2 summarizes research, assessment, guidelines, post part-em care, nutrition and legal and ethical issues.

Screening Instruments for Pregnant Women and Women of Childbearing Age

Screening Instruments for Pregnant Women and Women of Childbearing Age is compiled by the State of Virginia and available on its web site, this chart describes the screens, their population focus and availability. www.dbhds.virginia.gov/documents/scrn-perinatal/instrumentchart.

Substance Use, Mental Health and Intimate Partner Violence

Substance Use, Mental Health and Intimate Partner Violence gives the rationale and tips for screening as well as links to other resources, www.dbhds.virgina.gov/documentsscrn-pw-highriskscreen.pdf

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Produced by

CalMHSA, Integrated Behavioral Health Project

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October 2013

Endnotes:

[1] *www.integration.samhsa.gov*

Healthy Living Questionnaire 2011

Name: _____ **Date:** _____

Program: _____

Are you working on health goals in any of the following areas?: ☐ Mental Health ☐Check-ups ☐Exercise ☐Healthy Foods ☐Sex ☐Medications ☐Smoking ☐ER ☐COPD ☐Teeth

I participate in the Healthy Living Program: (Check all that apply) ☐ In groups ☐ Through discussions with my clinician

1. Overall, how would you rate your health during the **past 4 weeks**?
   Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor ☐

2. During the **past 4 weeks**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?
   Not at all ☐ Very little ☐ Somewhat ☐ Quite a lot ☐ Could not do physical activities ☐

3. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?
   None at all ☐ A little bit ☐ Some ☐ Quite a lot ☐ Could not do daily work ☐

4. How much bodily pain have you had during the **past 4 weeks**?
   None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe ☐

5. During the **past 4 weeks**, how much energy did you have?
   Very much ☐ Quite a lot ☐ Some ☐ A little ☐ None ☐

6. During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?
   Not at all ☐ Very little ☐ Somewhat ☐ Quite a lot ☐ Could not do social activities ☐

7. During the **past 4 weeks**, how much have you been bothered by **emotional problems** (such as feeling anxious, depressed or irritable)?
   Not at all ☐ Slightly ☐ Moderately ☐ Quite a lot ☐ Extremely ☐

8. During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?
   Not at all ☐ Very little ☐ Somewhat ☐ Quite a lot ☐ Could not do daily activities ☐

9. During the **past 4 weeks**, how often did your dinner include at least one vegetable per day?
   Not at all ☐ Very little ☐ Sometimes ☐ Quite a lot ☐ All the time ☐

10. During the **past 4 weeks**, how often did you engage in some form of exercise?

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Not at all ☐ Very little ☐ Sometimes ☐ Quite a lot ☐ Very frequently ☐

11. During the **past 4 weeks**, how often did you take all of your medications as prescribed?
Not at all ☐ Very little ☐ Sometimes ☐ Quite a lot ☐ All the time ☐

12. During the **past 4 weeks**, how often did you brush your teeth twice a day?
Not at all ☐ Rarely ☐ Usually ☐ All the time ☐ Not applicable ☐

13. During the **past 4 weeks**, when having sex, how often did you use a condom?
Not at all ☐ Rarely ☐ Usually ☐ All the time ☐ Not applicable ☐

14. During the **past 4 weeks**, how often did you smoke?
Not at all ☐ Very little ☐ Sometimes ☐ Quite a lot ☐ Very frequently ☐

15. I believe that I can make changes that will improve my physical health.
Totally agree ☐ Agree a little ☐ Disagree ☐

16. I believe that I can make changes that will improve my mental health
Totally agree ☐ Agree a little ☐ Disagree ☐

Please note that the following questions refer to different time frames than the previous questions.

17. During the **past *year***, how often did you visit your primary care provider?
0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times ☐

18. During the **past *3 months***, how many times did you visit the Emergency Room?
0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times ☐
→ The reason was (check all that apply): ☐ My mental health ☐ My physical Health

19. During the **past *3 months***, how many times were you admitted to a hospital?
0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times ☐
→ The reason was (check all that apply): ☐ My mental health ☐ My physical Health

Thank you for completing these questions!

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Date completed: __ __ / __ __ / __ __ __ __

K6+

Provider: _____

Provider ID:

|___|___|___|___|___|___|___|___|___|___|

Please use gummed label if available

Patient or Client Identifier:
|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Surname:

Other names:

Date of Birth: Sex:

___ ___ / ___ ___ / ___ ___ ___ ___ Male ☐1 Female ☐2

Address:

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

Q1. During the past 30 days, about how often did you feel …	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. …nervous?	**1**	**2**	**3**	**4**	**5**
b. …hopeless?	**1**	**2**	**3**	**4**	**5**
c. …restless or fidgety?	**1**	**2**	**3**	**4**	**5**
d. …so depressed that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
e. …that everything was an effort?	**1**	**2**	**3**	**4**	**5**
f. …worthless?	**1**	**2**	**3**	**4**	**5**

Please turn over the page to continue

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Q2. The last six questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur More often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, circle response option "4.")

More often than usual			About the same as usual	Less often than usual		
A lot	Some	A little		A little	Some	A lot
1	2	3	4	5	6	7

The next few questions are about how these feelings may have affected you in the past 30 days. You need not answer these questions if you answered "None of the time" to **all** of the six questions about your feelings.

Q3. During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?

_____ **(Number of days)**

Q4. **Not counting the days you reported in response to Q3**, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?

_____ **(Number of days)**

Q5. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

_____ **(Number of times)**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Q6. During the past 30 days, how often have physical health problems been the main cause of these feelings?	1	2	3	4	5

Thank you for completing this questionnaire.

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Binding margin – do not write

Date completed: __ __ / __ __ / __ __ __ __

K10+

Provider: _____

Provider ID:

|___|___|___|___|___|___|___|___|

Please used gummed label if available	Patient or Client Identifier: |__|__|__|__|__|__|__|__|__|__|__|__|
Surname:	
Other names:	
Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___	Sex: Male ☐1 Female ☐2
Address:	

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

Q1. During that month, how often did you feel …	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. … tired out for no good reason?	**1**	**2**	**3**	**4**	**5**
b. …nervous?	**1**	**2**	**3**	**4**	**5**
c. …so nervous that nothing could calm you down?	**1**	**2**	**3**	**4**	**5**
d. …hopeless?	**1**	**2**	**3**	**4**	**5**
e. …restless or fidgety?	**1**	**2**	**3**	**4**	**5**
f. …so restless that you could not sit still?	**1**	**2**	**3**	**4**	**5**
g. …depressed?	**1**	**2**	**3**	**4**	**5**
h. …so depressed that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
i. …that everything was an effort?	**1**	**2**	**3**	**4**	**5**
j. …worthless?	**1**	**2**	**3**	**4**	**5**

Please turn over the page to continue

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Q2. The last ten questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur More often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, circle response option "4.")

More often than usual			About the same as usual	Less often than usual		
A lot	Some	A little		A little	Some	A lot
1	2	3	4	5	6	7

The next few questions are about how these feelings may have affected you in the past 30 days. You need not answer these questions if you answered "None of the time" to **all** of the ten questions about your feelings.

Q3. During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?

_____ **(Number of days)**

Q4. **Not counting the days you reported in response to Q3**, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?

_____ **(Number of days)**

Q5. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

_____ **(Number of times)**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Q6. During the past 30 days, how often have physical health problems been the main cause of these feelings?	1	2	3	4	5

Thank you for completing this questionnaire.

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الصحة النفسية والعقلية

التاريخ: __ __ / __ __ / __ __ __ __

ك٦+

K6+

المحقق: _____

رقم تعريف المحقق:
|__|__|__|__|__|__|__|__|__|__|

رقم تعريف المريض:
|__|__|__|__|__|__|__|__|__|__|

يرجى وضع ورقة لاصقة اذا كان ممكناً

إسم العائلة:

الإسم:

تاريخ الميلاد: __ __ / __ __ / __ __ __ __

الجنس: ذكر ☐1 أنثى ☐2

العنوان:

الرجاء عدم الكتابة في هذا الفراغ

الأسئلة التالية تهدف إلى معرفة شعورك **خلال الأيّام الثلاثين الماضية**. يرجى وضع دائرة حول الرقم الذي يصف بالشكل الأفضل كم غالباً أحسست بهذه المشاعر.

س1 : خلال الأيّام الثلاثين الماضية، كم غالباً كنت تشعر بأنك...	**دائماً**	**غالباً**	**قليلاً**	**نادراً**	**أبداً**
أ ... متوتّر(ة)؟	1	2	3	4	5
ب ... يائس(ة)؟	1	2	3	4	5
ج ....متململ (ة) أو حائص (ة)[1] ؟	1	2	3	4	5
د ... شديد(ة) الإكتئاب لدرجة أنه لم يعد أي شيء يفرحك؟	1	2	3	4	5
ه ... تتطلب مجهوداً للقيام بأي شيء ؟	1	2	3	4	5
و ... لا قيمة لك؟	1	2	3	4	5

إيقم سرير قد ذاتي ك 10 + (ص2/1)

أقلب الصفحة رجاءً من أجل المتابعة

[1] مترجمون عرب من عدة بلدان (تونس، مصر،ليبيا، لبنان ومختصون‌عرب في علم النفس مقيمون بالولايات المتحدة الأمريكية) يرون أن الترجمة الأفضل للجملة "Restless and Fidgety " في **س1 ج** أعلاه تختلف من بلد إلى آخر و نظراً لذلك فإن الباحثين يحتاجون لتحديد أي من هذه الجمل تتماشى الأفضل مع لهجتهم المحلية.

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س2 : الأسئلة الستة السابقة كانت تتعلق بمشاعرك خلال الأيّام الثلاثين الماضية. آخذاً بعين الاعتبار كل هذه الأسئلة، هل كانت هذه المشاعر أكثر تكراراً من العادة خلال الأيام الثلاثين الماضية، كالعادة، أو أقل تكراراً من العادة؟ (إذا لم تشعر أبداً بأي من هذه المشاعر، ضع دائرة حول الإجابة رقم "4".)

أقل تكراراً من العادة			**كالعادة**	**أكثر تكراراً من العادة**		
بكثير	**بعض الشيء**	**بقليل**		**بقليل**	**بعض الشيء**	**بكثير**
7	**6**	**5**	**4**	**3**	**2**	**1**

الهدف من الأسئلة القليلة التالية هو معرفة كيف أثرت هذه المشاعر عليك خلال الأيّام الثلاثين الماضية. ليس عليك الإجابة إذا كانت إجابتك **"أبداً"** على **كلِّ** الأسئلة الستة السابقة.

س3 : كم يوماً خلال الأيّام الثلاثين الماضية، كنت غير قادراً(ة) كليّاً على العمل أو القيام بنشاطاتك اليومية المعتادة بسبب مشاعرك هذه؟

_____ **(عدد الأيّام)**

س4 : دون اعتبار عدد الأيّام المذكورة في س3 ، كم يوماً خلال الأيّام الثلاثين الماضية كنت قادراً(ة) على القيام فقط بنصف أو أقلّ من نصف الأعمال التي اعتدت على القيام بها بسبب مشاعرك هذه؟

_____ **(عدد الأيّام)**

س5 : خلال الأيّام الثلاثين الماضية، كم مرّة ذهبت إلى الطبيب أو أي أخصائي صحّة آخر بسبب هذه المشاعر؟

_____ **(عدد المرّات)**

	أبدًا	**نادراً**	**قليلاً**	**غالباً**	**دائماً**
س6 : خلال الأيّام الثلاثين الماضية، كم غالباً كانت مشاكل صحية هي السبب الرئيسي لهذه المشاعر؟	**5**	**4**	**3**	**2**	**1**

شكراً على مشاركتك في الرَدّ على هذه الأسئلة.

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填寫日期: __ __ / __ __ / __ __ __ __

K6+

提供者: _____

提供者編號:

|__|__|__|__|__|__|__|__|

請使用膠粘標籤（若有）

病人或案主編號

|__|__|__|__|__|__|__|__|__|__|__|__|

姓:

名:

出生日期: ___ ___ / ___ ___ / ___ ___ ___ ___

性別: 男 □1 女 □2

聯繫地址:

以下問題係有關你<u>過去一個月</u>嘅情緒狀況。回答每一個問題時，請圈出最能描述這種情緒程度的號碼。

1. **在過去一個月，你有幾多時候會覺得…**		全部時候	大部分時候	有啲時候	好少時候	完全無
a.	…緊張？	**1**	**2**	**3**	**4**	**5**
b.	…無哂希望？	**1**	**2**	**3**	**4**	**5**
c.	…煩躁，或不安？	**1**	**2**	**3**	**4**	**5**
d.	…情緒低落到無嘢令你開心_?	**1**	**2**	**3**	**4**	**5**
e.	…覺得做事好吃力？	**1**	**2**	**3**	**4**	**5**
f.	…覺得自己無用？	**1**	**2**	**3**	**4**	**5**

請翻頁繼續

情緒健康

2. 上面詢問你過去一個月曾經出現的情緒狀況。整體而言，你在過去一個月出現的這些情緒狀況，是比平時多見、跟平時差不多、還是比平時少見？
(若你從未有過其中的任何一種情緒，請在“4”上劃圈。)

比平時多見 很多	比平時多見 一些	比平時多見 少少	跟平時 差不多	比平時少見 很少	比平時少見 一些	比平時少見 很多
1	2	3	4	5	6	7

如果你對以上關於情緒的**所有**問題 (1a 至 1f) 都回答“無”，便無須回答以下問題。

接下來的幾個問題是詢問**過去一個月**這些情緒是如何影響你。

3. 在**過去一個月**中，你有多少日因爲這些情緒狀況而**完全不能**工作或從事正常的活動？

_____ 日

4. **除了以上問題３ 的日子(即是完全不能工作或正常活動的日子)，**在**過去一個月**，你有多少日，因爲這些情緒狀況而只能完成平時的一半或比一半更少的活動？

_____ 日

5. 在**過去一個月**，你有多少次因爲這些情緒狀況而去看過醫生或其他醫療專業人員？

_____ 次

	全部 時候	大部分 時候	有啲 時候	好少 時候	完全 無
6. 請描述在**過去一個月**中，你有幾多時候因爲身體健康問題而出現這些情緒？	**1**	**2**	**3**	**4**	**5**

K6+ 自評量表 (2 of 2)

謝謝你完成這份問卷。

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記入日： 西暦__ __ __ __年__ __ 月__ __ 日

K6+

調査場所: _____

調査場所 ID:

|___|___|___|___|___|___|___|___|

対象者 ID:

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

姓:

名:

生年月日:

西暦___ ___ ___ ___年

___ ___ 月___ ___ 日

性別:

男性 □1　女性 □2

住所:

次の質問では、**過去 30 日**の間、あなたがどのように感じていたかについておたずねします。それぞれの質問に対して、そういう気持ちをどれくらいの頻度で感じていたか、一番当てはまる番号に○を付けてください。

問 1．過去 30 日の間にどれくらいしばしば…		いつも	たいてい	ときどき	少しだけ	全くない
a.	神経過敏に感じましたか	1	2	3	4	5
b.	絶望的だと感じましたか	1	2	3	4	5
c.	そわそわしたり、落ち着きなく感じましたか	1	2	3	4	5
d.	気分が沈みこんで、何が起こっても気が晴れないように感じましたか	1	2	3	4	5
e.	何をするのも骨折りだと感じましたか	1	2	3	4	5
f.	自分は価値のない人間だと感じましたか	1	2	3	4	5

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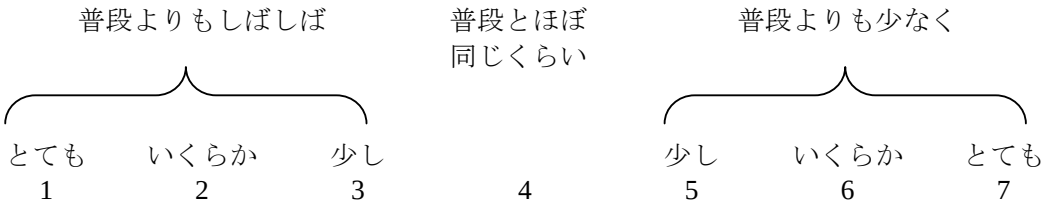
問 2. 問 1 の 10 個の質問は、過去 30 日の間に起こったかもしれない気持ちについてのものでした。全部ひっくるめて、これらの気持ちは、過去 30 日の間には、普段のあなたよりもしばしば感じられたのでしょうか。普段と同じくらい感じられたのでしょうか。それとも、普段よりも少なく感じられたのでしょうか。（もし、これらの気持ちが全然なかったならば、「４」に○を付けてください）



次の質問では、これらの気持ちが過去 30 日の間にどれくらいあなたに影響を及ぼしたかについておたずねします。問 1 の 10 個の質問のすべてに「全くない」と答えられた場合は、以下の質問にお答えいただく必要はありません。

問 3. 過去 30 日のうち、これらの気持ちのために、まったく働くことができなかったり、普段の活動を行うことができなかった日は、何日ありましたか。

_____日間

問 4. 問 3 で答えた日数を除外して、過去 30 日のうち、これらの気持ちのために、普通だったらできたであろう事の半分かそれ以下しかできなかった日は、何日ありましたか。

_____日間

問 5. 過去 30 日の間に、これらの気持ちについて何度、医者やそれ以外の医療の専門家を受診しましたか。

_____回

問 6. 過去 30 日の間にこれらの気持ちの原因が、主に、身体的な健康上の問題だったことはどれくらいありましたか。

いつも	たいてい	ときどき	少しだけ	全くない
1	2	3	4	5

どうもありがとうございました。

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Fecha de aplicación: __ __ / __ __ / __ __ __ __

K6+

Administrador : _____

No. de identificación del administrador:

|___|___|___|___|___|___|___|___|

Por favor use etiqueta autoadhesiva si está disponible

No. Identificación del paciente|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Apellido:

Nombre:

Fecha de Nacimiento: Sexo:

___ ___ / ___ ___ / ___ ___ ___ ___ Masculino ☐1 Femenino ☐2

Domicilio:

Las siguientes preguntas se refieren a cómo se ha sentido en los **últimos 30 días**. Para cada pregunta, por favor encierre con un círculo el número que describa mejor con qué frecuencia ha tenido estos sentimientos.

Q1.	**En los últimos 30 días, ¿con qué frecuencia se sintió …**	**Siempre**	**Casi siempre**	**A veces**	**Casi nunca**	**Nunca**
a.	…nervioso(a)?	**1**	**2**	**3**	**4**	**5**
b.	…sin esperanza?	**1**	**2**	**3**	**4**	**5**
c.	…inquieto(a) o intranquilo(a)?	**1**	**2**	**3**	**4**	**5**
d.	… tan deprimido(a) que nada podía animarle?	**1**	**2**	**3**	**4**	**5**
e.	…que todo le suponía un gran esfuerzo?	**1**	**2**	**3**	**4**	**5**
f.	…inútil?	**1**	**2**	**3**	**4**	**5**

Por favor continúe en la página siguiente.

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Q2. Las preguntas anteriores se referían a sentimientos que pudo haber tenido en los últimos 30 días. Tomándolos todos en cuenta, en los últimos 30 días ¿estos sentimientos fueron más frecuentes que lo que es habitual en usted, fueron casi igual de frecuentes que lo habitual, o fueron menos frecuentes que lo habitual? (Si nunca ha tenido alguno de estos sentimientos, encierre con un círculo la opción "4".)

Más frecuentes que lo habitual			**Casi igual de frecuentes que lo habitual**	**Menos frecuentes que lo habitual**		
Mucho	**Algo**	**Poco**		**Poco**	**Algo**	**Mucho**
1	**2**	**3**	**4**	**5**	**6**	**7**

Las siguientes preguntas se refieren a cómo estos sentimientos le han afectado en los últimos 30 días. No es necesario contestar estas preguntas si contestó "Nunca" **a todas y cada una de** las seis preguntas anteriores sobre sus sentimientos.

Q3. En los últimos 30 días, ¿cuántos días fue totalmente incapaz de trabajar o realizar sus actividades habituales debido a estos sentimientos?

_____ **(Número de días)**

Q4. **Descontando los días que apuntó en la pregunta Q3**, ¿cuántos días, de los últimos 30, pudo hacer sólo la mitad o menos de lo que normalmente podría haber hecho debido a estos sentimientos?

_____ **(Número de días)**

Q5. En los últimos 30 días, ¿cuántas veces visitó a un médico u otro profesional de la salud debido a estos sentimientos?

_____ **(Número de veces)**

		Siempre	**Casi siempre**	**A veces**	**Casi nunca**	**Nunca**
Q6.	En los últimos 30 días, ¿con qué frecuencia los problemas de salud física fueron la causa principal de estos sentimientos?	**1**	**2**	**3**	**4**	**5**

Muchas gracias por contestar este cuestionario.

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الصحة النفسية والعقلية

مقياس تقرير ذاتي ك 10 + (ص1/2)

الرجاء عدم الكتابة في هذا الفراغ

التاريخ:__ __ / __ __ / __ __ __ __

ك١٠+

K10+

المحقق: _____

رقم تعريف المحقق:
|__|__|__|__|__|__|__|__|__|__|

رقم تعريف المريض:
|__|__|__|__|__|__|__|__|__|__|
يرجى وضع ورقة لاصقة اذا كان ممكناً

إسم العائلة:

الإسم:

تاريخ الميلاد: __ __ / __ __ / __ __ __ __ الجنس: ذكر ☐1 أنثى ☐2

العنوان:

الهدف من الأسئلة التالية هو معرفة شعورك خلال **الأيّام الثلاثين الماضية**. يرجى وضع دائرة حول الرقم الذي يصف بالشكل الأفضل كم غالباً أحسست بهذه المشاعر.

س1 : خلال الشهر السابق، كم غالباً كنت تشعر بأنك...	**دائماً**	**غالباً**	**قليلاً**	**نادراً**	**أبداً**
أ ... متعب(ة) دون سبب حقيقي؟	1	2	3	4	5
ب ... متوتّر(ة)؟	1	2	3	4	5
ج ... شديد(ة) التوتّر لدرجة أنه لم يعد أي شيء يهدؤك؟	1	2	3	4	5
د ... يائس(ة)؟	1	2	3	4	5
ه ... متململ (ة) أو حائص (ة)[1] ؟	1	2	3	4	5
و ... كثير(ة) الحوصة/التململ لدرجة أنك عاجز(ة) عن الجلوس؟	1	2	3	4	5
ز ... مكتئب(ة)؟	1	2	3	4	5
ح ... شديد(ة) الإكتئاب لدرجة أنه لم يعد أي شيء يفرحك؟	1	2	3	4	5
ط ... تتطلب مجهوداً للقيام بأي شيء ؟	1	2	3	4	5
ي ... لا قيمة لك؟	1	2	3	4	5

أقلب الصفحة رجاءً من أجل المتابعة

[1] مترجمون عرب من عدة بلدان (تونس، مصر،ليبيا، لبنان و مختصون عرب في علم النفس مقيمون بالولايات المتحدة الأمريكية) يرون أن الترجمة الأفضل للجملة "Restless and Fidgety" في **س1 ه** أعلاه تختلف من بلد إلى آخر و نظراً لذلك فإن الباحثين يحتاجون لتحديد أي من هذه الجمل تتماشى الأفضل مع لهجتهم المحلية.

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س2 : الأسئلة العشرة السابقة كانت تتعلق بمشاعرك خلال الأيّام الثلاثين الماضية. آخذاً بعين الاعتبار كل هذه الأسئلة، هل كانت هذه المشاعر أكثر تكراراً من العادة خلال الأيام الثلاثين الماضية، كالعادة، أو أقل تكراراً من العادة؟ (إذا لم تشعر أبداً بأي من هذه المشاعر، ضع دائرة حول الإجابة رقم "4".)

أكثر تكراراً من العادة			**كالعادة**	**أقل تكراراً من العادة**		
بكثير	**بعض الشيء**	**بقليل**		**بقليل**	**بعض الشيء**	**بكثير**
1	**2**	**3**	**4**	**5**	**6**	**7**

الهدف من الأسئلة القليلة التالية هو معرفة كيف أثرت هذا المشاعر عليك خلال الأيّام الثلاثين الماضية. ليس عليك الإجابة إذا كانت إجابتك **"أبداً"** على **كلِّ** الأسئلة العشرة السابقة.

س3 : كم يوماً خلال الأيّام الثلاثين الماضية، كنت غير قادراً(ة) كليّاً على العمل أو القيام بنشاطاتك اليومية المعتادة بسبب مشاعرك هذه؟

_____ **(عدد الأيّام)**

س4 : دون اعتبار عدد الأيّام المذكورة في س3 ، كم يوماً خلال الأيّام الثلاثين الماضية كنت قادراً(ة) على القيام فقط بنصف أو أقلّ من نصف الأعمال التي اعتدت على القيام بها بسبب مشاعرك هذه؟

_____ **(عدد الأيّام)**

س5 : خلال الأيّام الثلاثين الماضية، كم مرّة ذهبت إلى الطبيب أو أي أخصائي صحّة آخر بسبب هذه المشاعر؟

_____ **(عدد المرّات)**

	دائماً	**غالباً**	**قليلاً**	**نادراً**	**أبداً**
س6 : خلال الأيّام الثلاثين الماضية، كم غالباً كانت مشاكل صحية هي السبب الرئيسي لهذه المشاعر ؟	**1**	**2**	**3**	**4**	**5**

شكراً على مشاركتك في الرَدّ على هذه الأسئلة.

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完成日期: __ __ / __ __ / __ __ __ __

K10+

提供者: _____

提供者编号:

|__|__|__|__|__|__|__|__|__|__|

请使用胶粘标签（若有）

病人或委托人编号

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

姓:	姓:
曾用名:	曾用名:
出生日期: ___ ___ / ___ ___ / ___ ___ ___ ___	性别: 男 □1 女 □2
联系地址:	

下面的问题是询问您**过去 30 天**中的情绪。回答每一个问题时，请圈出最能描述这种情绪出现频率的号码。

问 1. 上个月中，您经常会感到 …		**全部时间**	**大部分时间**	**一部分时间**	**偶尔**	**无**
a.	…无法解释的筋疲力尽?	**1**	**2**	**3**	**4**	**5**
b.	…紧张?	**1**	**2**	**3**	**4**	**5**
c.	…太紧张以至于什么都不能让您平静下来?	**1**	**2**	**3**	**4**	**5**
d.	…绝望?	**1**	**2**	**3**	**4**	**5**
e.	…不安或烦躁?	**1**	**2**	**3**	**4**	**5**
f.	…太不安以至于静坐不能?	**1**	**2**	**3**	**4**	**5**
g.	…沮丧的?	**1**	**2**	**3**	**4**	**5**
h.	…太沮丧以至于什么都不能让您愉快起来?	**1**	**2**	**3**	**4**	**5**
i.	…做每一件事情都很费劲?	**1**	**2**	**3**	**4**	**5**
j.	…无价值?	**1**	**2**	**3**	**4**	**5**

请翻页继续

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问 2. 上面的 10 个问题是询问您过去 30 天中曾经出现的情绪。将它们总而言之，在过去的 30 天中出现的这些情绪对您来说是比平时多见、跟平时差不多、还是比平时少见？ (若您从未有过其中的任一种情绪，请在相应选项“ 4 ”上划圈。)

比平时多见			跟平时差不多	比平时少见		
很多	有些	很少		很少	有些	许多
1	**2**	**3**	**4**	**5**	**6**	**7**

接下来的几个问题是询问过去 30 天中这些情绪是如何影响您的。如果您对**所有**关于情绪的 10 个问题答案都是“无”，则无需作答。

问 3. 在过去 30 天中，您有多少天因为这些情绪而完全不能工作或从事正常的活动？

_____ **(天数)**

问 4. **不算您在问 3 报告的天数，**在过去 30 天中，您有多少天因为这些情绪而只能完成平时的一半或更少些的活动？

_____ **(天数)**

问 5. 在过去 30 天中，您有多少次因为这些情绪而去看过医生或其他保健专业人员？

_____ **(次数)**

	全部时间	大部分时间	一部分时间	偶尔	无
问 6. 请描述在过去 30 天中，因躯体健康问题而出现这些情绪的频率？	**1**	**2**	**3**	**4**	**5**

谢谢您完成这份问卷。

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記入日: 西暦__ __ __ __年__ __ 月__ __ 日

K10+

調査場所: _____

調査場所 ID:

|___|___|___|___|___|___|___|___|

対象者 ID:

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

姓:

名:

生年月日:

西暦___ ___ ___ ___年

___ ___ 月___ ___ 日

性別:

男性 ☐1　女性 ☐2

住所:

次の質問では、**過去 30 日**の間、あなたがどのように感じていたかについておたずねします。それぞれの質問に対して、そういう気持ちをどれくらいの頻度で感じていたか、一番当てはまる番号に○を付けてください。

問 1．過去 30 日の間にどれくらいしばしば…		いつも	たいてい	ときどき	少しだけ	全くない
a.	理由もなく疲れきったように感じましたか	1	2	3	4	5
b.	神経過敏に感じましたか	1	2	3	4	5
c.	どうしても落ち着けないくらいに、神経過敏に感じましたか	1	2	3	4	5
d.	絶望的だと感じましたか	1	2	3	4	5
e.	そわそわしたり、落ち着きなく感じましたか	1	2	3	4	5
f.	じっと座っておれないほど、落ち着きなく感じましたか	1	2	3	4	5
g.	ゆううつに感じましたか	1	2	3	4	5
h.	気分が沈みこんで、何が起こっても気が晴れないように感じましたか	1	2	3	4	5
i.	何をするのも骨折りだと感じましたか	1	2	3	4	5
j.	自分は価値のない人間だと感じましたか	1	2	3	4	5

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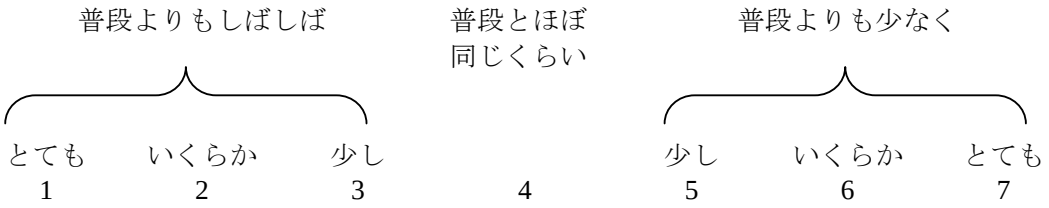
問 2. 問 1 の 10 個の質問は、過去 30 日の間に起こったかもしれない気持ちについてのものでした。全部ひっくるめて、これらの気持ちは、過去 30 日の間には、普段のあなたよりもしばしば感じられたのでしょうか。普段と同じくらい感じられたのでしょうか。それとも、普段よりも少なく感じられたのでしょうか。（もし、これらの気持ちが全然なかったならば、「４」に○を付けてください）



次の質問では、これらの気持ちが過去 30 日の間にどれくらいあなたに影響を及ぼしたかについておたずねします。問 1 の 10 個の質問のすべてに「全くない」と答えられた場合は、以下の質問にお答えいただく必要はありません。

問 3. 過去 30 日のうち、これらの気持ちのために、まったく働くことができなかったり、普段の活動を行うことができなかった日は、何日ありましたか。

_____日間

問 4. 問 3 で答えた日数を除外して、過去 30 日のうち、これらの気持ちのために、普通だったらできたであろう事の半分かそれ以下しかできなかった日は、何日ありましたか。

_____日間

問 5. 過去 30 日の間に、これらの気持ちについて何度、医者やそれ以外の医療の専門家を受診しましたか。

_____回

問 6. 過去 30 日の間にこれらの気持ちの原因が、主に、身体的な健康上の問題だったことはどれくらいありましたか。

いつも	たいてい	ときどき	少しだけ	全くない
1	2	3	4	5

どうもありがとうございました。

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Margen de encuadernación - no escribir

Fecha de aplicación: __ __ / __ __ / __ __ __ __

K10+

Administrador : _____

No. de identificación del administrador:

|__|__|__|__|__|__|__|__|__|__|

Por favor use etiqueta autoadhesiva si está disponible

No. Identificación del paciente|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Apellido:

Nombre:

Fecha de Nacimiento: Sexo:

___ ___ / ___ ___ / ___ ___ ___ ___ Masculino ☐1 Femenino ☐2

Domicilio :

Las siguientes preguntas se refieren a cómo se ha sentido en los **últimos 30 días**. Para cada pregunta, por favor encierre con un círculo el número que describa mejor con qué frecuencia ha tenido estos sentimientos.

Q1.	**En los últimos 30 días, ¿con qué frecuencia se sintió…**	**Siempre**	**Casi siempre**	**A veces**	**Casi nunca**	**Nunca**
a.	… cansado(a) sin ningún motivo?	**1**	**2**	**3**	**4**	**5**
b.	…nervioso(a)?	**1**	**2**	**3**	**4**	**5**
c.	…tan nervioso(a) que nada podía calmarlo(a)?	**1**	**2**	**3**	**4**	**5**
d.	… sin esperanza?	**1**	**2**	**3**	**4**	**5**
e.	…inquieto(a) o intranquilo(a)?	**1**	**2**	**3**	**4**	**5**
f.	…tan inquieto(a) que no podía permanecer sentado(a)?	**1**	**2**	**3**	**4**	**5**
g.	…deprimido(a)?	**1**	**2**	**3**	**4**	**5**
h.	…tan deprimido(a) que nada podía animarle?	**1**	**2**	**3**	**4**	**5**
i.	…que todo le costaba mucho esfuerzo?	**1**	**2**	**3**	**4**	**5**
j.	… inútil?	**1**	**2**	**3**	**4**	**5**

Por favor continúe en la página siguiente.

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Q2. Las preguntas anteriores se referían a sentimientos que pudo haber tenido en los últimos 30 días. Tomándolos todos en cuenta, en los últimos 30 días ¿estos sentimientos fueron más frecuentes que lo que es habitual en usted, fueron casi igual de frecuentes que lo habitual, o fueron menos frecuentes que lo habitual? (Si nunca ha tenido alguno de estos sentimientos, encierre con un círculo la opción "4".)

Más frecuentes que lo habitual			**Casi igual de frecuentes que lo habitual**	**Menos frecuentes que lo habitual**		
Mucho	**Algo**	**Poco**		**Poco**	**Algo**	**Mucho**
1	**2**	**3**	**4**	**5**	**6**	**7**

Las siguientes preguntas se refieren a cómo estos sentimientos le han afectado en los últimos 30 días. No es necesario contestar estas preguntas si contestó "Nunca" **a todas y cada una** de las diez preguntas anteriores sobre sus sentimientos.

Q3. En los últimos 30 días, ¿cuántos días fue totalmente incapaz de trabajar o realizar sus actividades habituales debido a estos sentimientos?

_____ **(Número de días)**

Q4. **Descontando los días que apuntó en la pregunta Q3**, ¿cuántos días, de los últimos 30, pudo hacer sólo la mitad o menos de lo que normalmente podría haber hecho debido a estos sentimientos?

_____ **(Número de días)**

Q5. En los últimos 30 días, ¿cuántas veces visitó a un médico u otro profesional de la salud debido a estos sentimientos?

_____ **(Número de veces)**

	Siempre	**Casi siempre**	**A veces**	**Casi nunca**	**Nunca**
Q6. En los últimos 30 días, ¿con qué frecuencia los problemas de salud física fueron la causa principal de estos sentimientos?	**1**	**2**	**3**	**4**	**5**

Muchas gracias por contestar este cuestionario.

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Binding margin – do not write

Tarehe: __ __ / __ __ / __ __ __ __

K10+

Msaili: _____

Namba ya msaili:

|__|__|__|__|__|__|__|__|__|__|

Please used gummed label if available	Patient or Client Identifier: |__|__|__|__|__|__|__|__|__|__|__|__|
Jina la ukoo:	
Jina menginee:	
Tarehe ya kuzaliwa: __ __ / __ __ / __ __ __ __	Jinsia: Mwanamume ☐ Mwanamke ☐
Anwani:	

Maswali yafuatayo ni kuhusu jinsi ulivyo kuwa unajisikia katika kipindi cha siku 30 zilizopita. Kwa kila swali, tafadhali weka alama ya duara katika namba unayo dhani inaeleza mara ngapi ulijihisi hivi.

Q1. Katika mwezi ule, mara ngapi ulijihisi…	**Wakati wote**	**Kila mara**	**Wakati mwingine**	**Kamwe**	
a. …kuchoka bila sababu?	**1**	**2**	**3**	**4**	**5**
b. …kuwa na wasiwasi?	**1**	**2**	**3**	**4**	**5**
c. …kuwa na wasiwasi kiasi kwamba hakuna kitakacho kutuliza?	**1**	**2**	**3**	**4**	**5**
d. …huna matumaini?	**1**	**2**	**3**	**4**	**5**
e. …una wahaka au kutokuwa na makini?	**1**	**2**	**3**	**4**	**5**
f. …una wahaka mpaka ulikuwa huwezi kutulia?	**1**	**2**	**3**	**4**	**5**
g. …kutokuwa na furaha?	**1**	**2**	**3**	**4**	**5**
h. …kutokuwa na furaha kiasi kwamba hukuwa na kitu kilicho weza kukufurahisha?	**1**	**2**	**3**	**4**	**5**
i. …kila kitu kilikuwa tabu kwako?	**1**	**2**	**3**	**4**	**5**
j. …kutokuwa na thamani?	**1**	**2**	**3**	**4**	**5**

Tafadhali gauza upande wapili wakaratasi hii

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Q2. Maswali kumi yaliyopita yali uliza kuhusu hali uliyo hisi katika kipindi cha siku 30 zilizopita. Ukiangalia hizi hisia, je zimekutokea mawa kwa mara kuliko kawaida, au sawa na kawaiada, au mara chache kuliko kawaida? (Kama ujawahi kuhisi hizi hisa, weka duara kuzunka namba “4”)

Mara kwa mara kuliko kawaida			**Sawa na kawaida**	**Mara chache kuliko kawaida**		
Nyingi	**Kiasi**	**Kidogo**		**Nyingi**	**Kiasi**	**Kidogo**
1	**2**	**3**	**4**	**5**	**6**	**7**

Maswali yafuatayo yanauliza kuhusu hisia zime kuathiri vipi katika kipindi cha siku 30 zilizopita. Uhitaji kujibu haya maswali kama umejibu "kamwe" kwenye maswali yote kumi yaliyopita kuhusu hisia zako.

Q3. Je katika hizo siku 30 zilizopita, kuna siku ngapi ambazo ulishindwa kufanya kazi zako zakawaida kabisa kwa ajili ya hizi hisia?

(Siku) _____

Q4. **Bila kuhisabu siku ulizoandika kwenye Q3,** siku ngapi katika kipindi cha siku 30 zilizopita uliweza kufanya kazi zaku nusu au chache kuliko kawaida kwa ajili ya hisi hisia?

(Siku) _____

Q5. Katika kipindi cha siku 30 zilizopita, je mara ngapi ulimwona dakatari au mtaalam wa afya kuhusu hizo hisia?

(Mara) _____

		Wakati wote	**Kila mara**	**Wakati mwingine**	**Mara chache**	**Kamwe**
Q6.	Katika kipindi cha siku 30 zilizopita, je ni mara ngapi maradhi ya mwili yamekuwa chanzo cha hizi hisia?	**1**	**2**	**3**	**4**	**5**

Asante kwa kujibu maswali hayo.

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FORM A: FOR SELF-ADMINISTRATION BY THE RESPONDENT (revised 4-2000)

DUKE HEALTH PROFILE (The DUKE)

Date Today:_____ **Name:** _____ **ID Number:**_____
Date of Birth:_____ **Female**____ **Male**____

INSTRUCTIONS: **Here are some questions about your health and feelings. Please read each question carefully and check (√) your best answer. You should answer the questions in your own way. There are no right or wrong answers. (Please ignore the small scoring numbers next to each blank.)**

		Yes, describes me exactly	Somewhat describes me	No, doesn't describe me at all
1.	I like who I am	12	11	10
2.	I am not an easy person to get along with	20	21	22
3.	I am basically a healthy person	32	31	30
4.	I give up too easily	40	41	42
5.	I have difficulty concentrating	50	51	52
6.	I am happy with my family relationships	62	61	60
7.	I am comfortable being around people	72	71	70

TODAY would you have any physical trouble or difficulty:

		None	Some	A Lot
8.	Walking up a flight of stairs	82	81	80
9.	Running the length of a football field	92	91	90

DURING THE PAST WEEK: How much trouble have you had with:

		None	Some	A Lot
10.	Sleeping.	102	101	100
11.	Hurting or aching in any part of your body.	112	111	110
12.	Getting tired easily	122	121	120
13.	Feeling depressed or sad	132	131	130
14.	Nervousness	142	141	140

DURING THE PAST WEEK: How often did you:

		None	Some	A Lot
15.	Socialize with other people (talk or visit with friends or relatives).	150	151	152
16.	Take part in social, religious, or recreation activities (meetings, church, movies, sports, parties).	160	161	162

DURING THE PAST WEEK: How often did you:

		None	1-4 Days	5-7 Days
17.	Stay in your home, a nursing home, or hospital because of sickness, injury, or other health problem.	172	171	170

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MANUAL SCORING FOR THE DUKE HEALTH PROFILE

Item		Raw Score*
8	=	_____
9	=	_____
10	=	_____
11	=	_____
12	=	_____
Sum	=	_____ x 10 =

PHYSICAL HEALTH SCORE

Item		Raw Score*
1	=	_____
4	=	_____
5	=	_____
13	=	_____
14	=	_____
Sum	=	_____ x 10 =

MENTAL HEALTH SCORE

Item		Raw Score*
2	=	_____
6	=	_____
7	=	_____
15	=	_____
16	=	_____
Sum	=	_____ x 10 =

SOCIAL HEALTH SCORE

GENERAL HEALTH SCORE

Physical Health score = _____
Mental Health score = _____
Social Health score = _____
Sum = _____ ÷ 3 =

PERCEIVED HEALTH SCORE

Item		Raw Score*
3	=	_____ x 50 =

Item		Raw Score*
1	=	_____
2	=	_____
4	=	_____
6	=	_____
7	=	_____
Sum	=	_____ x 10 =

SELF-ESTEEM SCORE

To calculate the scores in this column the raw scores must be revised as follows:
If 0, change to 2; if 2, change to 0; if 1, no change.

Item		Raw Score*	Revised
2	=	_____	_____
5	=	_____	_____
7	=	_____	_____
10	=	_____	_____
12	=	_____	_____
14	=	_____	_____
		Sum = _____	x 8.333 =

ANXIETY SCORE

Item		Raw Score*	Revised
4	=	_____	_____
5	=	_____	_____
10	=	_____	_____
12	=	_____	_____
13	=	_____	_____
		Sum = _____	x 10 =

DEPRESSION SCORE

Item		Raw Score*	Revised
4	=	_____	_____
5	=	_____	_____
7	=	_____	_____
10	=	_____	_____
12	=	_____	_____
13	=	_____	_____
14	=	_____	_____
		Sum = _____	x 7.143 =

ANXIETY-DEPRESSION (DUKE-AD) SCORE

Item		Raw Score*	Revised
11	=	_____	_____ x 50 =

PAIN SCORE

Item		Raw Score*	Revised
17	=	_____	_____ x 50 =

DISABILITY SCORE

* Raw Score = last digit of the numeral adjacent to the blank checked by the respondent for each item. For example, if the second blank is checked for item 10 (blank numeral = 101), then the raw score is "1", because 1 is the last digit of 101.

Final Score is calculated from the raw scores as shown and entered into the box for each scale. For physical health, mental health, social health, general health, self-esteem, and perceived health, 100 indicates the best health status, and 0 indicates the worst health status. For anxiety, depression, anxiety-depression, pain, and disability, 100 indicates the worst health status and 0 indicates the best health status.

Missing Values: If one or more responses is missing within one of the eleven scales, a score cannot be calculated for that particular scale.

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Patient Stress Questionnaire*

Name: _____

Date:_____ **Birthdate**_____

Over the ***last two weeks*** , how often have you been bothered by any of the following problems? (please circle your answer & **check the boxes that apply to you**)	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've been moving around a lot more than usual	0	1	**2**	**3**	
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	**1**	**2**	**3**	**Total**
(10)		add columns:			

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**	**Total**
(8)		add columns:			

*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Please also complete back side →

Provider:_____

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Are you currently in any physical pain?	No	Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, ***in the past month*** , you:

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities, or your surroundings?	No	Yes

(3)

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

These questions are about your drinking habits. We've listed the serving size of one drink below.

Please circle your answer	0	1	2	3	4
How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the ***last year*** have you……					
…found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…needed a first drink in the morning to get yourself going after heavy drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	0		2		4
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year			Yes, during the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year			Yes, during the last year

(8)

Total:

Standard serving of one drink:

12 ounces of beer or wine cooler
1.5 ounces of 80 proof liquor
5 ounces of wine
4 ounces of brandy, liqueur or aperitif

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Cuestionario de Estrés del Paciente*

Nombre: _____

Dia:_____ **Fecha de Nacimiento**_____

Durante las últimas dos (2) semanas, ¿con qué frecuencia ha sentido molestias debido a los siguientes problemas? **(por favor, circule sus respuestas y haga una marca en los cuadros que apliquen a usted)**	Nunca	Varios días	Durante más de la mitad de los días	Casi todos los días	
1. Poco interés o placer en hacer las cosas	0	1	**2**	**3**	
2. Sentirse desanimado/a, deprimido/a o desesperanzado/a	0	1	**2**	**3**	
3. ☐ Problemas para dormir o mantenerse dormido/a, ☐ o dormir demasiado	0	1	**2**	**3**	
4. Sentirse cansado/a o tener poca energía	0	1	**2**	**3**	
5. ☐ Poco apetito o ☐ comiendo en exceso	0	1	**2**	**3**	
6. Sentirse mal acerca de sí mismo/a - o sentir que es un/a fracasado/a o que se ha fallado a sí mismo o a su familia	0	1	**2**	**3**	
7. Dificultad para concentrarse en las cosas, tales como leer el periódico o ver la televisión	0	1	**2**	**3**	
8. ☐¿Moverse o hablar tan despacio que puede que otras personas se hayan dado cuenta ☐O lo opuesto — estar tan inquieto/a o intranquilo/a que se ha estado moviendo mucho más de lo normal	0	1	**2**	**3**	
9. ☐ Tiene pensamientos de que sería mejor estar muerto/a ☐ que quisiera lastimarse de alguna forma	0	**1**	**2**	**3**	**Total**
(10)		Sume:			

1. Sentirse nervioso/a, ansioso/a, o con los nervios de punta	0	1	**2**	**3**	
2. No poder dejar o controlar la preocupación	0	1	**2**	**3**	
3. Preocuparse demasiado por cosas diferentes	0	1	**2**	**3**	
4. Problemas para relajarse	0	1	**2**	**3**	
5. Estar tan inquieto/a que es difícil permanecer sentado/a tranquilamente	0	1	**2**	**3**	
8. Molestarse o irritarse fácilmente	0	1	**2**	**3**	
7. Sentir miedo como si algo terrible pudiera ocurrir	0	1	**2**	**3**	**Total**
(8) *adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11		Sume:			

Provider Signature:_____

Favor de continuar en la parte de atrás de esta página →

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¿Está usted sintiendo dolor físico en estos momentos?	No	Si

Alguna vez en su vida ha tenido experiencias tan aterradoras, horribles o perturbadoras que haya provocado que en el último mes usted haya experimentado lo siguiente:

1. ¿Haya tenido pesadillas o pensamientos sobre estas experiencias aun cuando no	No	Si
2. ¿Ha intentado no pensar en esto o evita situaciones que le recuerdan este evento?	No	Si
3. ¿Esta constantemente vigilante, en guardia o se sobresalta con facilidad?	No	Si
4. ¿Se ha sentido insensible o distanciado de otras personas, actividades o su entorno?	No	Si
(3)		

Ingerir alcohol puede afectar su salud. Esto es especialmente importante si toma cierto tipo de medicamento. Queremos ayudarlo o ayudarla a estar saludable y reducir el riesgo de problemas causados por tomar alcohol. Las siguientes preguntas están relacionadas a su consumo de alcohol.

Para ayudarlo a contestar las preguntas correctamente, utilice los dibujos en la parte de debajo de esta hoja para determinar las cantidades de alcohol.

Favor de circular su respuesta	0	1	2	3	4
¿Con que frecuencia consume alguna bebida alcohólica?	Nunca	Una o menos veces al mes	De 2 a 4 veces al mes	De 2 a 3 veces a la semana	4 o más veces a la semana
¿Cuantas bebidas alcohólicas suele realizar en un día de consumo normal?	1 o 2	3 o 4	5 o 6	7 a 9	10 o más
¿Con que frecuencia toma 6 o más bebidas alcohólicas en un solo día?	nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario
¿Con que frecuencia durante el último año …					
…Ha sido incapaz de parar de beber una vez había empezado?	nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario
…no pudo hacer lo que se esperaba de usted porque había bebido?	nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario
…Ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?	nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario
…ha tenido remordimientos o sentimientos de culpa después de haber bebido?	nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario
…no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?	nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario
		0	2		4
¿Usted o alguna otra persona ha resultado herido porque usted había bebido?		No	Sí, pero no en el curso del último año		Sí, el último año
¿Algún familiar, amigo, médico o profesional de salud ha mostrado preocupación por un consumo de bebidas alcohólicas o le ha sugerido que deje de beber?		No	Sí, pero no en el curso del último año		Sí, el último año

Total:

Cantidad estándar para un trago:

12 onzas de cerveza o vino frío

1.5 onzas de licor 80 grados prueba

5 onzas de vino

4 onzas de brandy, licor o cordial

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Patient Health Questionnaire 15-Item Somatic Symptom Severity Scale (PHQ-15)

During the *past 4 weeks*, how much have you been bothered by any of the following problems?	Not bothered at all	Bothered a little	Bothered a lot
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods [Women only]	☐	☐	☐
e. Headaches	☐	☐	☐
f. Chest pain	☐	☐	☐
g. Dizziness	☐	☐	☐
h. Fainting spells	☐	☐	☐
i. Feeling your heart pound or race	☐	☐	☐
j. Shortness of breath	☐	☐	☐
k. Pain or problems during sexual intercourse	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐
n. Feeling tired or having low energy	☐	☐	☐
o. Trouble sleeping	☐	☐	☐

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SÍNTOMAS FÍSICOS
(PHQ-15)

Durante las <u>últimas 4 semanas</u>, ¿cuánta molestia ha tenido por cualquiera de los siguientes problemas?

	Sin molestia (0)	Un poco de molestia (1)	Mucha molestia (2)
a. Dolor de estómago	☐	☐	☐
b. Dolor de espalda	☐	☐	☐
c. Dolor en sus brazos, piernas o coyunturas (rodillas, caderas, etc.)	☐	☐	☐
d. Calambres menstruales u otros problemas con sus períodos ***PARA MUJERES SOLAMENTE***	☐	☐	☐
e. Dolores de cabeza	☐	☐	☐
f. Dolores en el pecho	☐	☐	☐
g. Mareos	☐	☐	☐
h. Episodios de desmayos	☐	☐	☐
i. Ha sentido su corazón palpitar o acelerarse	☐	☐	☐
j. Corto(a) de respiración	☐	☐	☐
k. Dolor o problemas durante la penetración sexual	☐	☐	☐
l. Estreñimiento, intestino suelto o diarrea	☐	☐	☐
m. Náusea, gas o indigestión	☐	☐	☐
n. Se ha sentido cansado(a) o con poca energía	☐	☐	☐
o. Ha tenido dificultad para dormir	☐	☐	☐

(*For office coding: Total Score T*_____ = _____ + _____)

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American Chronic Pain Association

Quality Of Life Scale

A Measure Of Function For People With Pain

0 Non-functioning	Stay in bed all day Feel hopeless and helpless about life
1	Stay in bed at least half the day Have no contact with outside world
2	Get out of bed but don't get dressed Stay at home all day
3	Get dressed in the morning Minimal activities at home Contact with friends via phone, email
4	Do simple chores around the house Minimal activities outside of home two days a week
5	Struggle but fulfill daily home responsibilities No outside activity Not able to work/volunteer
6	Work/volunteer limited hours Take part in limited social activities on weekends
7	Work/volunteer for a few hours daily. Can be active at least five hours a day. Can make plans to do simple activities on weekends
8	Work/volunteer for at least six hours daily Have energy to make plans for one evening social activity during the week Active on weekends
9	Work/volunteer/be active eight hours daily Take part in family life Outside social activities limited
10 Normal Quality of Life	Go to work/volunteer each day Normal daily activities each day Have a social life outside of work Take an active part in family life

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American Chronic Pain Association

Quality Of Life Scale

A Measure Of Function For People With Pain

Pain is a highly personal experience. The degree to which pain interferes with the quality of a person's life is also highly personal.

The American Chronic Pain Association Quality of Life Scale looks at ability to function, rather than at pain alone. It can help people with pain and their health care team to evaluate and communicate the impact of pain on the basic activities of daily life. This information can provide a basis for more effective treatment and help to measure progress over time.

The scale is meant to help individuals measure activity levels. We recognize that homemakers, parents and retirees often don't work outside the home, but activity can still be measured in the amount of time one is able to "work" at fulfilling daily responsibilities be that in a paid job, as a volunteer, or within the home.

With a combination of sound medical treatment, good coping skills, and peer support, people with pain can lead more productive, satisfying lives. The American Chronic Pain Association can help.

For more information, contact the ACPA:

Post Office Box 850
Rocklin, CA 95677
916.632-0922 800.533.3231
Fax: 916.632.3208
E-mail: acpa@pacbell.net
Web Page: www.theacpa.org

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PIRS

ID ___ ___ ___ ___ ___ ___

Date ___ ___ / ___ ___ / ___ ___
m m d d y y

A. Overall sleep quality: Consider the quality of your sleep in the past 7 days. Then mark that point along the line that best describes your sleep quality in the past 7 days:

Horrible |——————————————————————| Wonderful

*The following questions ask about your sleep **in the past 7 days and nights**. Please circle the one **best** answer for each question.*

B. In the past week, how much were you bothered by:	**Not at all bothered**	**Slightly bothered**	**Moderately bothered**	**Severely bothered**
1. Difficulty getting to sleep at bedtime	0	1	2	3
2. One or more awakenings after getting to sleep	0	1	2	3
3. Waking up too early in the morning	0	1	2	3
4. Not getting enough sleep	0	1	2	3
5. Different sleep patterns from one night to the next	0	1	2	3
6. Sleep occurring at odd times or not at all	0	1	2	3
7. Intense or disturbing dreams	0	1	2	3
8. Sensations (like noises, hot or cold, pain) during the night	0	1	2	3
9. Physical tension at night	0	1	2	3
10. Moving too much in bed	0	1	2	3
11. Anxiety or worries about getting to sleep	0	1	2	3
12. Anxiety or worries about lack of sleep	0	1	2	3
13. Anxiety or worries about what might happen during sleep	0	1	2	3
14. General nervousness and stress	0	1	2	3
15. Poor sleeping causing you to feel stress	0	1	2	3
16. Stress causing poor sleeping	0	1	2	3
17. Your mind not slowing down at bedtime	0	1	2	3
18. Loss of desire for physical intimacy or sex	0	1	2	3
19. Sleep that doesn't fully refresh you	0	1	2	3
20. Difficulty waking up	0	1	2	3
21. Poor alertness during the daytime	0	1	2	3
22. Difficulty keeping your thoughts focused	0	1	2	3

PIRS

ID ___ ___ ___ ___ ___ ___ Date ___ ___ / ___ ___ / ___ ___
m m d d y y

In the past week, how much were you bothered by:	Not at all bothered	Slightly bothered	Moderately bothered	Severely bothered
23. Your mind never slowing down during the daytime	0	1	2	3
24. Difficulty remembering things	0	1	2	3
25. Difficulty thinking clearly and making decisions	0	1	2	3
26. Tiredness or fatigue	0	1	2	3
27. Dozing off or napping when you really didn't want to	0	1	2	3
28. Others noticing you appeared tired or fatigued	0	1	2	3
29. Too many difficulties to overcome	0	1	2	3
30. Being unsure about handling your personal problems	0	1	2	3
31. Being unsure about dealing with day-to-day problems	0	1	2	3
32. Irritation with sounds, sights, or sensations during the day	0	1	2	3
33. Bad mood(s) because you had poor sleep	0	1	2	3
34. Irritation with people even when they were polite	0	1	2	3
35. Difficulty controlling your emotions	0	1	2	3
36. Needing to keep quiet around other people	0	1	2	3
37. Lack of energy because of poor sleep	0	1	2	3
38. Poor sleep that interferes with your relationships	0	1	2	3
39. Feeling sleepy	0	1	2	3
40. Being unable to sleep	0	1	2	3
41. Feeling that time itself slowed down	0	1	2	3
42. Being able to do only enough to get by	0	1	2	3
43. Difficulty getting along with other people	0	1	2	3
44. Physical clumsiness	0	1	2	3
45. Feeling physically ill or prone to infections	0	1	2	3
46. Being forced to pay special attention to what you eat or what you do so that you can sleep better	0	1	2	3

PIRS

ID ___ ___ ___ ___ ___ ___ Date ___ ___ / ___ ___ / ___ ___
m m d d y y

C. Please circle the best answer for each question about the past week:

47. From the time you tried to go to sleep, how long did it take to fall asleep on the **worst** night?

0 Less than ½ hour
1 Between ½ to 1 hour
2 Between 1 to 3 hours
3 More than 3 hours or I didn't sleep

48. From the time you tried to go to sleep, how long did it take to fall asleep on **most** nights?

0 Less than ½ hour
1 Between ½ to 1 hour
2 Between 1 to 3 hours
3 More than 3 hours or I didn't sleep

49. If you woke up during the night, how long did it take to fall back to sleep on the **worst** night?

0 Less than ½ hour or I didn't wake up
1 Between ½ to 1 hour
2 Between 1 to 3 hours
3 More than 3 hours or I didn't fall back to sleep

50. If you woke up during the night, how long did it take to fall back to sleep on **most** nights?

0 Less than ½ hour or I didn't wake up
1 Between ½ to 1 hour
2 Between 1 to 3 hours
3 More than 3 hours or I didn't fall back to sleep

51. Not counting times when you were awake in bed, how many hours of **actual** sleep did you get during the **worst** night?

0 More than 7 hours
1 Between 4 to 7 hours
2 Between 2 to 4 hours
3 Less than 2 hours or I didn't sleep

52. Not counting times when you were awake in bed, how many hours of **actual** sleep did you get during **most** nights?

0 More than 7 hours
1 Between 4 to 7 hours
2 Between 2 to 4 hours
3 Less than 2 hours or I didn't sleep

PIRS

ID ___ ___ ___ ___ ___ ___

Date ___ ___ / ___ ___ / ___ ___
m m d d y y

53. On how many nights did it take **longer** than 30 minutes to fall to sleep?

0 None or 1 night
1 On 2 or 3 nights
2 On 4 or 5 nights
3 On 6 or all nights

54. On how many nights did you wake up and have **trouble falling back** to sleep?

0 None or 1 night
1 On 2 or 3 nights
2 On 4 or 5 nights
3 On 6 or all nights

55. On how many mornings did you wake up **not fully rested**?

0 None or 1 morning
1 On 2 or 3 mornings
2 On 4 or 5 mornings
3 On 6 or all mornings

56. On how many days did you have trouble coping **because of poor sleep**?

0 None or 1 day
1 On 2 or 3 days
2 On 4 or 5 days
3 On 6 or all days

D. Over the past week, how would you rate:	Excellent	Good	Fair	Poor
57. Your sleep quality, compared to most people	0	1	2	3
58. Your satisfaction with your sleep	0	1	2	3
59. Your ability to get things done, compared to your best	0	1	2	3
60. Your satisfaction with how you got things done	0	1	2	3
61. The regularity of your sleep	0	1	2	3
62. The soundness of your sleep	0	1	2	3
63. How well you talked and communicated with others	0	1	2	3
64. Your sense of humor	0	1	2	3
65. Your quality of life	0	1	2	3

PIRS

ID ___ ___ ___ ___ ___ ___

Date ___ ___ / ___ ___ / ___ ___
m m d d y y

E. Thank you for completing this rating scale. We welcome your comments.

66. Please feel free to tell us about any aspects of your sleep or wakefulness we may have missed. Also feel free to tell us your opinion about this insomnia rating scale.

Insomnia Severity Index

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia problem	None	Mild	Moderate	Severe	Very severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:

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0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Print out your completed Insomnia Severity Index, along with the Guidelines for Scoring/Interpretation, to show to your health care provider.

Used with permission from Charles M. Morin, Ph.D., Université Laval

Close

Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# _____

Do not write above this line

Date: _____ Time: _____

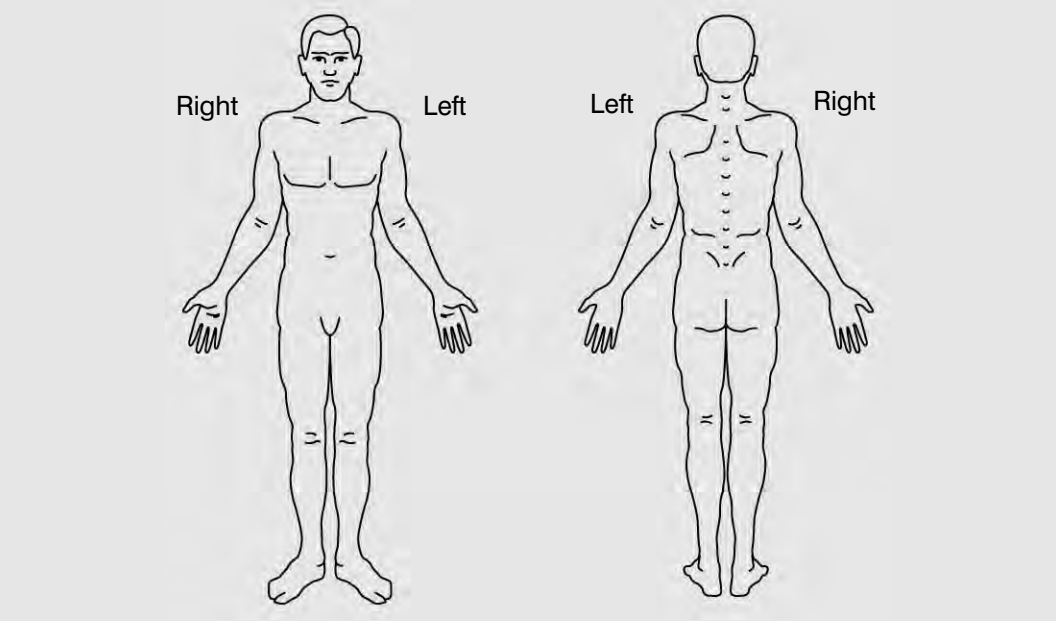
Name: _____

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

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5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

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D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

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ADHD

NICHQ VANDERBILT ASSESSMENT SCALE - PARENT

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child: ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	○ 0	○ 1	○ 2	○ 3
2. Has difficulty keeping attention to what needs to be done	○ 0	○ 1	○ 2	○ 3
3. Does not seem to listen when spoken to directly	○ 0	○ 1	○ 2	○ 3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	○ 0	○ 1	○ 2	○ 3
5. Has difficulty organizing tasks and activities	○ 0	○ 1	○ 2	○ 3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	○ 0	○ 1	○ 2	○ 3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	○ 0	○ 1	○ 2	○ 3
8. Is easily distracted by noises or other stimuli	○ 0	○ 1	○ 2	○ 3
9. Is forgetful in daily activities	○ 0	○ 1	○ 2	○ 3
10. Fidgets with hands or feet or squirms in seat	○ 0	○ 1	○ 2	○ 3
11. Leaves seat when remaining seated is expected	○ 0	○ 1	○ 2	○ 3
12. Runs about or climbs too much when remaining seated is expected	○ 0	○ 1	○ 2	○ 3
13. Has difficulty playing or beginning quiet play activities	○ 0	○ 1	○ 2	○ 3
14. Is "on the go" or often acts as if "driven by a motor"	○ 0	○ 1	○ 2	○ 3
15. Talks too much	○ 0	○ 1	○ 2	○ 3
16. Blurts out answers before questions have been completed	○ 0	○ 1	○ 2	○ 3
17. Has difficulty waiting his or her turn	○ 0	○ 1	○ 2	○ 3
18. Interrupts or intrudes in on others' conversations and/or activities	○ 0	○ 1	○ 2	○ 3

Timepoint **Subject ID #** **Assessment Date** / /

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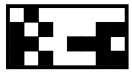
NICHQ VANDERBILT ASSESSMENT SCALE - PARENT

Symptoms	Never	Occasionally	Often	Very Often
19. Argues with adults	○ 0	○ 1	○ 2	○ 3
20. Loses temper	○ 0	○ 1	○ 2	○ 3
21. Actively defies or refuses to go along with adults' requests or rules	○ 0	○ 1	○ 2	○ 3
22. Deliberately annoys people	○ 0	○ 1	○ 2	○ 3
23. Blames others for his or her mistakes or misbehaviors	○ 0	○ 1	○ 2	○ 3
24. Is touchy or easily annoyed by others	○ 0	○ 1	○ 2	○ 3
25. Is angry or resentful	○ 0	○ 1	○ 2	○ 3
26. Is spiteful and wants to get even	○ 0	○ 1	○ 2	○ 3
27. Bullies, threatens, or intimidates others	○ 0	○ 1	○ 2	○ 3
28. Starts physical fights	○ 0	○ 1	○ 2	○ 3
29. Lies to get out of trouble or to avoid obligations (ie "cons" others)	○ 0	○ 1	○ 2	○ 3
30. Is truant from school (skips school) without permission	○ 0	○ 1	○ 2	○ 3
31. Is physically cruel to people	○ 0	○ 1	○ 2	○ 3
32. Has stolen things that have value	○ 0	○ 1	○ 2	○ 3
33. Deliberately destroys others' property	○ 0	○ 1	○ 2	○ 3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	○ 0	○ 1	○ 2	○ 3
35. Is physically cruel to animals	○ 0	○ 1	○ 2	○ 3
36. Has deliberately set fires to cause damage	○ 0	○ 1	○ 2	○ 3

Subject ID #



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NICHQ VANDERBILT ASSESSMENT SCALE - PARENT

Symptoms	Never	Occasionally	Often	Very Often
37. Has broken into someone else's home, business, or car	○ 0	○ 1	○ 2	○ 3
38. Has stayed out at night without permission	○ 0	○ 1	○ 2	○ 3
39. Has run away from home overnight	○ 0	○ 1	○ 2	○ 3
40. Has forced someone into sexual activity	○ 0	○ 1	○ 2	○ 3
41. Is fearful, anxious, or worried	○ 0	○ 1	○ 2	○ 3
42. Is afraid to try new things for fear of making mistakes	○ 0	○ 1	○ 2	○ 3
43. Feels worthless or inferior	○ 0	○ 1	○ 2	○ 3
44. Blames self for problems, feels guilty	○ 0	○ 1	○ 2	○ 3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	○ 0	○ 1	○ 2	○ 3
46. Is sad, unhappy, or depressed	○ 0	○ 1	○ 2	○ 3
47. Is self-conscious or easily embarrassed	○ 0	○ 1	○ 2	○ 3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problemataic
48. Overall school performance	○ 1	○ 2	○ 3	○ 4	○ 5
49. Reading	○ 1	○ 2	○ 3	○ 4	○ 5
50. Writing	○ 1	○ 2	○ 3	○ 4	○ 5
51. Mathematics	○ 1	○ 2	○ 3	○ 4	○ 5
52. Relationship with parents	○ 1	○ 2	○ 3	○ 4	○ 5
53. Relationship with siblings	○ 1	○ 2	○ 3	○ 4	○ 5
54. Relationship with peers	○ 1	○ 2	○ 3	○ 4	○ 5
55. Participation in organized activities (eg, teams)	○ 1	○ 2	○ 3	○ 4	○ 5

Subject ID #

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Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity	ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional-Defiant Disorder Screen ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Oppositional-Defiant/Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

myADHD.com
Vanderbilt Assessment Scale—Teacher Informant #6176

Adapted from the Vanderbilt Rating Scale by Mark L. Wolraich, MD

Student:_____ Gender: _____ Age: _____ Grade: _____

Completed by: _____ Date: _____

Directions Each rating should be considered in the context of what is appropriate for the age of the student. When completing this form, please think about the student's behaviors in the past 6 months. Is this evaluation based on a time when the student:
☐was on medication ☐ was not on medication ☐not sure?

	Symptoms	**Never (0)**	**Occa-sionally (1)**	**Often (2)**	**Very Often (3)**
1.	Fails to pay attention to details or makes careless mistakes in schoolwork	☐	☐	☐	☐
2.	Has difficulty sustaining attention to tasks or activities	☐	☐	☐	☐
3.	Does not seem to listen when spoken to directly	☐	☐	☐	☐
4.	Does not follow through on instructions and fails to finish schoolwork (not due to refusal or failure to understand)	☐	☐	☐	☐
5.	Has difficulty organizing tasks and activities	☐	☐	☐	☐
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	☐	☐	☐	☐
7.	Loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)	☐	☐	☐	☐
8.	Is distracted by extraneous stimuli	☐	☐	☐	☐
9.	Is forgetful in daily activities	☐	☐	☐	☐
10.	Fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	☐	☐	☐	☐
12.	Runs about or climbs excessively in situations in which remaining seated is expected	☐	☐	☐	☐
13.	Has difficulty playing or engaging in leisure activities quietly	☐	☐	☐	☐
14.	Is “on the go” or often acts as if “driven by a motor”	☐	☐	☐	☐
15.	Talks excessively	☐	☐	☐	☐
16.	Blurts out answers before questions have been completed	☐	☐	☐	☐
17.	Has difficulty awaiting turn	☐	☐	☐	☐
18.	Interrupts or intrudes on others (e.g., butts into conversations/games)	☐	☐	☐	☐
19.	Loses temper	☐	☐	☐	☐
20.	Actively defies or refuses to go along with adult requests or rules	☐	☐	☐	☐

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21.	Is angry or resentful	☐	☐	☐	☐
22.	Is spiteful and wants to get even	☐	☐	☐	☐
23.	Bullies, threatens, or intimidates others	☐	☐	☐	☐
24.	Initiates physical fights	☐	☐	☐	☐
25.	Lies to get out of trouble or to avoid obligations (ie, "cons" others)	☐	☐	☐	☐
26.	Is physically cruel to people	☐	☐	☐	☐
27.	Has stolen things that have value	☐	☐	☐	☐
28.	Deliberately destroys others' property	☐	☐	☐	☐
29.	Is fearful, anxious, or worried	☐	☐	☐	☐
30.	Is self-conscious or easily embarrassed	☐	☐	☐	☐
31.	Is afraid to try new things for fear of making mistakes	☐	☐	☐	☐
32.	Feels worthless or inferior	☐	☐	☐	☐
33.	Blames self for problems; feels guilty	☐	☐	☐	☐
34.	Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	☐	☐	☐	☐
35.	Is sad, unhappy, or depressed	☐	☐	☐	☐

	Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36.	Reading	☐	☐	☐	☐	☐
37.	Mathematics	☐	☐	☐	☐	☐
38.	Written Expression	☐	☐	☐	☐	☐
	Performance *Classroom Behavior*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39.	Relationship with peers	☐	☐	☐	☐	☐
40.	Following directions	☐	☐	☐	☐	☐
41.	Disrupting class	☐	☐	☐	☐	☐
42.	Assignment completion	☐	☐	☐	☐	☐
43.	Organizational skills	☐	☐	☐	☐	☐

Comments:

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Total number of items scored 2 or 3 in items 1-9: _____ (ADHD, predominantly inattentive type—6 or more symptoms)

Total number of items scored 2 or 3 in items 10-18:_____ (ADHD, predominantly hyperactive-impulsive type—6 or more symptoms)

Total Symptoms Score for items 1-18:_____ (ADHD,predominantly combined type—6 or more symptoms of both types)

Total number of items scored 2 or 3 in items 19-28:_____ (oppositional and conduct disorder screen—3 or more symptoms)

Total number of items scored 2 or 3 in items 29-35:_____ (anxiety/depression screen—3 or more symptoms)

Total number of items scored 2 or 3 in items 36-43:_____ (academic and classroom behavior symptoms)

Average Performance Score:_____ (average score on items 36-43)

Scoring Instructions for the Vanderbilt Assessment Scale—Teacher Informant

The Vanderbilt Assessment Scale has two components: symptom assessment and impairment of performance.

For the ADHD screen, the symptoms assessment component screens for symptoms that meet the criteria for both inattentive (items 1-9) and hyperactive-impulsive ADHD (items 10-18). To meet DSM-IV criteria for the diagnosis of ADHD, one must have at least 6 responses of "Often" or "Very Often" (scored 2 or 3) to either the 9 inattentive or 9 hyperactive-impulsive items, or both and a score of 4 or 5 on any of the Performance items (36-43). There is a place to record the number of symptoms that meet this criteria in each subgroup.

The Vanderbilt Assessment Scale also contains items that screen for 3 other co-morbidities: oppositional defiant disorder (items 19-22), conduct disorder (items 23-28), and anxiety/depression (items29-35).

To screen for oppositional defiant disorder/conduct disorder one must have at least 3 responses of "Often" or "Very Often" on items 19-28 and a score of 4 or 5 on any of the Performance items (36-43).

To screen for anxiety/depression one must have at least 3 responses of "Often" or "Very Often" on items 29-35 and a score of 4 or 5 on any of the Performance items 36-43.

The Vanderbilt Assessment Scale should NOT be used alone to make a diagnosis. The practitioner must consider information from other sources and may ask for the child's report cards, samples of the child's schoolwork, as well as any psychometric testing done.

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D5s1 Seguimiento de la Evaluación NICHQ Vanderbilt. Cuestionario para PADRES
NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Fecha de hoy/*Today's Date:* _____

Nombre del niño(a)/*Child's Name:* _____

Fecha de nacimiento/*Date of Birth:* _____

Nombre del padre o de la madre/*Parent's Name*: _____

Teléfono/*Parent's Phone Number:* _____

Instrucciones: **Conteste basándose en lo que considera apropiado para un niño de esa edad. Al completar este cuestionario, piense por favor en la conducta de su niño(a) desde la última vez que llenó el primer cuestionario.**

Directions: ***Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.***

Durante el período de evaluación su hijo(a)
Is this evaluation based on a time when the child

☐ **tomaba medicamentos** ***was on medication***
☐ **no tomaba medicamentos** ***was not on medication***
☐ **no lo recuerda** ***not sure?***

Síntomas/ ***Symptoms***	**Nunca/** ***Never***	**A veces/** ***Occasionally***	**Seguido/** ***Often***	**Muy seguido/** ***Very Often***
1. No pone atención a los detalles o comete errores por descuido como por ejemplo, cuando hace la tarea *Does not pay attention to details or makes careless mistakes with, for example, homework*	0	1	2	3
2. Se le dificulta mantenerse atento al llevar a cabo sus actividades *Has difficulty keeping attention to what needs to be done*	0	1	2	3
3. Parece no estar escuchando cuando se le habla directamente *Does not seem to listen when spoken to directly*	0	1	2	3
4. No sigue las instrucciones hasta el final y no concluye sus actividades (no porque se rehúse a seguirlas o porque no las comprenda) *Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)*	0	1	2	3
5. Tiene dificultad al organizar sus tareas y actividades *Has difficulty organizing tasks and activities*	0	1	2	3
6. Evita, le disgusta o no quiere comenzar actividades que requieren un continuo esfuerzo mental *Avoids, dislikes, or does not want to start tasks that require ongoing mental effort*	0	1	2	3
7. Pierde cosas que son indispensables para cumplir con sus tareas o actividades (juguetes, tareas de la escuela, lápices o libros) *Loses things necessary for tasks or activities (toys, assignments, pencils, or books)*	0	1	2	3
8. Se distrae fácilmente con ruidos u otros estímulos externos *Is easily distracted by noises or other stimuli*	0	1	2	3
9. Es olvidadizo(a) en sus actividades cotidianas *Is forgetful in daily activities*	0	1	2	3
10. Mueve constantemente las manos o los pies, o no se está quieto(a) en su asiento *Fidgets with hands or feet or squirms in seat*	0	1	2	3
11. Se pone de pie cuando debiera permanecer sentado(a) *Leaves seat when remaining seated is expected*	0	1	2	3

Adaptación de las Escalas de Clasificación Vanderbilt, diseñadas por Mark L. Wolraich, MD.
Revisión - 0303

D5s2 Seguimiento de la Evaluación NICHQ Vanderbilt. Cuestionario para PADRES
NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Fecha de hoy/*Today's Date:* _____

Nombre del niño(a)/*Child's Name:* _____

Fecha de nacimiento/*Date of Birth:* _____

Nombre del padre o de la madre/*Parent's Name:* _____

Teléfono/*Parent's Phone Number:* _____

Síntomas (continuación)/ ***Symptoms (continued)***	**Nunca/** ***Never***	**A veces/** ***Occasionally***	**Seguido/** ***Often***	**Muy seguido/** ***Very Often***
12. Corre o camina por todos lados cuando debiera permanecer sentado *Runs about or climbs too much when remaining seated is expected*	0	1	2	3
13. Se le dificulta jugar o empezar actividades recreativas más tranquilas *Has difficulty playing or beginning quiet play activities*	0	1	2	3
14. Está en constante movimiento o actúa como si "tuviera un motor por dentro" *Is "on the go" or often acts as if "driven by a motor"*	0	1	2	3
15. Habla demasiado *Talks too much*	0	1	2	3
16. Responde precipitadamente, incluso antes de escuchar la pregunta completa *Blurts out answers before questions have been completed*	0	1	2	3
17. Tiene dificultad al esperar su turno *Has difficulty waiting his or her turn*	0	1	2	3
18. Interrumpe o se entromete en conversaciones o actividades ajenas *Interrupts or intrudes in on others' conversations and/or activities*	0	1	2	3

Comportamiento ***Performance***	**Excelente/** ***Excellent***	**Sobre lo normal/** ***Above Average***	**Normal/** ***Average***	**Cierta dificultad/** ***Somewhat of a Problem***	**Con dificultad/** ***Problematic***
19. Comportamiento general en la escuela *Overall school performance*	1	2	3	4	5
20. Lectura *Reading*	1	2	3	4	5
21. Escritura *Writing*	1	2	3	4	5
22. Matemáticas *Mathematics*	1	2	3	4	5
23. Relación con sus padres *Relationship with parents*	1	2	3	4	5
24. Relación con sus hermanos *Relationship with siblings*	1	2	3	4	5
25. Relación con sus compañeros *Relationship with peers*	1	2	3	4	5
26. Participación en actividades organizadas (ejemplo: equipos deportivos) *Participation in organized activities (eg, teams)*	1	2	3	4	5

D5s3 Seguimiento de la Evaluación NICHQ Vanderbilt. Cuestionario para PADRES
NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Fecha de hoy/*Today's Date:* _____

Nombre del niño(a)/*Child's Name:* _____

Fecha de nacimiento/*Date of Birth:* _____

Nombre del padre o de la madre/*Parent's Name:* _____

Teléfono/*Parent's Phone Number:* _____

Efectos colaterales: Durante la semana pasada, ¿ha padecido su hijo(a) alguno de los siguientes problemas de salud o posibles efectos colaterales del tratamiento? ***Side Effects:*** *Has your child experienced any of the following side effects or problems in the past week?*	**¿Estos efectos colaterales son un problema actual?** ***Are these side effects currently a problem?***			
	No/ ***None***	**Leve/** ***Mild***	**Moderado/** ***Moderate***	**Severo/** ***Severe***
Dolor de cabeza *Headache*				
Dolor de estómago *Stomachache*				
Alteración del apetito (explique abajo) *Change of appetite—explain below*				
Problemas para dormir *Trouble sleeping*				
Irritabilidad al mediodía, al anochecer o por las tardes (explique abajo) *Irritability in the late morning, late afternoon, or evening—explain below*				
Conducta antisocial (su interacción con los otros se ha reducido) *Socially withdrawn—decreased interaction with others*				
Tristeza profunda o llanto sin motivo aparente *Extreme sadness or unusual crying*				
Aburrido(a), cansado(a), apático(a) *Dull, tired, listless behavior*				
Escalofríos/siente que le tiembla el cuerpo *Tremors/feeling shaky*				
Movimientos involuntarios, tic nerviosos, pestañeos continuos (explique abajo) *Repetitive movements, tics, jerking, twitching, eye blinking—explain below*				
Se come las uñas, se rasca la piel o se muerde los labios (explique abajo) *Picking at skin or fingers, nail biting, lip or cheek chewing—explain below*				
Ve o escucha cosas imaginarias *Sees or hears things that aren't there*				

Explique/Comentarios:
Explain/Comments:

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Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Este cuadro clínico se basa en el Índice de efectos colaterales de Pittsburgh, desarrollado por William E. Pelham, Jr, PhD.
En el sitio http://wings.buffalo.edu/adhd encontrará información disponible para descargarlo en formato expandido a su computadora sin ningún costo.

www.m-chat.org

Child's name _____ Filled out by _____
Date of birth _____ Relationship to child _____
Today's date _____

M-CHAT (*Modified Checklist for Autism in Toddlers*)

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes	No
2.	Does your child take an interest in other children?	Yes	No
3.	Does your child like climbing on things, such as up stairs?	Yes	No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes	No
5.	Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	Yes	No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes	No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes	No
8.	Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling, or dropping them?	Yes	No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes	No
10.	Does your child look you in the eye for more than a second or two?	Yes	No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes	No
12.	Does your child smile in response to your face or your smile?	Yes	No
13.	Does your child imitate you? (e.g., you make a face-will your child imitate it?)	Yes	No
14.	Does your child respond to his/her name when you call?	Yes	No
15.	If you point at a toy across the room, does your child look at it?	Yes	No
16.	Does your child walk?	Yes	No
17.	Does your child look at things you are looking at?	Yes	No
18.	Does your child make unusual finger movements near his/her face?	Yes	No
19.	Does your child try to attract your attention to his/her own activity?	Yes	No
20.	Have you ever wondered if your child is deaf?	Yes	No
21.	Does your child understand what people say?	Yes	No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes	No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes	No

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M-CHAT Best7 Scoring Instructions

A child screens positive, or shows **Risk for Autism**, when 2 or more "Best7" items are failed OR when any three items are failed. If fewer than 2 "Best7" items are failed, and fewer than 3 total items are failed, the result is **Low Risk for Autism**. The design of M-CHAT Best7 is to retain high sensitivity with a low false-positive rate for Autism concern. If the result of the checklist is "Risk for Autism" the corresponding M-CHAT Follow-up Interview™ should be given to obtain the most accurate responses.

Yes/no answers convert to pass/fail responses. Below are listed the failed responses for each item on the M-CHAT. **BOLD CAPITALIZED** items are "Best7" items.

Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum. However, children who screen positive on the M-CHAT should be evaluated in more depth by the physician or referred for a developmental evaluation with a specialist.

1. No	6. No	11. Yes	16. No	21. No
2. **NO**	**7. NO**	12. No	17. No	22. Yes
3. No	8. No	13. No	18. Yes	23. No
4. No	**9. NO**	**14. NO**	19. No	
5. NO	10. No	**15. NO**	**20. YES**	

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M-CHAT: Evaluación del desarollo de niños en edad de caminar

Por favor conteste acerca de como su niño (a) es **usualmente**. Por favor trata de contestar cada pregunta. Si el comportamiento de su niño no ocurre con frecuencia, conteste como si no lo hiciera.

1. ¿Disfruta su niño (a) cuando lo balancean o hacen saltar sobre su rodilla?	Sí	No
2. ¿Se interesa su niño (a) en otros niños?	Sí	No
3. ¿Le gusta a su niño (a) subirse a las cosas, por ejemplo subir las escaleras?	Sí	No
4. ¿Disfruta su niño (a) jugando "peek-a-boo" o "hide and seek" (a las escondidas)?	Sí	No
5. ¿Le gusta a su niño (a) jugar a pretendar, como por ejemplo, pretende que habla por teléfono, que cuida sus muñecas, o pretende otras cosas?	Sí	No
6. ¿Utiliza su niño (a) su dedo índice para señalar algo, o para preguntar alguna cosa?	Sí	No
7. ¿Usa su niño (a) su dedo índice para señalar o indicar interés en algo?	Sí	No
8. ¿Puede su niño (a) jugar bien con jugetes pequeños (como carros o cubos) sin llevárselos a la boca, manipularlos o dejarlos caer)?	Sí	No
9. ¿Le trae su niño (a) a usted (padre o madre) objetos o cosas, con el propósito de mostrarle algo alguna vez?	Sí	No
10. ¿Lo mira su niño (a) directamente a los ojos por mas de uno o dos segundos?	Sí	No
11. ¿Parece su niño (a) ser demasiado sensitivo al ruido? (por ejemplo, se tapa los oidos)?	Sí	No
12. ¿Sonrie su niño (a) en respuesta a su cara o a su sonrisa?	Sí	No
13. ¿Lo imita su niño (a)? Por ejemplo, si usted le hace una mueca, su niño (a) trata de imitarlo?	Sí	No
14. ¿Responde su niño (a) a su nombre cuando lo(a) llaman?	Sí	No
15. ¿Si usted señala a un juguete que está al otro lado de la habitación a su niño (a), lo mira?	Sí	No
16. ¿Camina su niño (a)?	Sí	No
17. ¿Presta su niño (a) atención a las cosas que usted está mirando?	Sí	No
18. ¿Hace su niño (a) movimientos raros con los dedos cerca de su cara?	Sí	No
19. ¿Trata su niño (a) de llamar su atención (de sus padres) a las actividades que estada llevando a cabo?	Sí	No
20. ¿Se ha preguntado alguna vez si su niño (a) es sordo (a)?	Sí	No
21. ¿Comprende su niño (a) lo que otras dicen?	Sí	No
22. ¿Ha notado si su niño (a) se queda con una Mirada fija en nada, o si camina algunas veces sin sentido?	Sí	No
23. ¿Su niño le mira a su cara para chequear su reacción cuando esta en una situación diferente?	Sí	No

Note: correction made to item 22, July 23, 2008

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修正的幼兒自閉症檢查表（M-CHAT）

請按照你孩子平常的狀況回答下列問題。儘量每個問題都回答。如果那種行為很少出現（例如：你看過一、兩次），請以孩子沒有做過來作答。

1. 你的孩子喜歡你搖他或是把他放在你的膝蓋上等等之類的事嗎？ 是 否
2. 你的孩子對其他孩子有興趣嗎？ 是 否
3. 你的孩子喜歡爬東西，像上樓梯嗎？ 是 否
4. 你的孩子喜歡玩捉迷藏嗎？ 是 否
5. 你的孩子會假裝，例如，講電話或照顧洋娃娃，或假裝其他事情嗎？ 是 否
6. 你的孩子曾用食指指著東西，要求要某樣東西嗎？ 是 否
7. 你的孩子曾用食指指著東西，表示對某樣東西有興趣嗎？ 是 否
8. 你的孩子會正確玩小玩具（例如車子或積木），而不是只把它們放在嘴裡、隨便亂動或是把它們丟掉？ 是 否
9. 你的孩子曾經拿東西給你（家長）看嗎？ 是 否
10. 你的孩子會注意看著你的眼睛超過一、兩秒鐘嗎？ 是 否
11. 你的孩子曾對聲音過分敏感嗎？（例如摀住耳朵） 是 否
12. 你的孩子看著你的臉或是你的微笑時會以微笑回應嗎？ 是 否
13. 你的孩子會模仿你嗎？（例如：你扮個鬼臉，你的孩子會模仿嗎？） 是 否
14. 你的孩子聽到別人叫他／她的名字時，他／她會回應嗎？ 是 否
15. 如果你指著房間另一頭的玩具，你的孩子會看那個玩具嗎？ 是 否
16. 你的孩子走路嗎？ 是 否
17. 你的孩子會看你正在看的東西嗎？ 是 否
18. 你的孩子會在他／她的臉附近做出一些不尋常的手指頭動作嗎？ 是 否
19. 你的孩子會設法吸引你看他／她自己的活動嗎？ 是 否
20. 你是否曾經懷疑你的孩子聽力有問題？ 是 否
21. 你的孩子能理解別人說的話嗎？ 是 否
22. 你的孩子有時候會兩眼失焦或是沒有目的地逛來逛去嗎？ 是 否
23. 你的孩子碰到不熟悉的事物時會看著你的臉，看看你的反應嗎？ 是 否

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M-CHAT

평상시 아이의 행동을 토대로 아래 항목에 답해 주시기 바랍니다. 반드시 전 문항에 응답해주십시오. 만약 아래 질문중 그 행동의 횟수가 빈번하지 않으면 (예- 한 두번 본 경우) 그 문항은 '아니오' 라고 답해 주십시오.

1. 당신이 아이를 안고 그네 처럼 흔들어 주는 놀이나 무릎에 앉혀 아래 위로 흔들어 주는 놀이를 아이가 좋아합니까?	예	아니오
2. 아이가 다른 아이들에게 관심을 표하나요?	예	아니오
3. 아이가 물건이나 가구에 올라가기나 계단 오르기를 좋아합니까?	예	아니오
4. 아이가 까꿍 놀이 나 숨바꼭질을 좋아합니까?	예	아니오
5. 아이가 흉내 놀이를 좋아합니까? (예--인형 돌보기, 전화 걸기 놀기)	예	아니오
6. 아이가 뭔가를 요구할 때 검지 손가락으로 가리킵니까?	예	아니오
7. 아이가 흥미로운 것을 가리키기 위해 검지 손가락을 사용합니까?	예	아니오
8. 아이가 자동차나 블록같은 작은 장난감을 입으로 빨거나 반복적으로 떨어뜨리지 않고 나이에 맞게 갖고 노나요?	예	아니오
9. 아이가 당신에게 보여주기 위해 장난감이나 기타 물건을 가지고 오나요?	예	아니오
10. 아이가 1 초에서 2 초 이상 당신의 눈을 응시하나요?	예	아니오
11. 아이가 소리에 민감하다고 느끼시나요? (예-- 시끄러워 귀를 막는 행동)	예	아니오
12. 당신의 얼굴을 보면 미소를 짓거나 당신이 웃으면 따라 웃나요?	예	아니오
13. 아이가 당신을 따라 하나요? (예--찡그리면 따라서 찡그림)	예	아니오
14. 당신이 아이의 이름을 부르면 반응을 하나요?	예	아니오
15. 당신이 멀리 있는 물건을 손으로 가리키면 그 쪽을 보나요?	예	아니오
16. 아이가 걸어 다니나요?	예	아니오
17. 아이가 당신이 보고 있는 것을 따라 보나요?	예	아니오
18. 아이가 얼굴 주위에서 손가락으로 특이한 행동을 하나요?	예	아니오
19. 아이가 자신의 행동으로 당신의 관심을 끌려고 하나요?	예	아니오
20. 아이의 청각에 문제가 있다고 생각한 적이 있나요?	예	아니오
21. 아이가 다른 사람의 말을 이해하나요?	예	아니오
22. 아이가 허공을 응시하거나 정처 없이 배회하나요?	예	아니오
23. 아이가 낯선 것을 봤을 때 당신의 반응을 보기 위해 당신의 얼굴을 보나요?	예	아니오

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M CHAT

Xin hãy cho điểm dựa trên các câu hỏi phỏng vấn ở trên trang này. Các câu hỏi tiêu chuẩn được in **ĐẬM** và những câu hỏi nghịch, nghĩa là với câu hỏi này câu trả lời "Có" ám chỉ nguy cơ bị tự kỷ (11, 18, 20, 22), được ghi chú bằng chữ **(CÂU NGHỊCH)**.

1.	Con bạn có thích được lắc lư hoặc nâng lên hạ xuống trên đầu gối của bạn không ?	Có	Không
2.	**Con bạn có chú ý đến các trẻ khác không ?**	**Có**	Không
3.	Con bạn có thích leo trèo không ? Như leo lên cầu thang chẳng hạn ?	Có	Không
4.	Con bạn có thích chơi trốn tìm/ cút ngào không ?	Có	Không
5.	Con bạn có bao giờ chơi giả vờ như vờ gọi điện thoại hoặc săn sóc búp bê hoặc giả vờ làm cái gì đó không ?	Có	Không
6.	Con bạn có bao giờ dùng ngón tay trỏ của bé để chỉ vào một thứ gì đó để đòi (vòi) không ?	Có	Không
7.	**Con bạn có bao giờ dùng ngón tay trỏ của bé để chỉ một thứ gì đó để tỏ sự quan tâm không ?**	**Có**	**Không**
8.	Con bạn có biết cách chơi với các đồ chơi nhỏ như xe, các khối đồ chơi v.v.. (mà không chỉ bỏ đồ chơi vào miệng, nghịch vớ vẩn hoặc thả rơi đồ chơi)?	Có	Không
9.	**Con bạn có bao giờ đem một vật gì đó đến cho bạn để chỉ cho bạn về vật đó không ?**	**Có**	**Không**
10.	Con bạn có bao giờ nhìn vào mắt bạn hơn một hoặc hai giây không ?	Có	Không
11.	Con bạn có bao giờ tỏ vẻ quá nhạy cảm với tiếng động không ? (Ví dụ bịt tai lại) **(CÂU NGHỊCH)**	**Có**	**Không**
12.	Con bạn có bao giờ cười khi thấy mặt bạn hoặc khi bạn cười với bé không ?	Có	Không
13.	**Con bạn có bắt chước bạn không ? (Ví dụ bạn làm bộ nhăn mặt, con bạn có sẽ bắt chước bạn không ?)**	**Có**	**Không**
14.	**Con bạn có đáp ứng với tên của bé khi bạn gọi không ?**	**Có**	**Không**
15.	**Nếu bạn chỉ một thứ đồ chơi nào đó ở trong phòng, bé có nhìn vào nó không ?**	**Có**	**Không**
16.	Con bạn có đi được không ?	Có	Không
17.	Con bạn có nhìn vào vật mà bạn đang nhìn không ?	Có	Không
18.	Con bạn có làm những cử động ngón tay bất thường gần mặt của bé không ? **(CÂU NGHỊCH)**	**Có**	**Không**
19.	Con bạn có có bắt bạn phải chú ý vào các hoạt động của bé không?	Có	Không
20.	Có khi nào bạn băn khoăn là con mình có thể bị điếc không? **(CÂU NGHỊCH)**	**Có**	**Không**
21.	Con bạn có hiểu những điều người khác nói không ?	Có	Không
22.	Con bạn có bao giờ nhìn chăm chăm vào một vật gì đó hoặc đi thơ thẩn mà không có mục đích gì hết không ? **(CÂU NGHỊCH)**	**Có**	**Không**
23.	Con bạn có nhìn vào mặt bạn để xem phản ứng của bạn khi đối diện với một vật nào đó không quen thuộc với bé không?	Có	Không

ĐIỂM TIÊU CHUẨN: _____

TỔNG ĐIỂM: _____

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修正的幼兒自閉症檢查表（M-CHAT）計分說明

關鍵性項目中有兩項或兩項以上的答案為未通過，或是所有項目當中有任何三項的答案為未通過，該名兒童就被評定為未通過。是／否的答案轉換為通過／未通過。
下列為M-CHAT上所有項目未通過的答案。粗體字的項目為關鍵性項目。
檢查表判定為未通過的兒童並非全都達到自閉症範圍診斷的標準。然而，未通過檢查表的兒童應該由醫師做更進一步的評估，或是交由專家做發展評估。

1.否	6.否	11.是	16.否	21.否
2.否	7.否	12.否	17.否	22.是
3.否	8.否	13.否	18.是	23.否
4.否	9.否	14.否	19.否	
5.否	10.否	15.否	20.是	

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Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	_____	_____	_____
2.	Spends more time alone	2	_____	_____	_____
3.	Tires easily, has little energy	3	_____	_____	_____
4.	Fidgety, unable to sit still	4	_____	_____	_____
5.	Has trouble with a teacher	5	_____	_____	_____
6.	Less interested in school	6	_____	_____	_____
7.	Acts as if driven by a motor	7	_____	_____	_____
8.	Daydreams too much	8	_____	_____	_____
9.	Distracted easily	9	_____	_____	_____
10.	Is afraid of new situations	10	_____	_____	_____
11.	Feels sad, unhappy	11	_____	_____	_____
12.	Is irritable, angry	12	_____	_____	_____
13.	Feels hopeless	13	_____	_____	_____
14.	Has trouble concentrating	14	_____	_____	_____
15.	Less interest in friends	15	_____	_____	_____
16.	Fights with others	16	_____	_____	_____
17.	Absent from school	17	_____	_____	_____
18.	School grades dropping	18	_____	_____	_____
19.	Is down on him or herself	19	_____	_____	_____
20.	Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21.	Has trouble sleeping	21	_____	_____	_____
22.	Worries a lot	22	_____	_____	_____
23.	Wants to be with you more than before	23	_____	_____	_____
24.	Feels he or she is bad	24	_____	_____	_____
25.	Takes unnecessary risks	25	_____	_____	_____
26.	Gets hurt frequently	26	_____	_____	_____
27.	Seems to be having less fun	27	_____	_____	_____
28.	Acts younger than children his or her age	28	_____	_____	_____
29.	Does not listen to rules	29	_____	_____	_____
30.	Does not show feelings	30	_____	_____	_____
31.	Does not understand other people's feelings	31	_____	_____	_____
32.	Teases others	32	_____	_____	_____
33.	Blames others for his or her troubles	33	_____	_____	_____
34.	Takes things that do not belong to him or her	34	_____	_____	_____
35.	Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

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Place Label Here

Completado por: (por favor circule uno)
Padres / Pariente / Guardián / Paciente
(Parent / Relative / Gaurdian / Self)

LISTA DE SÍNTOMAS PEDIÁTRICOS PEDIATRIC SYMPTOM CHECKLIST (PSC)

Indique cual síntoma mejor describe a su hijo: Please mark under the heading that best describes your child:	NUNCA Never (0)	A VECES Sometimes (1)	SEGUIDO Often (2)
1. Se queja de dolores y malestares (Complains of aches and pains)			
2. Pasa mucho tiempo solo (Spends more time alone)			
3. Se cansa fácilmente, tiene poca energía (Tires easily, has little energy)			
4. Es inquieto (Fidgety, unable to sit still)			
5. Tiene problemas con maestros (Has trouble with teacher)			
6. Menos interesado(a) en la escuela (Less interested in school)			
7. Es muy activo(a), tiene mucha energía (Acts as if driven by a motor)			
8. Es muy soñador(a) (Daydreams too much)			
9. Se distrae fácilmente (Distracted easily)			
10. Temeroso(a) de nuevas situaciónes (Is afraid of new situations)			
11. Se siente triste, infeliz (Feels sad, unhappy)			
12. Es irritable, enojón (Is irritable, angry)			
13. Se siente sin esperanzas (Feels hopeless)			
14. Tiene problemas para concentrarse (Has trouble concentrating)			
15. Está menos interesado(a) en sus amistades (Less interested in friends)			
16. Pelea con otros niños(as) (Fights with other children)			
17. Se ausenta de la escuela (Absent from school)			
18. Sus notas escolares están bajando (School grades dropping)			
19. Se critica a si mismo(a) (Is down on him or herself)			
20. Visita al doctor y el doctor no le encuentra nada malo (Visits the doctor with doctor finding nothing wrong)			
21. Tiene problemas para dormir (Has trouble sleeping)			
22. Se preocupa mucho (Worries a lot)			
23. Quiere estar con usted más que antes (Wants to be with you more than before)			
24. Se siente que él/ella es malo(a) (Feels he or she is bad)			
25. Toma riezgos innecesarios (Takes unnecessary risks)			
26. Se lastima facilmente/frecuentemente (Gets hurt frequently)			
27. Parece divertise menos (Seems to be having less fun)			
28. Actúa más chico que niños de su propia edad (Acts younger than children his or her age)			
29. No obedece reglas (Does not listen to rules)			
30. No demuestra sus sentimientos (Does not show feelings)			
31. No comprende los sentimientos de otros (Does not understand other people's feelings)			
32. Molesta a otros (Teases others)			
33. Culpa a otros por sus problemas (Blames other for his or her troubles)			
34. Toma cosas que no le pertenecen (Takes things that do not belong to him or her)			
35. Se rehusa a compartir (Refuses to share)			

36. ¿Su hijo tiene algun problema emocional, o de comportamiento, para el cual necesita ayuda? ☐ No ☐ Sí
Does your child have any emotional or behavioral problems for which she/he needs help?

37. De momento, ¿su hijo se está consultando con un profesional de salud mental? ☐ No ☐ Sí
Is your child currently seeing a mental health counselor?

FOR OFFICE USE ONLY ***Plan for follow-up*** **Total score** _____

❑ Annual Screening ❑ Return visit w/ PCP ❑ Referred to counselor
❑ Parent refused ❑ Already in treatment ❑ Referred to other professional

Comments:

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Child's Name _____ Record Number _____
兒童姓名 **紅卡號碼**

Today's Date _____ Filled out by _____
今天日期 **填寫者**

Date of Birth _____
出生日期

Pediatric Symptom Checklist (PSC) 小兒科症狀查對項目

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.
兒童們的情緒和身體的健康常會混合在一起。因為父母們通常是第一位發現他們的小孩在行為、情緒或學習出現問題, 你回答這些問題可幫助你的孩子獲得最好的照顧。請指出那一敘述是最恰當形容你的小孩。

Please mark under the heading that best describes your child:
請在下列的項目指出最恰當形容你的小孩：

		NEVER 永不	SOMETIMES 有時	OFTEN 時常
1. Complains of aches and pains **抱怨疼痛和痠痛**	1			
2. Spends more time alone **自己獨處的時間較多**	2			
3. Tires easily, has little energy **容易疲倦，很少精力**	3.			
4. Fidgety, unable to sit still **煩燥的，不能坐定**	4			
5. Has trouble with teacher **和教師難相處**	5			
6. Less interested in school **上學興趣少**	6			
7. Acts as if driven by a motor **太愛動／不停活動**	7			
8. Daydreams too much **太多白日夢（幻想）**	8			
9. Distracted easily **容易分心**	9			
10. Is afraid of new situations. **害怕新的事物同環境**	10			
11. Feels sad, unhappy **感覺悲哀，不快樂**	11			
12. Is irritable, angry **易激動，發怒**	12			
13. Feels hopeless **感覺無希望**	13			
14. Has trouble concentrating **難於集中精神**	14			
15. Less interested in friends **減少對朋友的興趣**	15			
16. Fights with other children **和其他孩子打架**	16			
17. Absent from school **缺課**	17			

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		NEVER 永不	SOMETIMES 有時	OFTEN 時常
18. School grades dropping **成績退步**	18			
19. Is down on him or herself **看不起自己**	19			
20. Visits the doctor with doctor finding nothing wrong **看病，但醫生發現沒有毛病**	20			
21. Has trouble sleeping **有睡眠問題**	21			
22. Worries a lot **太多憂慮**	22			
23. Wants to be with you more than before **想要和你在一起的情形比以前更多**	23			
24. Feels he or she is bad **感覺他或她自己是壞的**	24			
25. Takes unnecessary risks **冒不必要的危險**	25			
26. Gets hurt frequently **經常受傷**	26			
27. Seems to be having less fun **似乎興緻樂趣不多**	27			
28. Acts younger than children his or her age **行為比同齡的兒童幼稚**	28			
29. Does not listen to rules **不遵守規例**	29			
30. Does not show feelings **不表露感覺**	30			
31. Does not understand other people' s feelings **不明白他人的感覺**	31			
32. Teases others **取笑他人**	32			
33. Blames other for his or her troubles **因自己的煩擾而責備他人**	33			
34. Takes things that do not belong to him or her **拿取不屬於自己的東西**	34			
35. Refuses to share **拒絕分享**	35			

Total score **總記分數** _____

Does your child have any emotional or behavioral problems for which she/he needs help?
你的孩子有任何情緒上或行為上的問題而需要幫助嗎？

( ) No **無** ( ) Yes **有**

Are there any services that you would like your child to receive for these problems?
如有任何相關的服務，你願意你的孩子因為這些問題接受服務嗎？

( ) No **無** ( ) Yes **有**

If yes, what service? _____
如回答有，甚麼服務呢？

_____

Additional copies available on the Pediatric Development and Behavior Homepage, http://www. dbpods.org /handouts

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Pediatric Symptom Checklist (PSC)
Daim Ntawv Soj Ntsuam Txog Menyuam Kev Noj Qab Nyob Zoo

Kev xav (chim siab, nyuaj siab, zoo siab) thiab kev noj qab nyob zoo (health) tshwm sim ua ke ntawm menyuam. Vim tias niamtxiv yog cov xub paub thiab pom cov teeb meem tshwm sim ntawm lawv cov menyuam xws li kev coj cwj pwm phem, tej kev xav (emotions) lossis kev kawm tsis tau ntawv, koj yuav pab tau koj tus menyuam los ntawm pab teb cov lus nug nram no. Thov kos seb kab ntsiab lus twg haum rau koj tus menyuam dua.

Thov kos rau lo lus uas raug rau koj tus menyuam:

			Tsis muaj kiag Tsis yog kiag	**Muaj me ntsis Yog me ntsis**	**Muaj heev Yog kawg li**
1.	Yws tias mob ib ce…….	1			
2.	Siv sij hawm nyob nws ib leeg ntau dua txhia zaug…..	2			
3.	Tshuas hnov nkees, tsis muaj zog……...	3			
4.	Co tes co taw, zaum tsis taus twj ywm……...	4			
5.	Muaj teeb meem nrog tus xib hwb……..	5			
6.	Nkees kawm ntawv dua li txhia zaug…..…….	6			
7.	Cus heev…….	7			
8.	Ua npau suav nruab hnub tas li/xav txog lwm yam tas li	8			
9.	Pheej hloov mus hloov los ua tsis tiav ib yam……	9			
10.	Ntshai ua yam tshiab/qhov chaw tshiab……...	10			
11.	Tu siab, tsis muaj kev zoo siab……..	11			
12.	Ntxhov siab, chim siab……...	12			
13.	Zoo li tag kev cia siab……..……..…….	13			
14.	Xav dabtsi los xav tsis tau li…..……..……	14			
15.	Tsis nrog cov phooj ywg…….……	15			
16.	Nrog lwm cov menyuam sib ntaus…….…….	16			
17.	Tsis mus kawm ntawv…….	17			
18.	Kev kawm poob qab/poob qhab nias kawm……...	18			
19.	Nws rau txhim rau nws tus kheej……	19			
20.	Mus ntsib kws kho mob tab sis kws kho nrhiav tsis tau tus mob li…….	20			
21.	Muaj teeb meem, pw tsis tsaug zog li…….	21			
22.	Txhawj xeeb ntau heev……	22			
23.	Xav nrog niam thiab txiv ntau dua yav tag los……	23			
24.	Ntseeg tias nws yog tus phem…….	24			
25.	Ua txhua yam tsis ntshai tsam raug mob li…….	25			
26.	Ib sij raug mob ib zaug ….……..	26			
27.	Zoo li tsis muaj kev lom zem li ……..	27			
28.	Tsis paub tab li cov menyuam uas muaj hnoob nyoog ib yam nws …….……	28			
29.	Tsis mloog txoj cai li……..	29			
30.	Zoo li tsis txawj xav li…….……	30			
31.	Tsis to taub txog lwm tus tej kev xav …….	31			
32.	Hais lus saib tsis taus lwm tus/thab lwm tus……...	32			
33.	Liam tias lwm tus yog tus ua rau nws raug teeb meem.…	33			
34.	Muab/nqa tej khoom uas tsis yog nws tug……..	34			
35.	Tsis kam qiv/faib/koom…….……..	35			

Koj tus menyuam puas muaj teeb meem txog nws tej kev xav lossis coj cwj pwm tsis zoo uas nws xav tau kev pab? ( ) N ( ) Y
Koj puas tau nrhiav kev pab los ntawm koj tsev neeg thiab zej zog rau koj tus menyuam? ( ) N ( ) Y
Puas muaj tej yam kev pab uas koj xav kom koj tus menyuam tau txais rau tej teeb meem no? ( ) N ( ) Y
Yog tias xav tau, xav tau yam kev pab dabtsi? _____

Ramsey County (St. Paul, MN) Human Services Hmong Focus Group
Hmong Translation (September 2004)

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表1　PSC 日本語版

PSC 日本語版健康調査票

お子さんの状態について最もよく合っていると思う所に印（✓）をつけて下さい．

	全くない	時々ある	しばしばある
1 何らかの体の痛みを訴える			
2 一人で過ごすことが多い			
3 疲れやすい，あまり元気がない			
4 そわそわして，じっと坐っていられない			
5 先生とトラブルがある			
6 学校にあまり興味がない			
7 まるで“モーターで駆られるように”ふるまう			
8 空想にふけることが多い			
9 気が散りやすい			
10 新しい状況をこわがる			
11 悲しい，幸せでないと思う			
12 いらいらしたり，怒ったりする			
13 希望がないように見える			
14 一つのことに集中できない			
15 友達と遊びたがらない			
16 他の子供達と喧嘩をする			
17 学校を休む			
18 学校の成績が悪くなっている			
19 自分を卑下する			
20（体調の不調を訴え）診察してもらってもどこも悪い所はないと言われる			
21 よく眠れない			
22 心配性である			
23 以前と比べて親と一緒にいたがる			
24 自分は悪い子だと思っている			
25 必要がないのに危険なことをする			
26 よくケガをする			
27 あまり楽しそうに見えない			
28 自分の年齢よりも幼稚にふるまう			
29 規則を守らない			
30 気持ちを表さない			
31 他の人の気持ちを理解しない			
32 他の人をからかう			
33 都合の悪いことを人のせいにする			
34 他人の物をとる			
35 物を分けあうのをいやがる			

ると考えられた．9,10 歳児に陽性者がなく，11 歳以上が大半を占める点について考察する．健常児の PSC スコアは年齢が上がるにつれて徐々に高くなる傾向がある[8]が，それに加えて今回の対象地区では，例年卒業生の半数以上が，中学受験することも関与している可能性があると推察される．今回のアンケートでは学習時間や学習塾についての質問をしておらず，スクールカウンセラー

កំរងសំណួរាយតំលៃបញ្ហាសុខភាពផ្លូវចិត្តកុមារ

ចំពោះកុមារ សុខភាពរូបកាយ និង សុខភាពផ្លូវចិត្តមានការប្រែប្រួល និង អភិវឌ្ឍន៍ទាក់ទិនគ្នាទៅវិញទៅមក ។ ជាទូទៅមាតាបិតាគឺជាបុគ្គលទីមួយដែលឆាប់សង្កេតឃើញ អំពីបញ្ហាផ្នែកអាកប្បកិរិយា អារម្មណ៍ និងការរៀនសូត្ររបស់កូនបានមុនគេ។ ក្នុងនាមជាមាតាបិតា លោកអ្នកអាចជួយកូនរបស់ខ្លួនបានទាន់ពេលវេលាក្នុងករណីយពួកគេជួបប្រទះនឹងបញ្ហាណាមួយ តាមរយៈការបំពេញសំណួរខាងក្រោមនេះ ។

សូមមេត្តាគូសយកចំលើយដែលសមស្របបំផុតសំរាប់ស្ថានភាព ក្នុងរបស់អ្នក:

	មិនដែលសោះ	ម្តងម្កាល	ជាញឹកញាប់
១. គ្មញ្ចែរពីការឈឺចាប់:	☐	☐	☐
២. ចំណាយពេលភាគច្រើននៅតែឯង:	☐	☐	☐
៣. ឆាប់ហៅហត់ខ្សោយកំលាំង:	☐	☐	☐
៤. នៅមិនស្រណុក/មិនអាចនៅស្ងៀមមួយកន្លែងបាន:	☐	☐	☐
៥. បង្កបញ្ហាជាមួយគ្រូបង្រៀន	☐	☐	☐
៦. មិនសូវចូលចិត្តការសិក្សា:	☐	☐	☐
៧. លេងមិនចេះហត់:	☐	☐	☐
៨. ស្រមើស្រមៃច្រើនហួសហេតុ:	☐	☐	☐
៩. ងាយ/ឆាប់បែកអារម្មណ៍:	☐	☐	☐
១០. ភ័យ/ខ្លាចកន្លែងថ្មីហើយប្លែក:	☐	☐	☐
១១. មានអារម្មណ៍ក្រៀមក្រំមិនរីករាយ:	☐	☐	☐
១២. មានអារម្មណ៍មួរម៉ៅឆាប់ខឹង:	☐	☐	☐
១៣. មានអារម្មណ៍អស់សង្ឃឹម:	☐	☐	☐
១៤. ពិបាកក្នុងការប្រមូលអារម្មណ៍:	☐	☐	☐
១៥. មិនសូវចូលចិត្តមិត្តភក្តិ:	☐	☐	☐
១៦. ឈ្លោះវាយតប់ជាមួយអ្នកដ៏ទៃ:	☐	☐	☐
១៧. អវត្តមានពីការសិក្សា:	☐	☐	☐

១៨. ពិន្ទុសិក្សាធ្លាក់ចុះ:	☐	☐	☐
១៩. មិនចេះស្រឡាញ់ខ្លួន/ស្អប់ខ្លួនឯង:	☐	☐	☐
២០. ពិគ្រោះជាមួយគ្រូពេទ្យតែរកមិនឃើញថាមានបញ្ហាអ្វី:	☐	☐	☐
២១. មានវិបត្តិតំណេក:	☐	☐	☐
២២. ព្រួយបារម្ភច្រើន:	☐	☐	☐
២៣. កុមារតាម/មិនព្រមបែកពីឪពុកម្តាយឬអ្នកថែទាំ:	☐	☐	☐
២៤. មានអារម្មណ៍ថាខ្លួនជាមនុស្សអាក្រក់:	☐	☐	☐
២៥. ចូលចិត្តម្រឈមមុខជាមួយគ្រោះថ្នាក់ដោយគ្មានការចាំបាច់:	☐	☐	☐
២៦. ធ្វើអោយរងរបួសឈឺចាប់ជាញឹកញាប់:	☐	☐	☐
២៧. ហាក់ដូចជាមានអារម្មណ៍រីករាយតិចតួចណាស់:	☐	☐	☐
២៨. មានការប្រព្រឹត្តដូចក្មេងមានអាយុតិចជាងខ្លួន:	☐	☐	☐
២៩. មិនគោរពច្បាប់វិន័យ:	☐	☐	☐
៣០. មិនបង្ហាញចេញនូវអារម្មណ៍ពិតរបស់ខ្លួន:	☐	☐	☐
៣១. មិនយល់ពីអារម្មណ៍របស់អ្នកដ៏ទៃ:	☐	☐	☐
៣២. លលេងចំអែចំអន់អ្នកដ៏ទៃ:	☐	☐	☐
៣៣. មិនទទួលកំហុស/ទំលាក់កំហុសលើអ្នកដ៏ទៃ:	☐	☐	☐
៣៤. យក/ដណ្តើមរបស់អ្នកដ៏ទៃមកធ្វើជាជាកម្មសិទ្ធិខ្លួន:	☐	☐	☐
៣៥. បដិសេធមិនព្រមចែករំលែក/កំណាញ់ស្វិត:	☐	☐	☐

ពិន្ទុសរុប: .....

YOUTH PEDIATRIC SYMPTOM CHECKLIST-17 (Y PSC-17)

Name: _____ Record #: _____

Date of Birth: _____ Today's Date: _____

Please mark under the heading that best fits you:		NEVER	SOMETIMES	OFTEN
◆	Fidgety, unable to sit still ◆	0	1	2
❊	Feel sad, unhappy ❊	0	1	2
◆	Daydream too much ◆	0	1	2
❑	Refuse to share ❑	0	1	2
❑	Do not understand other people's feelings ❑	0	1	2
❊	Feel hopeless ❊	0	1	2
◆	Have trouble concentrating ◆	0	1	2
❑	Fight with other children ❑	0	1	2
❊	Down on yourself ❊	0	1	2
❑	Blame others for your troubles ❑	0	1	2
❊	Seem to be having less fun ❊	0	1	2
❑	Do not listen to rules ❑	0	1	2
◆	Act as if driven by a motor ◆	0	1	2
❑	Tease others ❑	0	1	2
❊	Worry a lot ❊	0	1	2
❑	Take things that do not belong to you ❑	0	1	2
◆	Distract easily ◆	0	1	2

OFFICE USE ONLY

Total ◆ _____ Total ❑ _____ Total ❊ _____ Grand Total ◆+❑+❊ _____

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Place Label Here

Completado por: Paciente

Nombre: _____ **ID #: _____**

Fecha de nacimiento: _____ **Fecha de hoy: _____**

LISTA DE SÍNTOMAS DE PEDIATRIA – INFORME DEL JOVEN (Y-PSC-17)

PEDIATRIC SYMPTOM CHECKLIST-17 YOUTH REPORT

Indique cual síntoma mejor te describe: (Please mark under the heading that best fits you)	NUNCA Never (0)	A VECES Sometimes (1)	SEGUIDO Often (2)
1. Eres inquieto(a) (Fidgety, unable to sit still)			
2. Te sientes triste, infeliz (Feel sad, unhappy)			
3. Eres muy soñador(a) (Daydream too much)			
4. Te rehusas a compartir (Refuse to share)			
5. No comprendes los sentimientos de otros (Do not understand other people's feelings)			
6. Te sientes sin esperanzas (Feel hopeless)			
7. Tienes problemas para concentrarte (Have trouble concentrating)			
8. Te peleas con otros niños(as) (Fight with other children)			
9. Te criticas a ti mismo(a) (Down on yourself)			
10. Culpas a otros por tus problemas (Blame others for your troubles)			
11. Parece que te diviertes menos (Seem to be having less fun)			
12. No obedeces reglas (Do not listen to rules)			
13. Eres incansable (Act as if driven by motor)			
14. Molestas a otros (Tease others)			
15. Te preocupas mucho (Worry a lot)			
16. Tomas cosas que no te pertenecen (Take things that do not belong to you)			
17. Te distraes fácilmente (Distracted easily)			

Total _____

- Tienes algún problema emocional o de comportamiento para el cual quieres ayuda? ❑No ❑Sí
  Do you have any emotional or behavioral problems for which you want help?

- De momento ¿te estás consultando con un profesional de salud mental? ❑No ❑Sí
  Are you currently seeing a mental health counselor?

M.S. Jellinek and J. M. Murphy, Massachusetts General Hospital

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Child's Name _____ Record Number _____
兒童姓名 **紅卡號碼**

Today's Date _____ Filled out by _____
今天日期 **填寫者**

Date of Birth _____
出生日期

Pediatric Symptom Checklist (PSC) 小兒科症狀查對項目

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.
兒童們的情緒和身體的健康常會混合在一起。因為父母們通常是第一位發現他們的小孩在行為、情緒或學習出現問題, 你回答這些問題可幫助你的孩子獲得最好的照顧。請指出那一敘述是最恰當形容你的小孩。

Please mark under the heading that best describes your child:
請在下列的項目指出最恰當形容你的小孩：

		NEVER 永不	SOMETIMES 有時	OFTEN 時常
1. Complains of aches and pains **抱怨疼痛和痠痛**	1			
2. Spends more time alone **自己獨處的時間較多**	2			
3. Tires easily, has little energy **容易疲倦，很少精力**	3.			
4. Fidgety, unable to sit still **煩燥的，不能坐定**	4			
5. Has trouble with teacher **和教師難相處**	5			
6. Less interested in school **上學興趣少**	6			
7. Acts as if driven by a motor **太愛動／不停活動**	7			
8. Daydreams too much **太多白日夢（幻想）**	8			
9. Distracted easily **容易分心**	9			
10. Is afraid of new situations. **害怕新的事物同環境**	10			
11. Feels sad, unhappy **感覺悲哀，不快樂**	11			
12. Is irritable, angry **易激動，發怒**	12			
13. Feels hopeless **感覺無希望**	13			
14. Has trouble concentrating **難於集中精神**	14			
15. Less interested in friends **減少對朋友的興趣**	15			
16. Fights with other children **和其他孩子打架**	16			
17. Absent from school **缺課**	17			

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		NEVER 永不	SOMETIMES 有時	OFTEN 時常
18. School grades dropping **成績退步**	18			
19. Is down on him or herself **看不起自己**	19			
20. Visits the doctor with doctor finding nothing wrong **看病，但醫生發現沒有毛病**	20			
21. Has trouble sleeping **有睡眠問題**	21			
22. Worries a lot **太多憂慮**	22			
23. Wants to be with you more than before **想要和你在一起的情形比以前更多**	23			
24. Feels he or she is bad **感覺他或她自己是壞的**	24			
25. Takes unnecessary risks **冒不必要的危險**	25			
26. Gets hurt frequently **經常受傷**	26			
27. Seems to be having less fun **似乎興緻樂趣不多**	27			
28. Acts younger than children his or her age **行為比同齡的兒童幼稚**	28			
29. Does not listen to rules **不遵守規例**	29			
30. Does not show feelings **不表露感覺**	30			
31. Does not understand other people' s feelings **不明白他人的感覺**	31			
32. Teases others **取笑他人**	32			
33. Blames other for his or her troubles **因自己的煩擾而責備他人**	33			
34. Takes things that do not belong to him or her **拿取不屬於自己的東西**	34			
35. Refuses to share **拒絕分享**	35			

Total score **總記分數** _____

Does your child have any emotional or behavioral problems for which she/he needs help?
你的孩子有任何情緒上或行為上的問題而需要幫助嗎？

( ) No **無** ( ) Yes **有**

Are there any services that you would like your child to receive for these problems?
如有任何相關的服務，你願意你的孩子因為這些問題接受服務嗎？

( ) No **無** ( ) Yes **有**

If yes, what service? _____
如回答有，甚麼服務呢？

_____

Additional copies available on the Pediatric Development and Behavior Homepage, http://www. dbpods.org /handouts

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Bảng Kiểm Tra Triệu Chứng Thuộc Khoa Nhi **(Bảng dành cho phụ huynh – PSC)**

Sức khỏe thuộc về thân thể và cảm xúc đi đôi với nhau ở trẻ em. Bởi vì cha mẹ là những người đầu tiên nhận ra trở ngại về tánh tình, cảm xúc, hay sự hiểu biết của con cái của mình, nên bạn có thể giúp con của bạn nhận được sự săn sóc tốt nhất bằng cách trả lời những câu hỏi này. Xin bạn cho biết câu nào mô tả tốt nhất con của bạn.

Xin đánh dấu dưới tiêu đề mô tả đúng nhất con của bạn:

		Không bao giờ	Đôi khi	Thường
1. Bồn chồn, ngồi yên không được Fidgety, unable to sit still	1	☐	☐	☐
2. Hành động như bị một động cơ điều khiển Acts as if driven by a motor	2	☐	☐	☐
3. Ban ngày mơ mộng nhiều Daydreams too much	3	☐	☐	☐
4. Dễ dàng bị quẫn trí, xao lãng Distracted easily	4	☐	☐	☐
5. Cảm thấy buồn bã, không vui Feels sad, unhappy	5	☐	☐	☐
6. Cảm thấy thất vọng Feels hopeless	6	☐	☐	☐
7. Khó tập trung tư tưởng Has trouble concentrating	7	☐	☐	☐
8. Hay đánh lộn với trẻ con Fights with other children	8	☐	☐	☐
9. Chán nãn Is down on his or herself	9	☐	☐	☐
10. Lo lắng quá nhiều Worries a lot	10	☐	☐	☐
11. Có vẻ ít vui thú Seems to be having less fun	11	☐	☐	☐
12. Bất chấp luật lệ Does not listen to rules	12	☐	☐	☐
13. Không hiểu được cảm giác của người khác Does not understand other people's feelings	13	☐	☐	☐
14. Chọc ghẹo người khác Teases others	14	☐	☐	☐
15. Khiển trách lỗi lầm của kẻ khác Blames others for his or her troubles	15	☐	☐	☐
16. Lấy những đồ vật không phải của mình Takes things that do not belong to him or her	16	☐	☐	☐
17. Từ chối chia sẽ với kẻ khác Refuses to share	17	☐	☐	☐

Con của bạn có những trở ngại gì về cảm xúc hay tánh tình mà cần phải được giúp đỡ không ? ( ) Không ( ) Có Có những dịch vụ nào mà bạn muốn con của bạn nhận được đối với những trở ngại này không? ( ) Không ( ) Có

Nếu có, những dịch vụ nào?_____

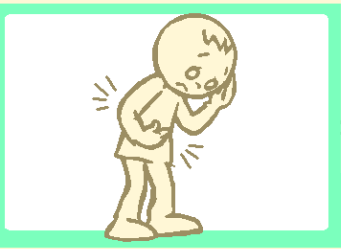
Pictorial Pediatric Symptom Checklist (PPSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions.

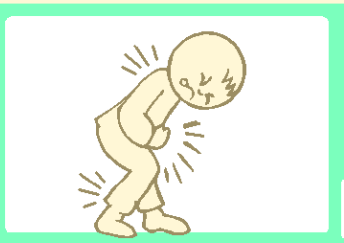
Please mark with a ✓ the statement that best describes your child:

1 Complains of aches and pains

NEVER ☐

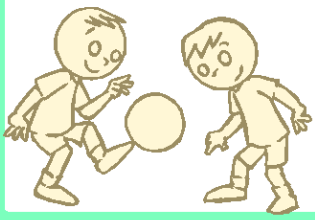


SOMETIMES ☐



OFTEN ☐

2 Spends more time alone



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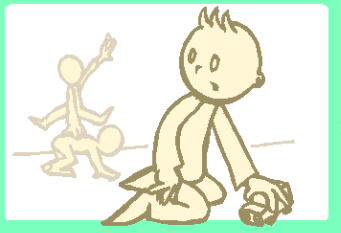

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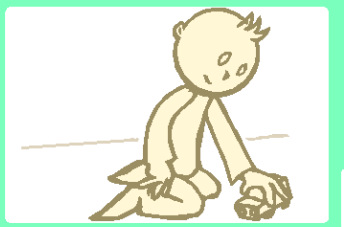
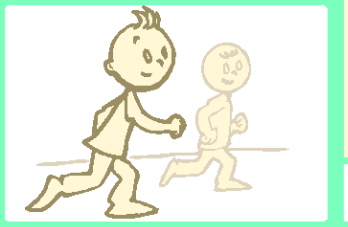


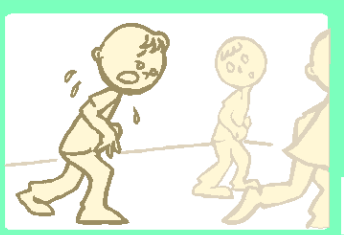
OFTEN ☐

3 Tires easily, has little energy



NEVER ☐

SOMETIMES ☐

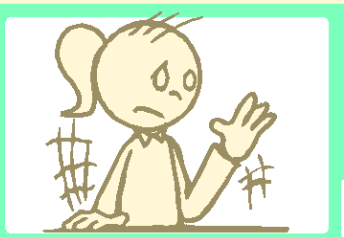


OFTEN ☐

4 Fidgety, unable to sit still

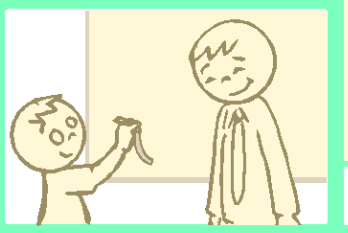
NEVER ☐

SOMETIMES ☐



OFTEN ☐

5 Has trouble with teacher



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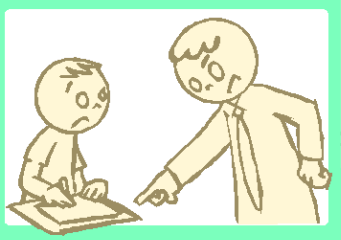

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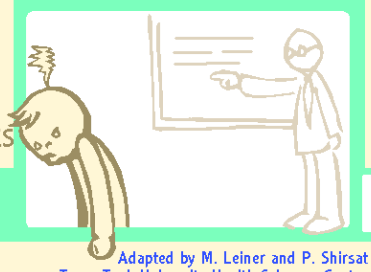

OFTEN ☐

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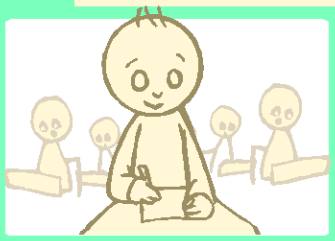
6 Less interested in school



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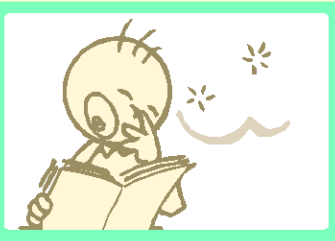


SOMETIMES

OFTEN

7 Acts as if driven by a motor

NEVER

SOMETIMES

OFTEN

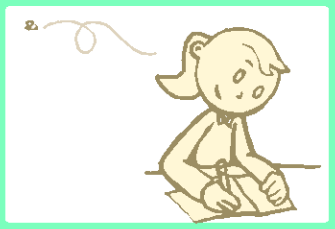
8 Daydreams too much

NEVER

SOMETIMES

OFTEN

9 Distracted easily



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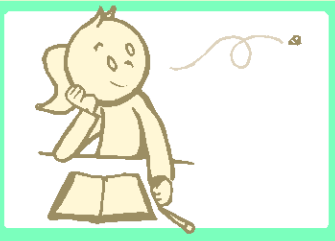

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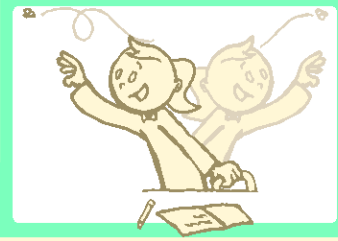
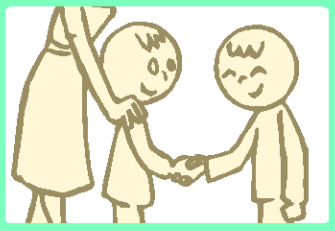


OFTEN

10 Is afraid of new situations



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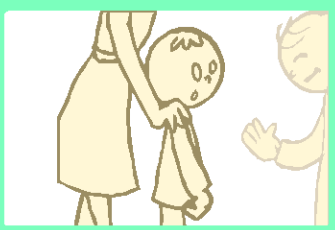

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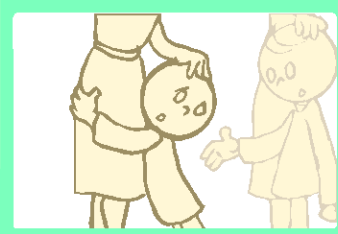
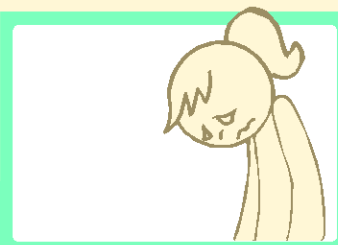


OFTEN

11 Feels sad, unhappy

NEVER

SOMETIMES



OFTEN

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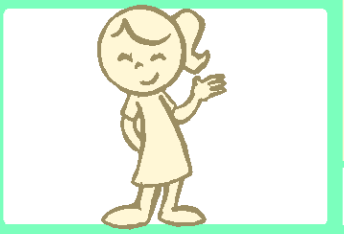
12 Is irritable, angry



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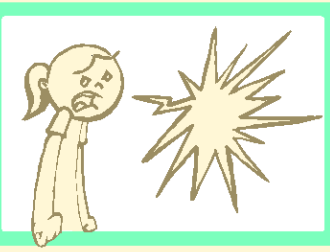
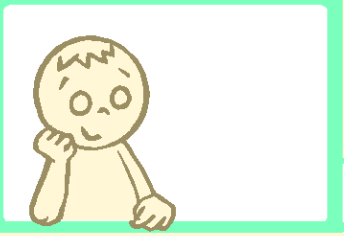


OFTEN

13 Feels hopeless

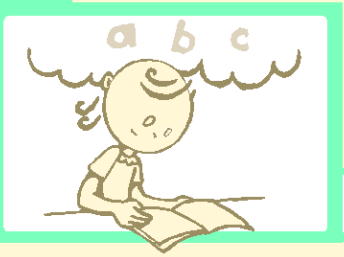


NEVER

SOMETIMES

OFTEN

14 Has trouble concentrating

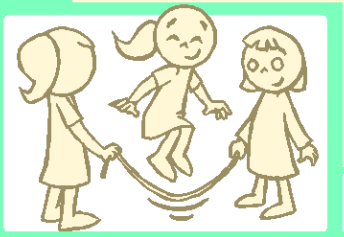


NEVER

SOMETIMES

OFTEN

15 Less interested in friends



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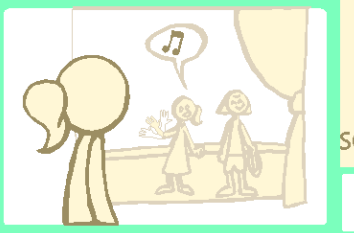

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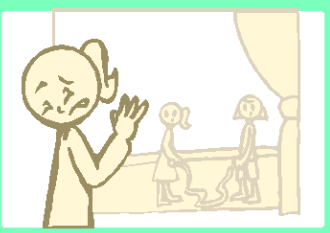
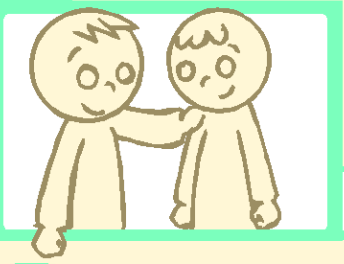


OFTEN

16 Fights with other children



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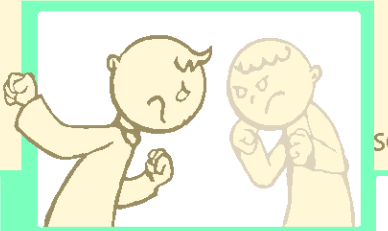
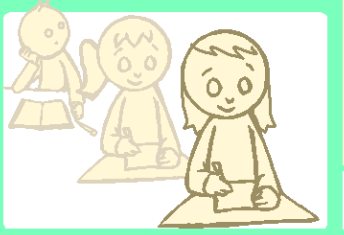


SOMETIMES

OFTEN

17 Absent from school



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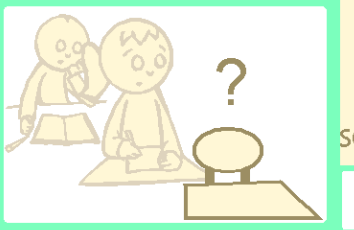
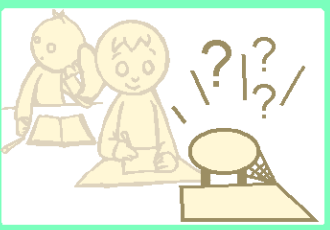


SOMETIMES



OFTEN

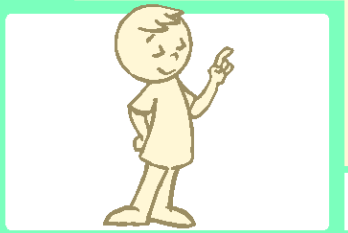
18 School grades dropping

NEVER

SOMETIMES

OFTEN

19 Is down on him or herself

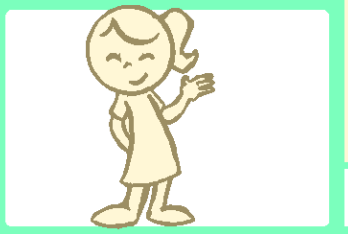


NEVER

SOMETIMES

OFTEN

20 Visits the doctor with doctor finding nothing wrong



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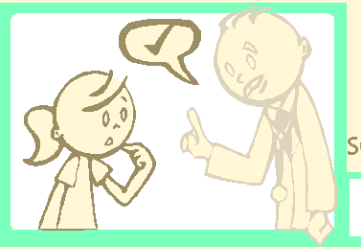

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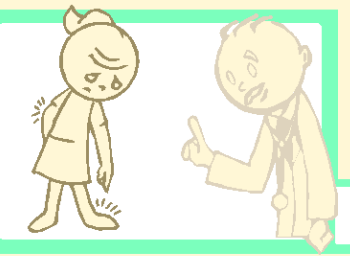
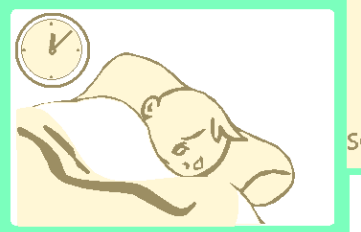


OFTEN

21 Has trouble sleeping

NEVER



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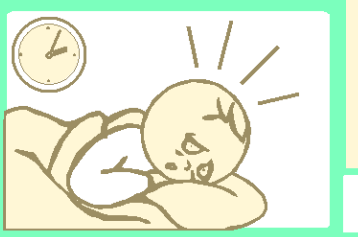
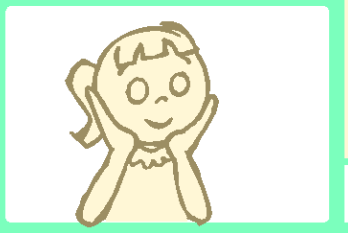


OFTEN

22 Worries a lot

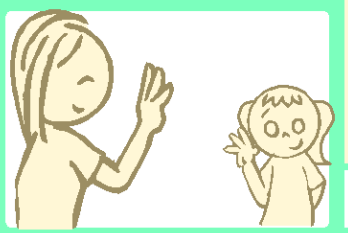


NEVER

SOMETIMES

OFTEN

23 Wants to be with you more than before



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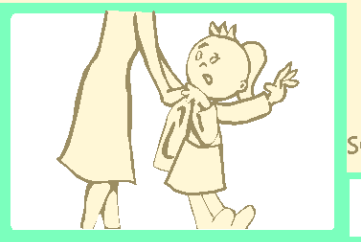

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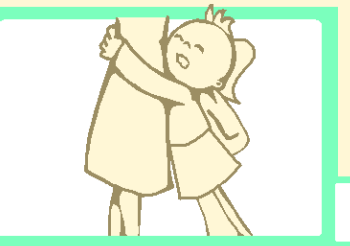

OFTEN

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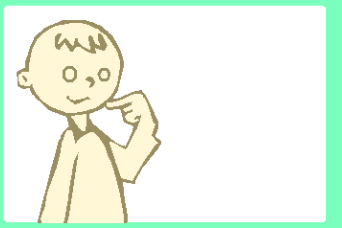
24 Feels he or she is bad



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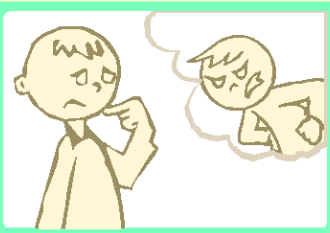

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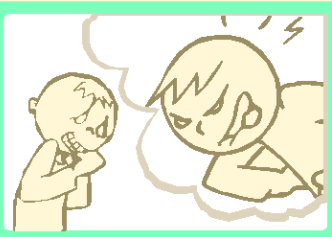
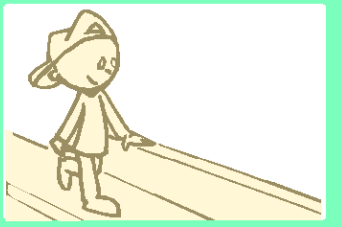


OFTEN

25 Takes unnecessary risks



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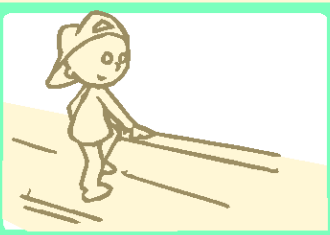

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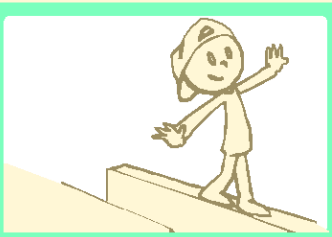
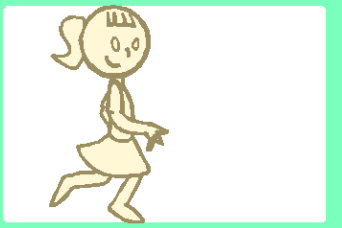


OFTEN

26 Gets hurt frequently



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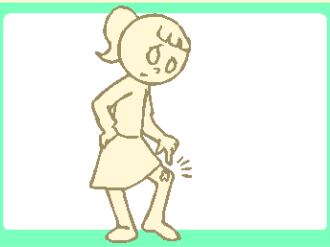

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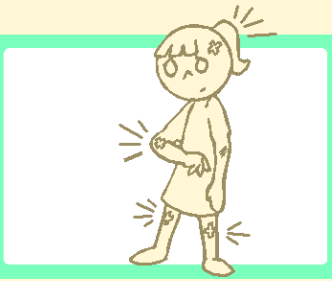
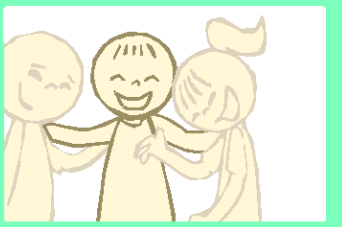


OFTEN

27 Seems to be having less fun



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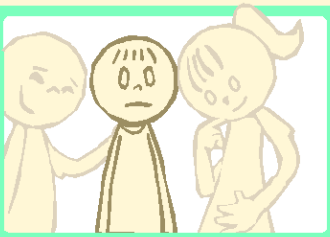

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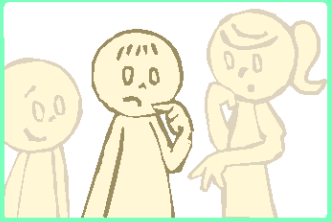
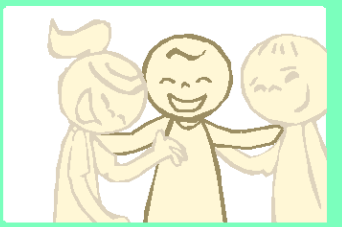


OFTEN

28 Acts younger than children his or her age



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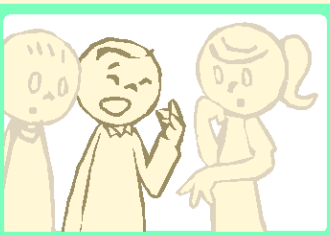

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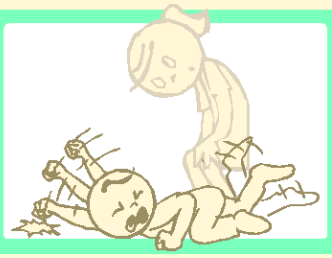
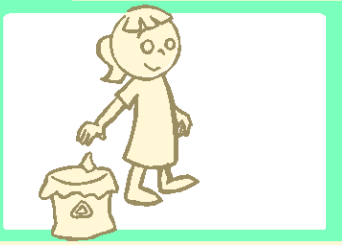


OFTEN

29 Does not listen to rules



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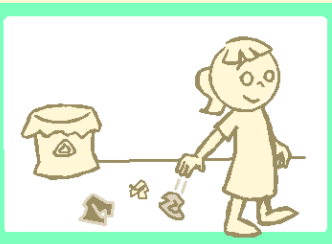
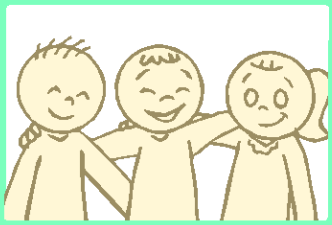
SOMETIMES



OFTEN

30 Does not show feelings



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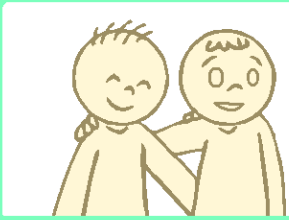

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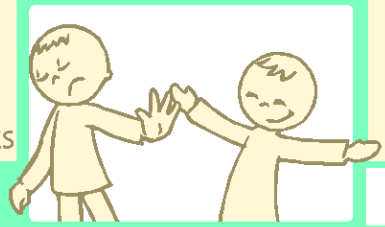
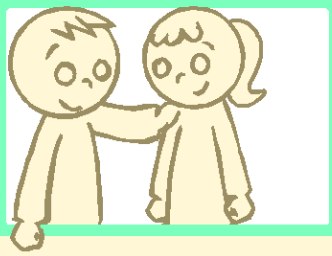


OFTEN

31 Does not understand other people's feelings



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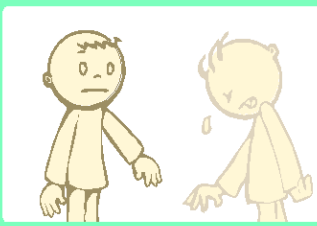

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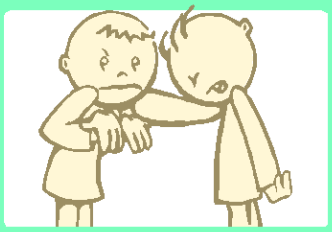
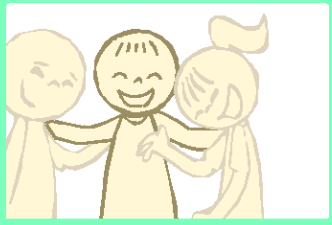


OFTEN

32 Teases other



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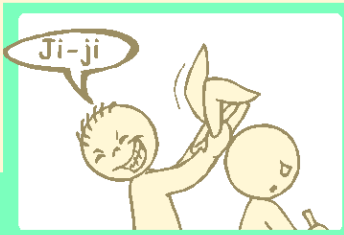

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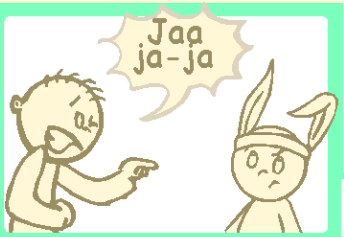
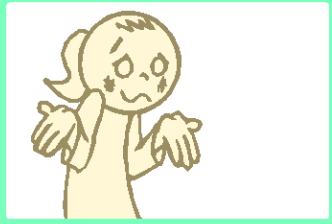


OFTEN

33 Blames others for his or her troubles



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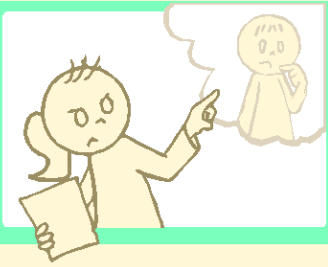
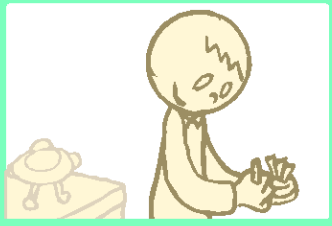


SOMETIMES

OFTEN

34 Takes things that do not belong to him or her



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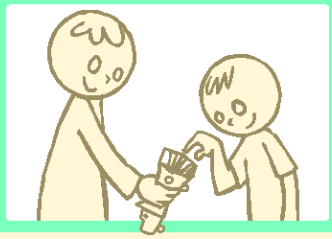
SOMETIMES

OFTEN

35 Refuses to share



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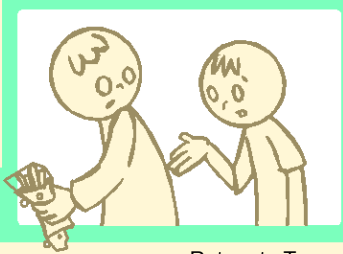

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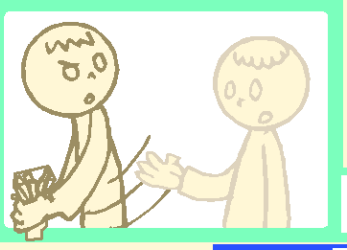


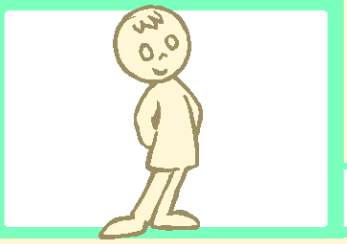
OFTEN

Pictorial Pediatric Symptom Checklist (PPSC)

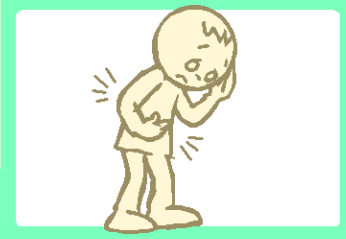
La salud física y emocional de su niño(a) van de la mano. Los padres son los primeros en notar un problema de comportamiento, de conducta emocional o de aprendizaje. Usted puede ayudar a su hijo(a) a obtener el mejor servicio del doctor al contestar a estas preguntas.

Indique con una ✓ la frecuencia con la que su niño(a) hace lo que se muestra en la pregunta:

1 Se queja de dolores y malestares



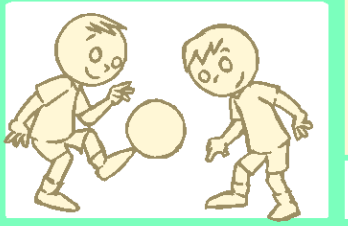
NUNCA ☐



ALGUNAS VECES ☐

CON FRECUENCIA ☐

2 Se pasa más tiempo solo(a)



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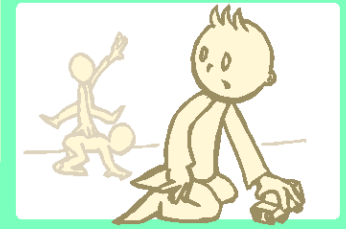
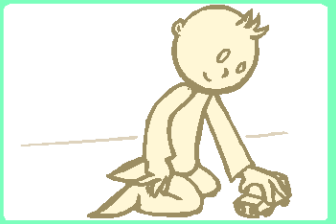
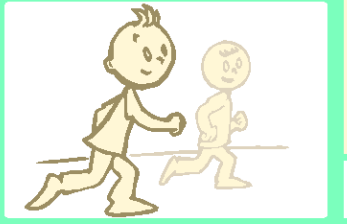


ALGUNAS VECES ☐



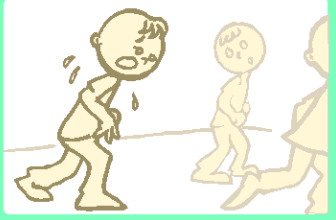
CON FRECUENCIA ☐

3 Se cansa fácilmente, tiene poca energía



NUNCA ☐

ALGUNAS VECES ☐

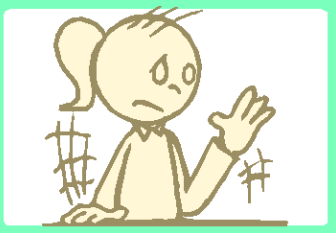


CON FRECUENCIA ☐

4 Nervioso(a), incapaz de estarse quieto(a)

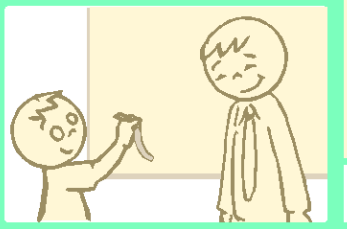
NUNCA ☐

ALGUNAS VECES ☐



CON FRECUENCIA ☐

5 Tiene problemas con un(a) maestro(a)



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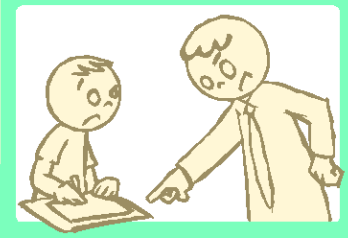
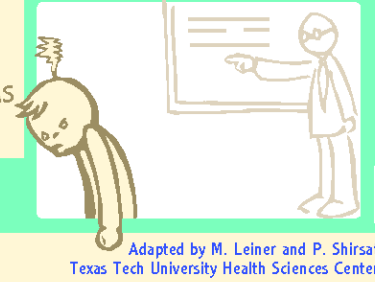


ALGUNAS VECES ☐



CON FRECUENCIA ☐

M.S. Jellinek and J.M. Murphy, Massachusetts General Hospital

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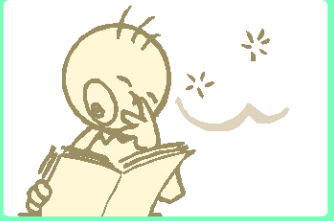
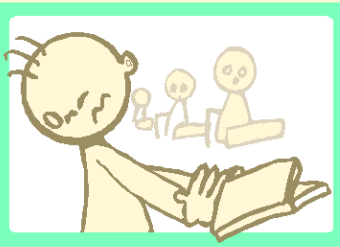
Adapted by M. Leiner and P. Shirsat
Texas Tech University Health Sciences Center

6 Esta menos interesado en la escuela

NUNCA



ALGUNAS VECES



CON FRECUENCIA

7 Es incansable

NUNCA

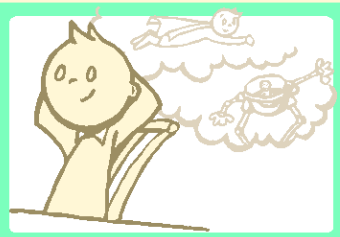
ALGUNAS VECES

CON FRECUENCIA

8 Sueña despierto con mucha frecuencia

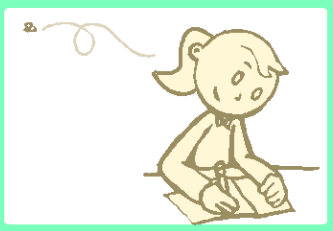
NUNCA

ALGUNAS VECES



CON FRECUENCIA

9 Se distrae con facilidad



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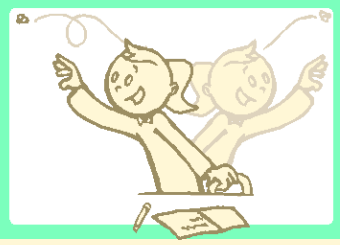
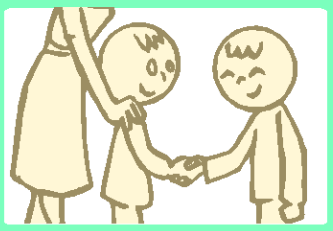
ALGUNAS VECES



CON FRECUENCIA

10 Temeroso(a) a nuevas situaciones



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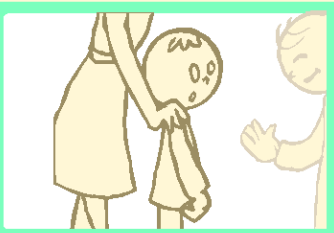
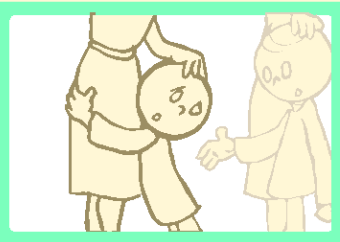


ALGUNAS VECES

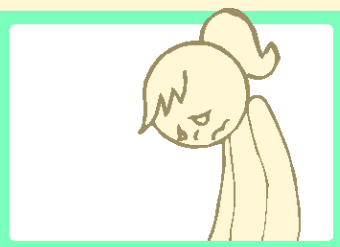


CON FRECUENCIA

11 Se siente triste, infeliz

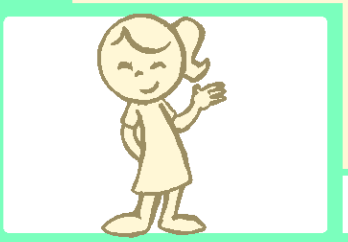
NUNCA

ALGUNAS VECES



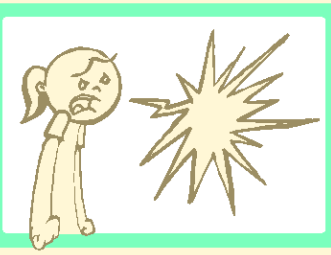
CON FRECUENCIA

12 Está irritable, enojado(a)



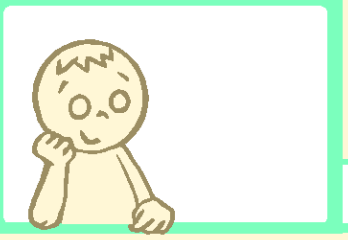
NUNCA ☐

ALGUNAS VECES ☐



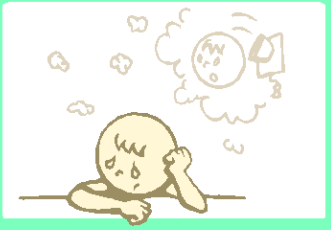
CON FRECUENCIA ☐

13 Se siente sin esperanzas



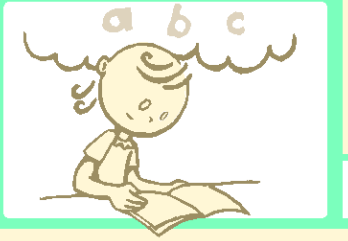
NUNCA ☐

ALGUNAS VECES ☐



CON FRECUENCIA ☐

14 Tiene problemas para concentrarse

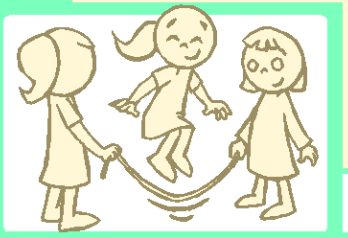


NUNCA ☐

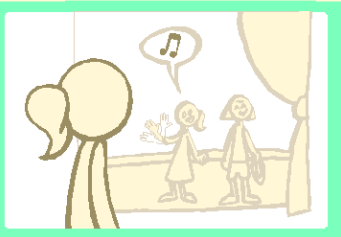
ALGUNAS VECES ☐

CON FRECUENCIA ☐

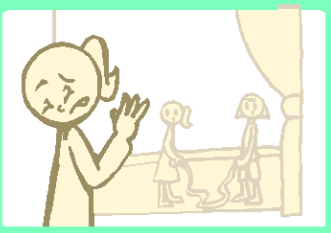
15 Se interesa menos en los amigos(as)



NUNCA ☐

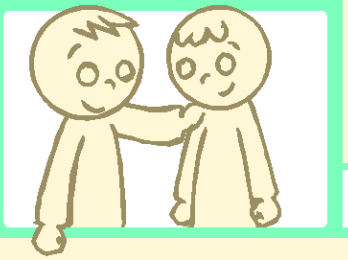


ALGUNAS VECES ☐



CON FRECUENCIA ☐

16 Pelea con los demás



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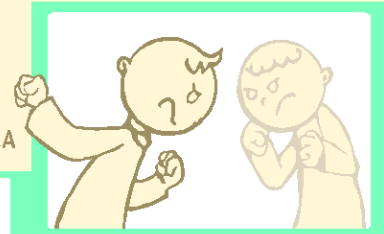

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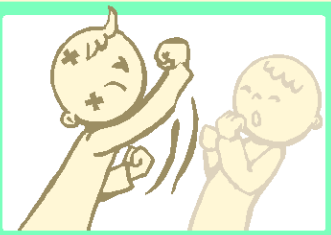
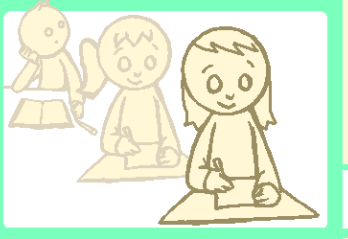


CON FRECUENCIA ☐

17 Falta a clases en la escuela a menudo



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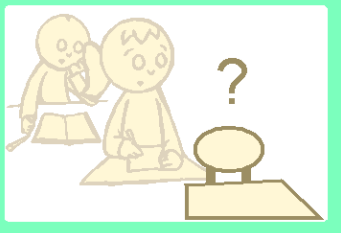

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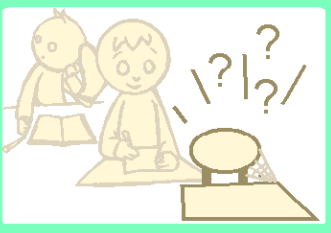
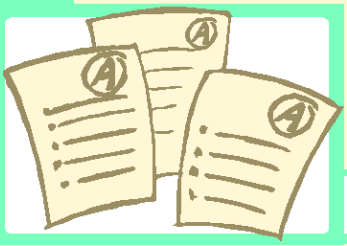


CON FRECUENCIA ☐

18 Sus calificaciones han bajado



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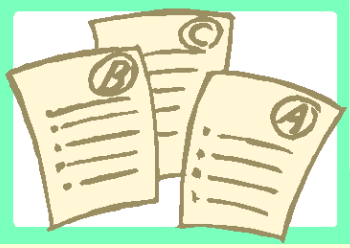
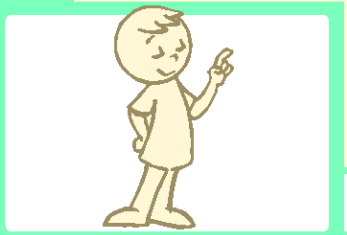


ALGUNAS VECES ☐

CON FRECUENCIA ☐

19 Se critica duramente a sí mismo



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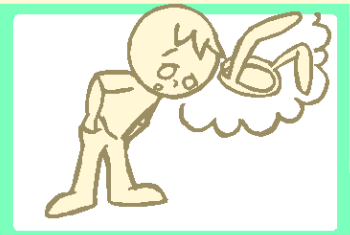
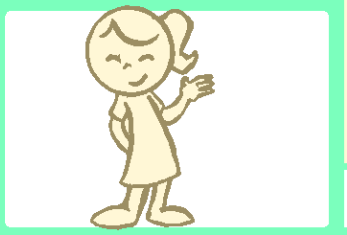


ALGUNAS VECES ☐

CON FRECUENCIA ☐

20 Visita al doctor sin que le encuentren nada malo



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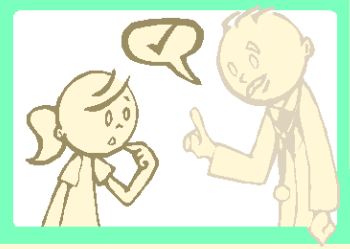

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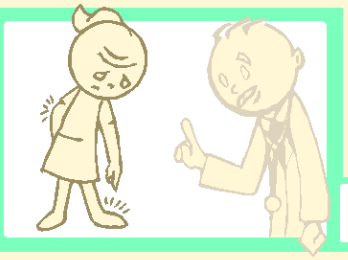
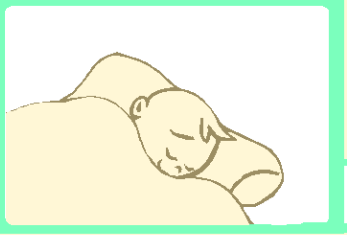


CON FRECUENCIA ☐

21 Tiene problemas para dormirse



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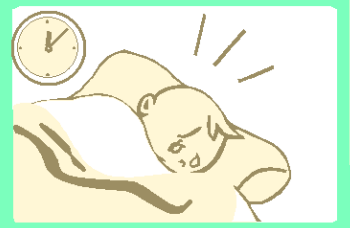

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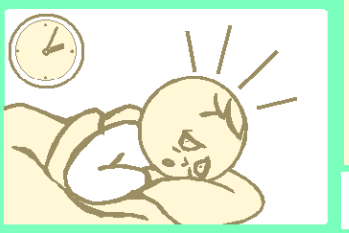
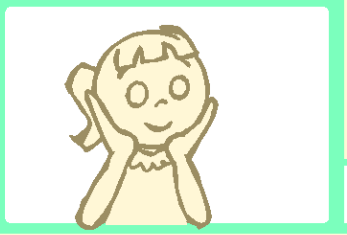


CON FRECUENCIA ☐

22 Se preocupa mucho

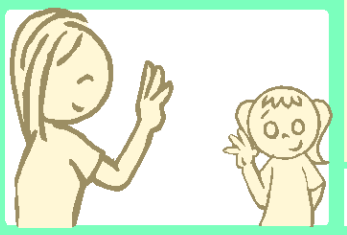


NUNCA ☐

ALGUNAS VECES ☐

CON FRECUENCIA ☐

23 Quiere estar cerca de usted más que antes



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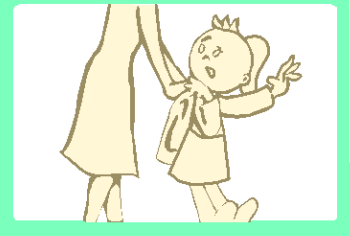

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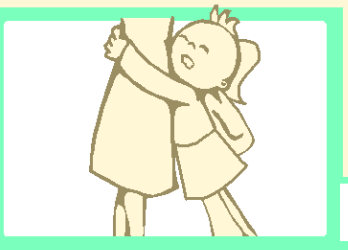
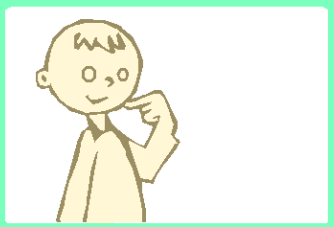


CON FRECUENCIA ☐

24 El niño o niña piensa que él es malo o ella es mala



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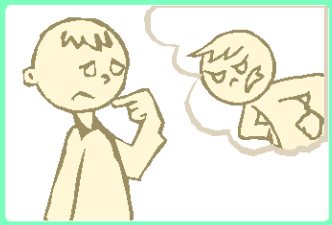

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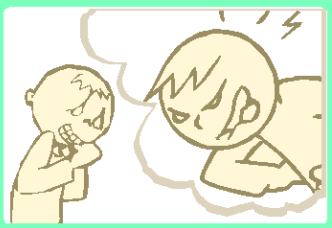
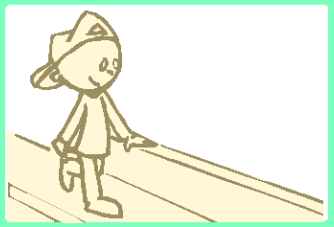


CON FRECUENCIA ☐

25 Toma riesgos innecesarios



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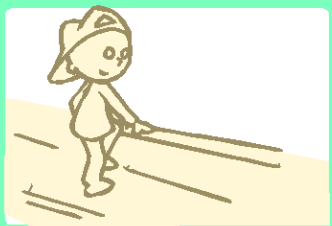

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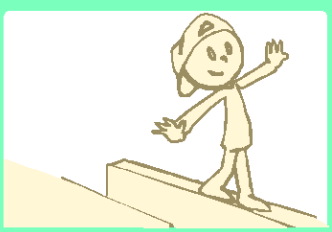
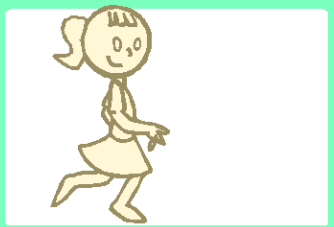


CON FRECUENCIA ☐

26 Se lastima con frecuencia



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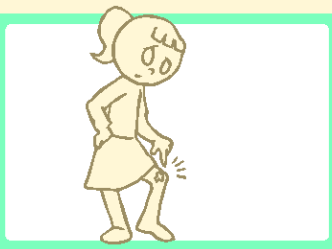

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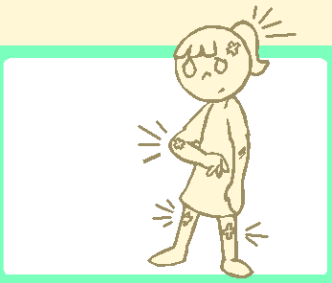
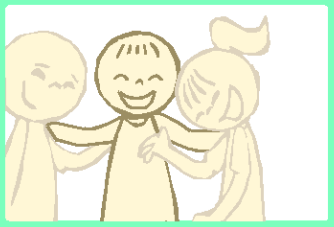


CON FRECUENCIA ☐

27 Parece divertirse menos que antes



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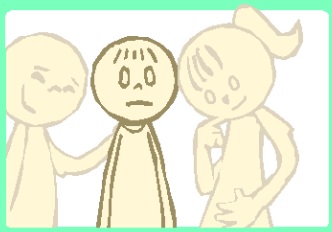

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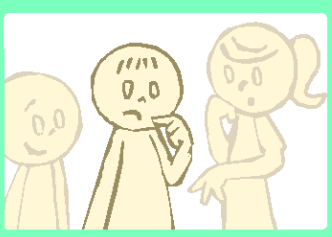
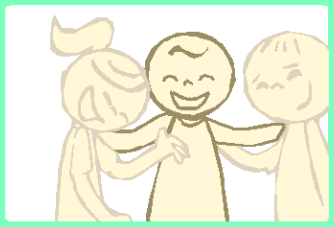


CON FRECUENCIA ☐

28 Actúa como si fuera menor a su edad



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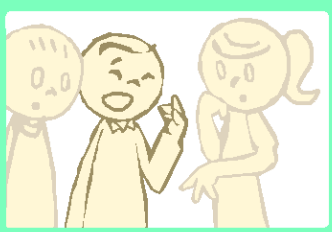

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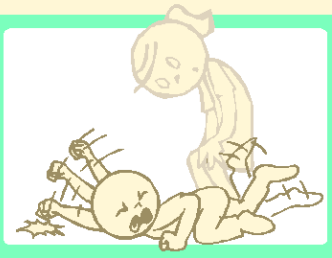
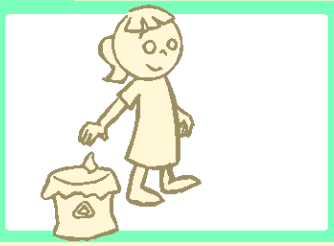


CON FRECUENCIA ☐

29 Desobedece las reglas



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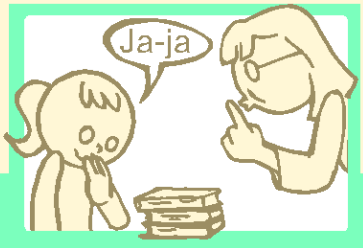

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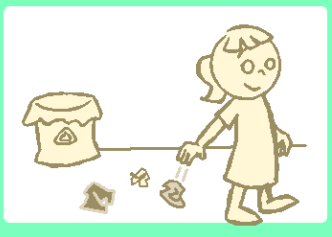
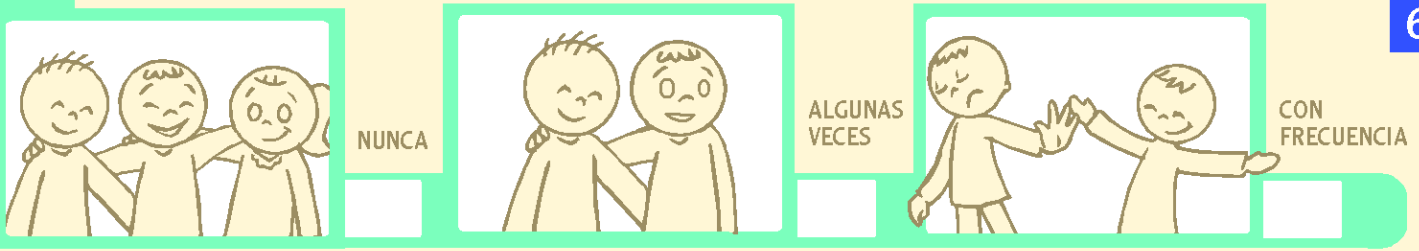
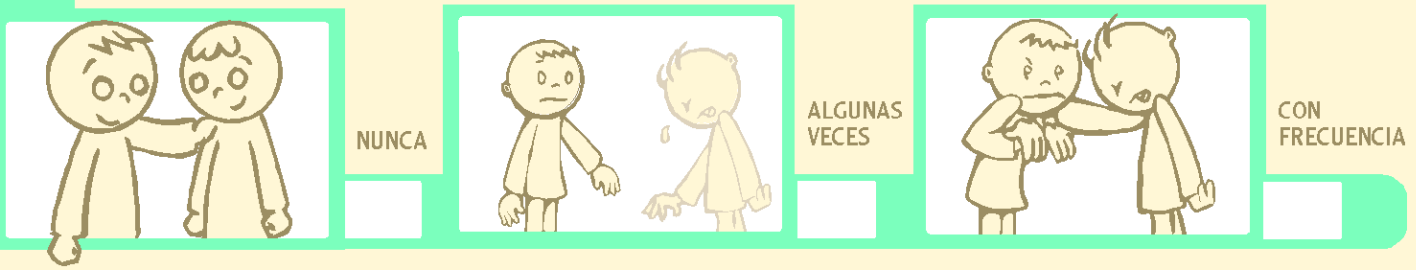


CON FRECUENCIA ☐

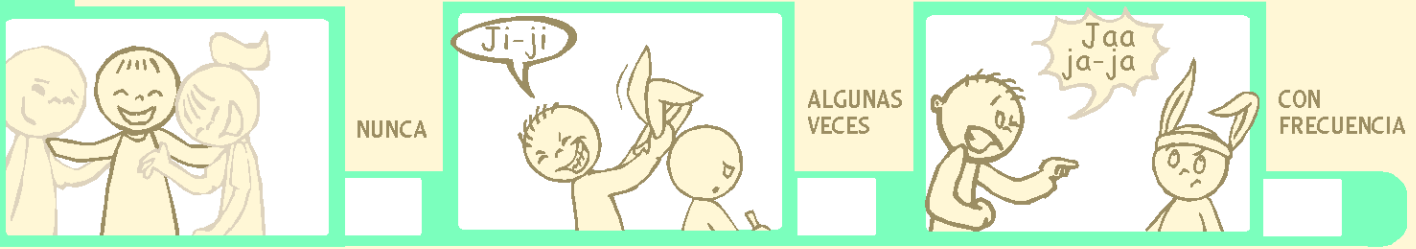
30 No muestra sus sentimientos



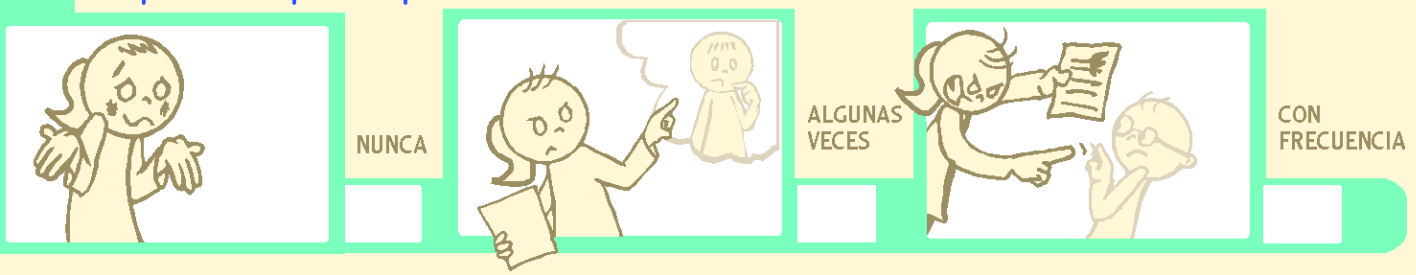
31 No entiende los sentimientos de los demás



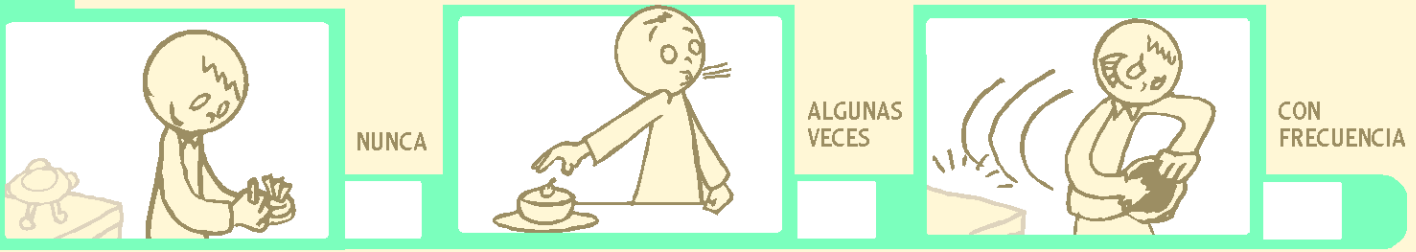
32 Molesta o se burla de otros



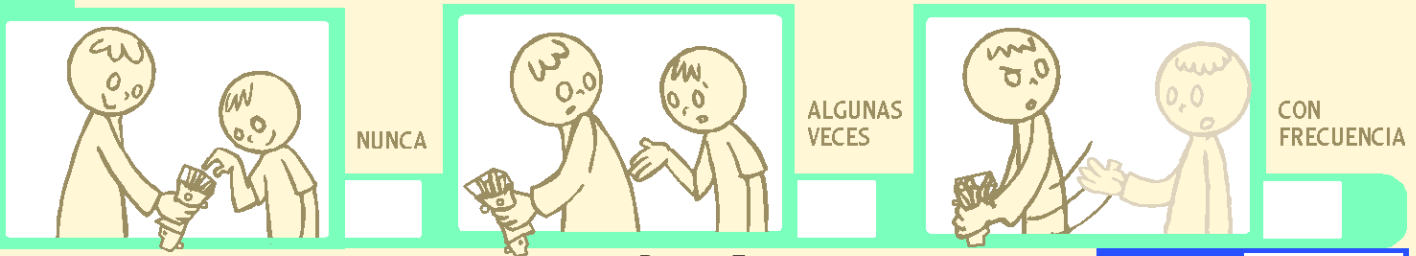
33 Culpa a otros por sus problemas



34 Toma cosas que no le pertenecen



35 Se rehusa a compartir



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

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

Consider Major Depressive Disorder

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

Consider Other Depressive Disorder

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

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

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

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

Scoring: add up all checked boxes on PHQ-9

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

Interpretation of Total Score

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

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Patient Health Questionnaire: modified

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:

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Patient Health Questionnaire PHQ-9

Nine Symptom Checklist (Spanish)

Nombre_____ Médico_____Fecha De Hoy_____

Durante las <u>últimas 2 semanas</u>, ¿cuan qué frecuencia le han molestado los siguientes problemas?

	Nunca **0**	**Varios dias** **1**	**Más de la mitad de los dias** **2**	**Casi todos los dias** **3**
a. Tener poco interés o placer en hacer las cosas	☐	☐	☐	☐
b. Sentirse desanimado/a, deprimido/a, o sin esperanza	☐	☐	☐	☐
c. Con problemas en dormirse o en mantenerse dormido/a, o en dormir demasiado	☐	☐	☐	☐
d. Sentirse cansado/a o tener poca energía	☐	☐	☐	☐
e. Tener poco apetito o comer en exceso	☐	☐	☐	☐
f. Sentir falta de amor propio – o que sea un fracaso o que decepcionara a si mismo/a su familia	☐	☐	☐	☐
g. Tener dificultad para concentrarse en cosas tales como leer el periódico o mirar la televisión	☐	☐	☐	☐
h. Se mueve o habla tan lentamente que otra gente se podria dar cuenta – o de lo contrario, esta tan agitado/a o inquieto/a que se mueve mucho más de lo acostumbrado	☐	☐	☐	☐
i. Se le han ocurrido pensamientos de que sería mejor estar muerto/a o de que haría daño de alguna manera*	☐	☐	☐	☐

1. Si usted se identificó con cualquier problema en este cuestionario, ¿cuan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

☐ Nada en absoluto ☐ Algo difícil ☐ Muy difícil ☐ Extremadamente difícil

11. Si estos problemas le han causado dificultad, ¿le han causado dificultad por dos años o más?

☐ Sí, he tenido dificultad con estos problemas por dos años o más.

☐ No, no he tenido dificultad con estos problemas por dos años o más.

*Si tiene pensamientos de que es major estar muerto/a o hacerse daño en alguna manera, favor de hablar con su médico, ir a una sala de emergencia o llamar al 911.

Number of symptoms:_____ Total score:_____

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Geriatric Depression Scale (short form)

Instructions: Circle the answer that best describes how you felt over the past week.

1.	Are you basically satisfied with your life?	yes	no
2.	Have you dropped many of your activities and interests?	yes	no
3.	Do you feel that your life is empty?	yes	no
4.	Do you often get bored?	yes	no
5.	Are you in good spirits most of the time?	yes	no
6.	Are you afraid that something bad is going to happen to you?	yes	no
7.	Do you feel happy most of the time?	yes	no
8.	Do you often feel helpless?	yes	no
9.	Do you prefer to stay at home, rather than going out and doing things?	yes	no
10.	Do you feel that you have more problems with memory than most?	yes	no
11.	Do you think it is wonderful to be alive now?	yes	no
12.	Do you feel 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 Score _____

Geriatric Depression Scale (GDS)
Scoring Instructions

Instructions: Score 1 point for each bolded answer. A score of 5 or more suggests depression.

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 things?	**yes**	no
10.	Do you feel that you have more problems with memory than most?	**yes**	no
11.	Do you think it is wonderful to be alive now?	yes	**no**
12.	Do you feel 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

A score of $\geq$ 5 suggests depression ***Total Score*** _____

Ref. Yes average: The use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986

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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

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SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke's Medical Center.

[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

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5.9. Cuestionario de Trastornos del Humor (Mood Disorder Questionnaire, MDQ)

Instrucciones: Por favor, responda cada pregunta lo mejor que pueda.

	Sí	*No*
1. ¿Ha tenido alguna vez algún período de tiempo en el que no estaba en su estado habitual y...		
... se sintiera tan bien o tan hiperactivo que otras personas han pensado que no estaba en su estado normal o que estaba tan hiperactivo que tenía problemas?	☐	☐
... estaba tan irritable que gritaba a la gente o se ha peleado o discutido?	☐	☐
... se sentía mucho más seguro que normalmente?	☐	☐
... dormía mucho menos de lo habitual y creía que realmente no era importante?	☐	☐
... estaba más hablador y hablaba mucho más rápido de lo habitual?	☐	☐
... sus pensamientos iban más rápidos en su cabeza o no podía frenar su mente?	☐	☐
... se distraía fácilmente por las cosas de alrededor o ha tenido problemas para concentrarse o seguir el hilo?	☐	☐
... tenía mucha más energía de la habitual?	☐	☐
... estaba mucho más activo o hacía muchas más cosas de lo habitual?	☐	☐
... era mucho más social o extrovertido de lo habitual, por ejemplo, llamaba a los amigos en plena noche?	☐	☐
... tenía mucho más interés de lo habitual por el sexo?	☐	☐
... hizo cosas que eran inusuales para usted o que otras personas pudieran pensar que eran excesivas, estúpidas o arriesgadas?	☐	☐
... ha gastado dinero que le trajera a problemas a usted o a su familia?	☐	☐
2. Si ha respondido SÍ a más de una de las cuestiones anteriores, ¿han ocurrido varias de estas durante el mismo período?	☐	☐
3. ¿Cuánto problema le han causado alguna de estas cosas – en el trabajo; problemas con la familia, el dinero o legales; metiéndose en discusiones o peleas? Por favor señale una sola respuesta ☐ Sin problema ☐ Pequeño ☐ Moderado ☐ Serio		
4. ¿Ha tenido alguno de sus parientes (p. ej., hijos, hermanos, padres, abuelos, tías, tíos) una enfermedad de tipo maníaco-depresiva o trastorno bipolar?	☐	☐
5. ¿Le ha dicho alguna vez un profesional de la salud que usted tiene una enfermedad maníaco-depresiva o trastorno bipolar?	☐	☐

RESOURCES

- Download this card and additional resources at **www.sprc.org** or at **www.stopasuicide.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1.800.273.TALK (8255)

www.sprc.org

www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

for Mental Health Professionals

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention and follow-up

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NATIONAL SUICIDE PREVENTION LIFELINE

1.800.273.TALK (8255)

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity). *Co-morbidity* and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history:** of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- **Assessment** of risk level is based on clinical judgment, after completing steps 1-3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

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Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Prins, Ouimette, & Kimerling, 2003

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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GAD-7

Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un " " para indicar su respuesta)*	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	0	1	2	3
2. No ha sido capaz de parar o controlar su preocupación	0	1	2	3
3. Se ha preocupado demasiado por motivos diferentes	0	1	2	3
4. Ha tenido dificultad para relajarse	0	1	2	3
5. Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	0	1	2	3
6. Se ha molestado o irritado fácilmente	0	1	2	3
7. Ha tenido miedo de que algo terrible fuera a pasar	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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GAD-7

在過去兩個星期中，以下的情況煩擾你有多少？ *（請用「✔」勾選你的答案）*	完全沒有	幾天	一半以上的天數	幾乎每天
1. 感到緊張、不安或煩躁	0	1	2	3
2. 無法停止或控制憂慮	0	1	2	3
3. 過份憂慮不同的事情	0	1	2	3
4. 難以放鬆	0	1	2	3
5. 心緒不寧以至坐立不安	0	1	2	3
6. 容易心煩或易怒	0	1	2	3
7. 感到害怕，就像要發生可怕的事情	0	1	2	3

(*For office coding: Total Score T* ____ = ____ + ____ + ____ + ____)

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The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

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6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

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Cuadro 4

Test de Identificación de Trastornos por consumo de alcohol: versión de entrevista.

Lea las preguntas tal como están escritas. Registre las respuestas cuidadosamente. Empiece el AUDIT diciendo «Ahora voy a hacerle algunas preguntas sobre su consumo de bebidas alcohólicas durante el último año». Explique qué entiende por «bebidas alcohólicas» utilizando ejemplos típicos como cerveza, vino, vodka, etc. Codifique las respuestas en términos de consumiciones («bebidas estándar»). Marque la cifra de la respuesta adecuada en el recuadro de la derecha.

1. ¿Con qué frecuencia consume alguna bebida alcohólica?
   (0) Nunca (Pase a las preguntas 9-10)
   (1) Una o menos veces al mes
   (2) De 2 a 4 veces al mes
   (3) De 2 a 3 veces a la semana
   (4) 4 o más veces a la semana

2. ¿Cuantas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?
   (0) 1 o 2
   (1) 3 o 4
   (2) 5 o 6
   (3) 7, 8, o 9
   (3) 10 o más

3. ¿ Con qué frecuencia toma 6 o más bebidas alcohólicas en un solo día?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario
   Pase a las preguntas 9 y 10 sí la suma total de las preguntas 2 y 3 = 0

4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de parar de beber una vez había empezado?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

5. ¿Con qué frecuencia en el curso del último año no pudo hacer lo que se esperaba de usted porque había bebido?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

7. ¿Con qué frecuencia en el curso del último año ha tenido remordimientos o sentimientos de culpa después de haber bebido?.
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?
   (0) Nunca
   (1) Menos de una vez al mes
   (2) Mensualmente
   (3) Semanalmente
   (4) A diario o casi a diario

9. ¿Usted o alguna otra persona ha resultado herido porque usted había bebido?
   (0) No
   (2) Sí, pero no en el curso del ultimo año
   (4) Sí, el último año

10. ¿Algún familiar, amigo, médico o profesional sanitario ha mostrado preocupación por su consumo de bebidas alcohólicas o le han sugerido que deje de beber?
    (0) No
    (2) Sí, pero no en el curso del ultimo año
    (4) Sí, el último año.

Registre la puntuación total aquí

Si la puntuación total es mayor que el punto de corte recomendado, consulte el Manual de Usuario

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Cuestionario CAGE-AID adaptado para incluir drogas

Fecha: ____/_____/_____

1. ¿**Alguna vez** ha sentido que debería disminuir o reducir su uso de alcohol y/o drogas?

   Alcohol: SÍ _____ NO _____

   Uso de Drogas: SÍ _____ NO _____

2. ¿Se ha sentido **alguna vez** molesto por las críticas de la gente acerca de su uso de alcohol y/o drogas?

   Alcohol: SÍ _____ NO _____

   Uso de Drogas: SÍ _____ NO _____

3. ¿**Alguna vez** se ha sentido culpable debido al uso de alcohol y/o drogas?

   Alcohol: SÍ _____ NO _____

   Uso de Drogas: SÍ _____ NO _____

4. ¿**Alguna vez** ha necesitado alcohol y/o drogas temprano en la mañana para estabilizar sus nervios o ayudarlo con la resaca)?

   Alcohol: SÍ _____ NO _____

   Uso de Drogas: SÍ _____ NO _____

Tabulacion

Puntuación: Total de respuestas “SI”: _____

Determinación positiva = Puntuación de 1 o más.

Reprinted with permission from the Wisconsin Medical Journal. Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. Wisconsin Medical Journal 94:135-140, 1995.

Incredible Years Study	Date / /	RI Initials	FAMID

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right.
You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months		**No**	**Yes**
1	Have you used drugs other than those required for medical reasons?	0	1
2	Do you abuse more than one drug at a time?	0	1
3	Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes".	0	1
4	Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5	Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No".	0	1
6	Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7	Have you neglected your family because of your use of drugs?	0	1
8	Have you engaged in illegal activities in order to obtain drugs?	0	1
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

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Alcohol Use Among Older Adults

Pocket Screening Instruments for Health Care and Social Service Providers

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

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The Facts

Alcohol and prescription drug misuse affects as many as 17% of older Americans. It is estimated that as many as 2.5 million older adults in America have problems related to alcohol, and this age group experiences more than half of all reported adverse drug reactions leading to hospitalization. These statistics could get worse: The U.S. Bureau of the Census predicts that America's 65+ population will be the fastest growing age group over the next 25 years.

Screener Uses

The Center for Substance Abuse Treatment (CSAT) has prepared this Pocket Screener to help health care and social service providers:

- Identify signs of possible alcohol problems among older adults
- Intervene to help reduce alcohol consumption
- Assist in obtaining evaluation and treatment for alcohol problems for older adults

Screening

The enclosed card contains two questionnaires that you can administer to see if clients may need to be referred for a complete evaluation to determine the nature and extent of their alcohol use.

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Referral Information

If you feel that the older person you have screened may have an alcohol problem that requires further evaluation, refer them to a local alcohol treatment program or provider. If no local provider or program is available, the back of this jacket contains a national hotline number that you can call for assistance.

Brief Intervention

You can help motivate relevant clients to accept and follow through on obtaining a thorough evaluation by taking a few minutes to provide a brief motivational intervention.

Discuss and write down for clients (if possible) what that individual considers to be the 'pros' and 'cons' of drinking, and telling their primary health care provider(s) about the amount and regularity of their alcohol use.

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AUDIT-C and CAGE
Brief Alcohol Screening Instrument

For use by both medical and non-medical health and social service providers, volunteers, and aides

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Introducing the Topic of Screening

Make your client comfortable. Mention that alcohol use can affect many areas of health and may interfere with certain medications. It is important to know how much the client usually drinks and whether he or she has experienced any problems associated with drinking. Clarify that alcoholic beverages include wine, beer, and liquor such as vodka, whiskey, brandy, and others.

Questionnaire: Circle the number that comes closest to the client's answer.

1. How often do you have a drink containing alcohol?

(0) Never (1) Monthly or less (2) 2 to 4 times a month
(3) 2 to 3 times a week (4) 4 or more times a week

[If the response is 'Never' you can skip the next two questions and move directly to questions 4 through 7]

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) None (1) 1 or 2 (2) 3 or 4 (3) 5 or 6 (4) 7 or more

3. How often do you have: **[for men]** five or more drinks on one occasion? **[for women]** four or more drinks on one occasion?

(0) Never (1) Less than monthly (2) Monthly (3)Weekly (4) Daily or almost daily

4. Have you ever felt you should cut down on your drinking?
Yes No

5. Have people annoyed you by criticizing your drinking?
Yes No

6. Have you ever felt bad or guilty about your drinking?
Yes No

7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?
Yes No

Scoring

Add the numbers of the circled responses for questions 1, 2, and 3. The client should be referred for evaluation if there is:

- a score of 3 or more points on questions 1 through 3; or
- a report of drinking 6 or more drinks on one occasion; or
- a "yes" answer to one of questions 4 through 7, and any drinking is indicated in answer to questions 1 through 3

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Short Michigan Alcoholism Screening Test – Geriatric Version (S-MAST-G)

For use by clinicians, physicians and/or primary care providers

1. When talking to others, do you ever underestimate how much you actually drink? *Yes* *No*

2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry? *Yes* *No*

3. Does having a few drinks help decrease your shakiness or tremors? *Yes* *No*

4. Does alcohol sometimes make it hard for you to remember parts of the day or night? *Yes* *No*

5. Do you usually take a drink to relax or calm your nerves? *Yes* *No*

6. Do you drink to take your mind off your problems? *Yes* *No*

7. Have you ever increased your drinking after experiencing a loss in your life? *Yes* *No*

8. Has a doctor or nurse ever said they were worried or concerned about your drinking? *Yes* *No*

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Short Michigan Alcoholism Screening Test – Geriatric Version (S-MAST-G)

9. Have you ever made rules to manage your drinking?
Yes *No*

10. When you feel lonely, does having a drink help?
Yes *No*

Total S-MAST-G Score (0-10) _____

For clients who answer 'yes' to two or more of the S-MAST-G questions, a referral for a complete assessment of their alcohol use should be made.

Referral: Brief Intervention

In cases of referral, you can employ the brief intervention related to client motivation described on the jacket of this pocket screener to strengthen the likelihood of follow-through with your referral.

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If screening reveals that the older person may have a problem with alcohol use, a national hotline is available 24 hours a day to assist in locating treatment providers:

1-800-662-HELP (4357)

http://findtreatment.samhsa.gov

This pocket screener was created to accompany the publication *Substance Abuse Among Older Adults*, #26 in CSAT's Treatment Improvement Protocol (TIP) series. The TIP series and its affiliated products are available free from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI). Call 1-800-729-6686 or 1-800-487-4889 TDD (for the hearing impaired), or visit www.csat.samhsa.gov.

DHHS Publication No. [SMA] 02-3621 Printed 2001

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MAST-G: Alcohol Screening for Older Adults

In the past year:

1. When talking with others, do you ever underestimate how much you actually drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?

Scoring: If the person answered "yes" to two or more questions, encourage a talk with the doctor.

Source: University of Michigan Alcohol Research Center, Michigan Alcohol Screening Test (MAST-G).

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UNCOPE Plus: Substance Use Disorder Outcome Screen

Please respond to the following ten questions as they apply to your experience **during the past 30 days**. The term "drugs" in this measure refers to any drug you might have used to get high or any prescription medication you might have used to get high or used in any way not according to the prescription.

During the past 30 days:

1. How often did you have a drink containing alcohol?
   - ____(0) Never
   - ____(1) 1 to 4 times
   - ____(2) 2 to 3 times a week
   - ____(3) Almost daily or daily

2. How many drinks containing alcohol did you have on a typical day when you are drinking?
   - ____(0) 1 or 2
   - ____(1) 3 or 4
   - ____(2) 5 or 6
   - ____(3) 7 or more

3. How often did you have five or more drinks on one occasion?
   - ____(0) Never
   - ____(1) 1 to 4 times
   - ____(2) 2 to 3 times a week
   - ____(3) Almost daily or daily

4. How often did you use marijuana, any other drug, or prescription medication to get high?
   - ____(0) Never
   - ____(1) 1 to 4 times
   - ____(2) 2 to 3 times a week
   - ____(3) Almost daily or daily

5. How often did you spend more time drinking or using drugs than you intended to?
   - ____(0) Never
   - ____(1) 1 time
   - ____(2) 2 to 3 times
   - ____(3) 4 or more times

6. How often did you neglect some of your usual responsibilities because of drinking or using drugs?
   - ____(0) Never
   - ____(1) 1 time
   - ____(2) 2 to 3 times
   - ____(3) 4 or more times

7. How often did you feel you wanted or needed to cut down on your drinking or drug use?
   - ____(0) Never
   - ____(1) 1 time
   - ____(2) 2 to 3 times
   - ____(3) 4 or more times

8. How often did anyone object to your drinking or drug use?
   - ____(0) Never
   - ____(1) 1 time
   - ____(2) 2 to 3 times
   - ____(3) 4 or more times

9. How often did you find yourself thinking a lot about drinking or using drugs?
   - ____(0) Never
   - ____(1) 1 time
   - ____(2) 2 to 3 times
   - ____(3) 4 or more times

10. How often did you use alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?
   - ____(0) Never
   - ____(1) 1 time
   - ____(2) 2 to 3 times
   - ____(3) 4 or more times

Developed by Norman G. Hoffmann, Ph.D.; evinceassessment@aol.com; www.evinceassessment.com
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UNCOPE Plus: ***Revisión*** de Resultados de Desorden de Uso de Sustancias.

Por favor responda las siguientes 10 preguntas ***relacionadas*** a su experiencia durante los ***últimos 30 días***. El término "drogas" se refiere a cualquier droga o ***medicamento recetado*** que usted **pudo haber usado** para drogarse o ***medicamento recetado*** que usted **pudo haber usado** en cualquier forma distinta a la ***recetada***.

Durante los últimos 30 días:

1. ¿**Qué** tan frecuente tom**ó** bebidas que contenían alcohol?
___ (0) Nunca
___ (1) 1 a 4 veces
___ (2) 2 a 3 veces por semana
___ (3) Casi a diario o diario

2. ¿**Cuántas** bebidas que contenían alcohol tom**ó** en un día típico en el que ***bebió***?
___ (0) 1 o 2
___ (1) 3 o 4
___ (2) 5 o 6
___ (3) 7 o más

3. ¿**Qué** tan frecuente tomó 5 o más bebidas en una ***sola*** ocasión?
___ (0) Nunca
___ (1) 1 a 4 veces
___ (2) 2 a 3 veces por semana
___ (3) Casi a diario o diario

4. ¿**Qué** tan seguido us**ó** marihuana, cualquier otra droga o ***medicamento recetado*** para drogarse?
___ (0) Nunca
___ (1) 1 a 4 veces
___ (2) 2 a 3 veces por semana
___ (3) Casi a diario o diario

5. ¿**Cuántas** veces pasó más tiempo tomando alcohol o usando drogas del que tenía ***planeado***?
___ (0) Nunca
___ (1) 1 vez
___ (2) 2 a 3 veces
___ (3) 4 veces o más

6. ¿**Qué** tan frecuente abandonó algunas de sus responsabilidades usuales ***debido al uso de alcohol o drogas?***
___ (0) Nunca
___ (1) 1 vez
___ (2) 2 a 3 veces
___ (3) 4 veces o más

7. ¿**Qué** tan frecuente sintió que quería o necesitaba reducir ***el uso de alcohol o drogas***?
___ (0) Nunca
___ (1) 1 vez
___ (2) 2 a 3 veces
___ (3) 4 veces o más

8. ¿**Cuántas** veces alguien desaprobó su uso de alcohol o drogas?
__ (0) Nunca
__ (1) 1 vez
__ (2) 2 a 3 veces
__ (3) 4 veces o más

9. ¿**Cuántas** veces se ha descubierto a sí mismo\a pensando mucho acerca de la posibilidad de usar alcohol o drogas?
___ (0) Nunca
___ (1) 1 vez
___ (2) 2 a 3 veces
___ (3) 4 veces o más

10. ¿**Cuántas** veces usó alcohol o drogas para aliviar un malestar emocional tal como: tristeza, rabia, o aburrimiento?
___ (0) Nunca
___ (1) 1 vez
___ (2) 2 a 3 veces
___ (3) 4 veces o más

Creado por Norman G. Hoffmann, Ph.D.; evinceassessment@aol.com; www.evinceassessment.com

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TWEAK *Excerpted from SAMHSA web site Fetal Alcoholism Syndrome Disorders*

TWEAK is a screening tool for identifying pregnant women with alcohol problems. The acronym stands for:

- **T**—Tolerance: How many drinks can you hold?
- **W**—Have close friends or relatives Worried or complained about your drinking in the past?
- **E**—Eye-Opener: Do you sometimes take a drink in the morning?
- **A**—Amnesia: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
- **K(c)**—Do you sometimes feel the need to Cut Down on your drinking?

On the tolerance question, 2 points are given if a woman reports that she can consume more than 5 drinks without falling asleep or passing out. A positive response to the worry question yields 2 points and positive responses to the last three questions yield 1 point each. A score of 2 signals an at-risk drinker. TWEAK has been found to be highly sensitive in identifying women who are at-risk drinkers.

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Screening Tools for Drug and Alcohol Use

4 Ps

This screening device is often used as a way to begin discussion about drug and alcohol use. Any woman who answers yes to one or more questions should be referred for further assessment.

1. Have you ever used drugs or alcohol during this Pregnancy?
    a) Yes
    b) No

2 Have you had a problem with drugs or alcohol in the Past?
    a) Yes
    b) No

3 Does your Partner have a problem with drugs or alcohol?
    a) Yes
    b) No

4 Do you consider one of your Parents to be an addict or alcoholic?
    a) Yes
    b) No

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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
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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 copied 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

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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

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Escala de Depresión de Post-Parto de Edinburgh

[EPDS, por sus siglas en inglés]

Obtenido de la British Journal of Psychiatry [Revista Británica de Psiquiatría] Junio de 1987, Volumen 150 por J.L. Cox, J.M. Holden, R. Sagovsky

La Escala de Depresión de Post-Parto de Edinburgh se creó para asistir a los profesionales de la atención primaria de salud en la detección de las madres que padecen de depresión de post-parto; una afección alarmante más prolongada que la "Melancolía de la Maternidad" ["Blues" en inglés] (lo cual ocurre durante la primera semana después del parto) pero que es menos grave que la psicosis del puerperio. Estudios previos demostraron que la depresión de post-parto afecta por lo menos a un 10% de las mujeres y que muchas de las madres deprimidas se quedan sin tratamiento. Estas madres logran sobrellevar la carga de su bebé y las tareas de la casa, pero su placer por la vida se ve gravemente afectado y puede que toda la familia sufra consecuencias a largo plazo. La EPDS se creó en centros de salud en Livingston y Edinburgh. Consiste de diez cortas declaraciones. La madre escoge cuál de las cuatro posibles respuestas es la que más se asemeja a la manera en la que se sintió durante la semana anterior. La mayoría de las madres pueden contestar la escala sin dificultad en menos de 5 minutos. El estudio de validación demostró que las madres que obtienen resultados por encima del umbral del 92.3% es más probable que padezcan de alguna enfermedad depresiva de diferentes niveles de gravedad. No obstante, no se le debe dar más importancia a los resultados de la EPDS que al juicio clínico. Se debe realizar una evaluación clínica prudente para confirmar el diagnóstico. La escala indica la manera en que la madre se sintió durante la semana anterior y en casos dudosos, podría ser útil repetirla después de 2 semanas. La escala no detecta las madres con neurosis de ansiedad, fobias o trastornos de la personalidad.

Instrucciones de uso:

1. Se le pide a la madre que escoja la respuesta que más se asemeje a la manera en que se sintió en los 7 días anteriores.
2. Tienen que responder las diez preguntas.
3. Se debe tener cuidado y evitar la posibilidad de que la madre hable sobre sus respuestas con otras personas.
4. La madre debe responder la escala ella misma, a no ser que sus conocimientos del inglés sean limitados o que tenga problemas para leer.
5. La EPDS se puede usar entre las 6 y 8 semanas para evaluar a las mujeres en la etapa de post-parto. La clínica de pediatría, la cita de control de post-parto o una visita al hogar pueden ser oportunidades convenientes para realizarla.

Pautas para la evaluación:

A las categorías de las respuestas se les dan puntos de 0, 1, 2 y 3 según el aumento de la gravedad del síntoma. Los puntos para las preguntas 3, 5, 6, 7, 8, 9, 10 se anotan en orden inverso (por ejemplo, 3, 2, 1, 0)

Se suman todos los puntos para dar la puntuación total. Una puntuación de 10+ muestra la probabilidad de una depresión, pero no su gravedad. Cualquier número que se escoja que no sea el "0" para la pregunta número 10, significa que es necesario hacer evaluaciones adicionales inmediatamente. La puntuación de la EPDS está diseñada para asistir al juicio clínico, no para reemplazarlo. Se les harán evaluaciones adicionales a las mujeres antes de decidir el tipo de tratamiento.

Cuestionario Sobre Depresión Postnatal Edimburgo (EPDS)

Nombre: _____
Dirección: _____
Su fecha de Nacimiento: _____
Fecha de Nacimiento del Bebé: _____ Teléfono: _____

Queremos saber cómo se siente si está embarazada o ha tenido un bebé recientemente. Por favor marque la respuesta que más se acerque ha cómo se ha sentido en LOS ÚLTIMOS 7 DÍAS, no solamente cómo se sienta hoy.

Esto significaría: Me he sentido feliz la mayor parte del tiempo durante la pasada semana. Por favor complete las otras preguntas de la misma manera.

1. He sido capaz de reír y ver el lado bueno de las cosas
   - Tanto como siempre
   - No tanto ahora
   - Mucho menos
   - No, no he podido

2. He mirado el futuro con placer
   - Tanto como siempre
   - Algo menos de lo que solía hacer
   - Definitivamente menos
   - No, nada

3. Me he culpado sin necesidad cuando las cosas no salían bien
   - Sí, la mayoría de las veces
   - Sí, algunas veces
   - No muy a menudo
   - No, nunca

4. He estado ansiosa y preocupada sin motivo
   - No, para nada
   - Casi nada
   - Sí, a veces
   - Sí, a menudo

5. He sentido miedo y pánico sin motivo alguno
   - Sí, bastante
   - Sí, a veces
   - No, no mucho
   - No, nada

6. Las cosas me oprimen o agobian
   - Sí, la mayor parte de las veces
   - Sí, a veces
   - No, casi nunca
   - No, nada

7. Me he sentido tan infeliz que he tenido dificultad para dormir
   - Sí, la mayoría de las veces
   - Sí, a veces
   - No muy a menudo
   - No, nada

8. Me he sentido triste y desgraciada
   - Sí, casi siempre
   - Sí, bastante a menudo
   - No muy a menudo
   - No, nada

9. He sido tan infeliz que he estado llorando
   - Sí, casi siempre
   - Sí, bastante a menudo
   - Sólo en ocasiones
   - No, nunca

10. He pensado en hacerme daño a mí misma
    - Sí, bastante a menudo
    - A veces
    - Casi nunca
    - No, nunca

Taken from the British Journal of Psychiatry
June, 1987, Vol. 150 by J.L. Cox, J.M. Holden, R. Sagovsky

Adolescent SBIRT Opening Questions

During the past 12 months, did you:

1. Drink any alcohol (more than a few sips)? **2.** Smoke any marijuana or hashish? **3.** Use anything else to get high? ("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff.")

No to all

Praise and Encouragement

"You have made some very good decisions in your choice not to use drugs and alcohol. I hope you keep it up."

CRAFFT "CAR" Question

If Yes to CAR

"Please don't ever ride with a driver who has had even a single drink, because people can feel that it's safe to drive even when it's not."

Offer a Contract for Life:
www.sadd.org/contract.htm

Yes to any

Administer CRAFFT

C = Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

R = Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

A = Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?

F = Do you ever **FORGET** things you did while using alcohol or drugs?

F = Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

T = Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

CRAFFT = 0 or 1

Brief Advice

"I recommend that you stop (drinking/smoking) and now is the best time. Alcohol/drugs kill brain cells and can make you do stupid things that you will regret. You are such a good (student/friend/athlete). I would hate to see anything interfere with your future."

CRAFFT ≥ 2

Brief Assessment

Tell me about your alcohol/substance use. Has it caused you any problems? Have you tried to quit? Why?

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No Signs of Acute Danger or Addiction

Brief Negotiated Interview to stop or cut down.

Give brief advice and summary.

"As your physician, I recommend that you quit drinking entirely for the sake of your health and your brain, but we both know that decision is up to you. You said that all of your friends drink and you enjoy drinking at parties; on the other hand, you recently had a blackout and are not sure how you got home that night. What are your plans regarding alcohol use in the future?"

Give praise and encouragement if willing to quit. Plan follow-up.

"It sounds like you have already started thinking about how alcohol use is affecting your life and that it would be a really smart decision to cut down. Would you be willing to quit drinking entirely for one month and then check in again with me?"

If unwilling to quit, encourage to cut down. Plan follow-up.

"OK, it sounds like you're not willing to quit entirely, but you do want to cut down. Are you willing to limit yourself to one drink when you are at a party to make sure you don't have another blackout? I'd like you to come back in one month to see how that goes.

Signs of Addiction

≤ 14 years, daily or near daily use of any substance, CRAFFT ≥ 5, alcohol related blackouts (memory lapses):

Refer to treatment.

Summarize

"I hear you saying that you depend on marijuana to help you concentrate and relax. You are frustrated because you are fighting with your parents all of the time and you were suspended from school. You tried quitting for a while, but that didn't last long. I am worried that you may be losing control over marijuana."

Refer

"I would like you to speak to someone to think more about the role marijuana is playing in your life, and the impact it could have on your future."

Invite parents

"Let's tell your parents that you have agreed to talk to someone about marijuana. They already know you use, and in my experience parents are usually relieved when their child agrees to speak to someone. I don't plan on saying much else, but is there anything you would like to be sure I keep confidential?"

Signs of Acute Danger

Drug-related hospital visits; use of IV drugs; combining alcohol use with benzodiazepines, barbiturates or opiates; consuming potentially lethal volume of alcohol (14 or more drinks); driving after substance use.

Make an Immediate Intervention

Contract for safety:

"I am really worried about your drinking. Could you agree not to drink at all this weekend until you can speak with your counselor/me again on Monday?"

Consider breaking confidentiality to ask parents to monitor and insure follow-through:

"I am going to tell your parents about our agreement so that they can support you."

*

CRAFFT

		yes	no
1.	Have you ever ridden in a **C**ar driven by someone (including yourself) who was high or had been using alcohol or drugs?	___	___
2.	Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in?	___	___
3.	Do you ever use alcohol or drugs while you are by yourself **A**lone?	___	___
4.	Do you ever **F**orget things you did while using alcohol or drugs?	___	___
5.	Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use?	___	___
6.	Have you ever gotten into **T**rouble while you were using alcohol or drugs?	___	___

Scoring: 2 or more positive items indicate the need for further assessment.

The CRAFFT is intended specifically for adolescents. It draws upon adult screening instruments, covers alcohol and other drugs, and calls upon situations that are suited to adolescents

From: Knight JR; Sherritt L; Shrier LA//Harris SK//Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent* 156(6) 607-614, 2002.

Bibliography (link)

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CRAFFT スクリーニングアンケート

全ての質問に正直に答えてください。答えは守秘義務によって守られます。

パート *A*

過去 12 ヶ月の間、あなたは、	いいえ	はい
1. アルコールを飲みましたか（２，３ロ以上）？	☐	☐
2. マリファナやハシシを吸いましたか？	☐	☐
3. ハイになるために何か他のものを使用したことはありますか？ (「何か他のもの」とは違法な薬物、薬局で買える薬物、処方箋の必要な薬物や嗅いだり「吸ったり」するものを含みます。)	☐	☐

全て(A1, A2, A3)の質問にいいえと答えた場合は、下の **B1** の質問にだけ答えて終了して下さい。

質問の内いずれかに(A1, A2, A3)はいと答えた場合は, 下の **B1** から **B6** に答えてください。

パート *B*

	いいえ	はい
1. これまでに薬物やアルコールを使用し、また「ハイ」になっている誰か（自分自身を含め）が運転する車に乗ったことはありますか？	☐	☐
2. これまでリラックスするためや、気分を良くするため、または周りに合わせるためという理由で、薬物やアルコールを使用したことはありますか？	☐	☐
3. 一人でいるとき、または自分一人でアルコールや薬物を使用したことはありますか?	☐	☐
4. これまでアルコールや薬物を使用している間に自分が何をしたか忘れてしまったことはありますか?	☐	☐
5. 家族や友達から、アルコールや薬物の量を減らすように言われた事はありますか?	☐	☐
6. アルコールや薬を使用している時に、何かトラブルに巻き込まれたことはありますか?	☐	☐

病院関係者・病院記録関連通知:

この用紙に記入された情報は特別連邦守秘義務規則(42 CFR Part 2) によって守られます。その結果これらの情報は特別な書面による合意なしの公開を禁じられています。一般的な医療関係の情報公開手続きでは、この条件を満たしません。

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CRAFFT 筛选问卷调查表

请如实回答所有问题；我们对您的答复保密。

第一部分

在过去的 12 个月中，您是否：	否	是
1. 喝过酒（而不只是抿上几口）？	☐	☐
2. 吸食大麻或印度大麻？	☐	☐
3. 使用过其它东西让自己兴奋？（“其它东西”包括非法药物、处方和非处方药以及任何您嗅或“吸入”的东西）	☐	☐

如果您对所有问题（1,2,3）的答复是“否”，请只回答下面**第一个问题**，然后结束问卷调查

如果您对任一问题（1,2,3）的答复是“是”，请回答下面**所有六个问题**。

第二部分

	否	是
1. 您是否乘坐过某人（包括您自己）在亢奋状态下、酒后或吸毒后驾驶的**汽车**？	☐	☐
2. 您是否用过酒精或毒品来**放松自己**，提升自尊感，或以求适应？	☐	☐
3. 您是否**独自一人**饮过酒或用过毒品？	☐	☐
4. 您可曾在饮酒或使用毒品时**忘记自己做过的事**？	☐	☐
5. 您的**家人**或**朋友**是否告诉过您应该节制饮酒或使用毒品？	☐	☐
6. 您在喝酒或使用毒品时是否引起过**麻烦**？	☐	☐

CRAFFT 翻印制作由马萨诸塞州行为健康合作伙伴提供支持。

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សំណួរចំរាញ់មើលដោយ CRAFT

សូមឆ្លើយសំណួរទាំងអស់ដោយស្មោះត្រង់ ។ ចម្លើយរបស់លោក-អ្នកជាការសម្ងាត់ ។

ផ្នែក A

ក្នុងរយៈពេល ១២ ខែកន្លងទៅនេះ តើលោក-អ្នកបាន ៖	**បាទ/ចាស៎**	**ទេ**
1. ទទួលទានគ្រឿងស្រវឹងណាមួយ (ច្រើនជាងពីរ-បីក្រែប) ដែរឬទេ	☐	☐
2. ជក់កញ្ឆា ឬត្រួយផ្កាណាមួយដែលមានជាតិស្រវឹងដែរឬទេ ?	☐	☐
3. ប្រើប្រាស់អ្វីផ្សេងទៀត ដើម្បីធ្វើឱ្យស្រវឹងដែរឬទេ ?	☐	☐

("អ្វីផ្សេងទៀត" រួមមានថ្នាំញៀនខុសច្បាប់ ថ្នាំទិញក្រៅធម្មតា និងថ្នាំទិញតាមវេជ្ជបញ្ជា ហើយសារធាតុផ្សេងៗដែលលោក-អ្នកហិត ឬ "ដកដង្ហើមចូល")

ប្រសិនបើលោក-អ្នកឆ្លើយទេចំពោះសំណួរទាំងអស់ (A1, A2, A3) ឆ្លើយសំណួរ B1 ខាងក្រោមរួចឈប់

ប្រសិនបើលោក-អ្នកឆ្លើយបាទ/ចាស៎ ចំពោះសំណួរណាមួយ (A1, A2, A3) ឆ្លើយសំណួរ B1 ដល់ B6 ខាងក្រោម

ផ្នែក B

	បាទ/ចាស៎	**ទេ**
1. តើលោក-អ្នកធ្លាប់ជិះក្នុង**ឡាន**ដែលបើកដោយអ្នកណាម្នាក់ (រួមទាំងខ្លួនអ្នក) ដែល"ស្រវឹង" ដែលទទួលទានគ្រឿងស្រវឹង ឬដែលប្រើប្រាស់ថ្នាំដែរឬទេ ?	☐	☐
2. តើលោក-អ្នកធ្លាប់ទទួលទានគ្រឿងស្រវឹង ឬប្រើថ្នាំដើម្បី**បន្ធូរអារម្មណ៍** ធ្វើឱ្យមានអារម្មណ៍ល្អចំពោះខ្លួនឯង ឬឱ្យចូលនឹងគេចុះដែរឬទេ ?	☐	☐
3. តើលោក-អ្នកធ្លាប់ទទួលទានគ្រឿងស្រវឹង ឬប្រើថ្នាំ ខណៈដែលលោក-អ្នកនៅតែឯង ឬ**តែម្នាក់ឯង**ដែរឬទេ ?	☐	☐
4. តើលោក-អ្នកធ្លាប់**ភ្លេច**ទង្វើដែលលោក-អ្នកបានធ្វើ ខណៈដែលទទួលទានគ្រឿងស្រវឹង ឬប្រើថ្នាំដែរឬទេ ?	☐	☐
5. តើ**គ្រួសារ**របស់លោក-អ្នក ឬក៏**មិត្តភក្តិ**ធ្លាប់ប្រាប់អ្នកថា អ្នកគួរតែកាត់បន្ថយការផឹក ឬប្រើថ្នាំដែរឬទេ ?	☐	☐
6. តើលោក-អ្នកធ្លាប់កើតមាន**បញ្ហា** ខណៈដែលលោក-អ្នកទទួលគ្រឿងស្រវឹង ឬប្រើថ្នាំដែរឬទេ ?	☐	☐

ការកត់ត្រាពីការរក្សាភាពសម្ងាត់ ៖

ព័ត៌មានដែលគេបានកត់ត្រាក្នុងទំព័រនេះ ត្រូវបានការពារដោយច្បាប់រក្សាភាពសម្ងាត់ពិសេសរបស់រដ្ឋាភិបាលសហព័ន្ធ(42 CFR ផ្នែកទី2) ដែលហាមឃាត់ការចែកចាយព័ត៌មាននេះ លុះត្រាតែមានការអនុញ្ញាតជាលាយលក្ខណ៍អក្សរ ។ ការអនុញ្ញាតទូទៅនៃការចែករំលែកព័ត៌មានវេជ្ជសាស្ត្រមិនគ្រប់គ្រាន់សម្រាប់ហេតុផលនេះឡើយ ។

បានផលិតឡើងវិញដោយមានការអនុញ្ញាតពីមជ្ឈមណ្ឌលស្រាវជ្រាវការប្រើប្រាស់សារធាតុខុសលើយុវជន (Center for Adolescent Substance Abuse Research)
CeASAR, Children's Hospital Boston. (www.ceasar.org)

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ການສຳພາດເພື່ອການກັ່ນຕອງ CRAFFT

ກະຣຸນາຕອບຄຳຖາມທຸກຂໍ້ຢ່າງຊື່ສັດ; ຄຳຕອບຂອງທ່ານໄດ້ຮັບການເກັບຮັກສາໄວ້ເປັນຄວາມລັບ.

ພາກ A

ໃນລະຫວ່າງ 12 ເດືອນຜ່ານມາ, ທ່ານໄດ້:	**ບໍ່ແມ່ນ**	**ແມ່ນ**
1. ດື່ມ<u>ອັລກໍຮໍ</u>ໃດໆ (ຫຼາຍກວ່າການຈິບດື່ມເທື່ອລະໜ້ອຍສອງ ສາມຄັ້ງ)?	☐	☐
2. ສູບ<u>ກັນຊາ</u>ໃດໆ?	☐	☐
3. ໃຊ້<u>ສິ່ງອື່ນໃດ</u> ເພື່ອຊ່ວຍໃຫ້ຮູ້ສຶກ<u>ເຄີບເຄີ້ມ</u>? (“ສິ່ງອື່ນໆ” ລວມມີ ຢາເສບຕິດຜິດກົດໝາຍ, ຢາຕາມຮ້ານຂາຍຢາ ແລະຢາຕາມໃບສັ່ງແພດ, ແລະ ສິ່ງຕ່າງໆ ຊຶ່ງທ່ານໃຊ້ເພື່ອດົມ ຫຼື “ສູດ”)	☐	☐

ຖ້າທ່ານຕອບ ບໍ່ແມ່ນ ໃນ<u>ທຸກຂໍ້</u> (A1, A2, A3) **ໃຫ້ຕອບ ສະເພາະ B1 ຂ້າງລຸ່ມນີ້, ຈາກນັ້ນ ຢຸດ.**

ຖ້າທ່ານຕອບ ແມ່ນ ໃນ<u>ຂໍ້ໃດໆ</u> (A1, A2, A3), **ໃຫ້ຕອບ B1 to B6 ຂ້າງລຸ່ມນີ້.**

ພາກ B

	ບໍ່ແມ່ນ	**ແມ່ນ**
1. ທ່ານເຄີຍຂີ່ຣົຖໃນ<u>ຣົຖ</u>ທີ່ຂັບໂດຍໃຜຜູ້ໜຶ່ງ (ລວມເຖິງໂຕທ່ານເອງ) ຊຶ່ງໄດ້ຢູ່ໃນອາລົມ “ເຄີບເຄີ້ມ” ຫຼື ກຳລັງນຳໃຊ້ເຫຼົ້າ ຫຼື ຢາເສບຕິດ ບໍ່?	☐	☐
2. ທ່ານເຄີຍໃຊ້ເຫຼົ້າ ຫຼື ຢາເສບຕິດ ເພື່ອ<u>ຜ່ອນຄາຍ</u>, ໃຫ້ຮູ້ສຶກດີຂຶ້ນ ກ່ຽວກັບຕົວເອງ, ຫຼື ໃຫ້ເຂົ້າກັນໄດ້ ບໍ່?	☐	☐
3. ທ່ານເຄີຍໃຊ້ເຫຼົ້າ ຫຼື ຢາເສບຕິດໃນຂະນະທີ່ທ່ານຢູ່ຕາມລຳພັງ, ຫຼື <u>ຢູ່ຜູ້ດຽວ</u> ບໍ່?	☐	☐
4. ທ່ານເຄີຍ<u>ລືມ</u>ສິ່ງຕ່າງໆ ທີ່ທ່ານໄດ້ເຮັດ ໃນຂະນະນຳໃຊ້ເຫຼົ້າ ຫຼື ຢາເສບຕິດ ບໍ່?	☐	☐
5. <u>ຄອບຄົວ</u> ຫຼື <u>ໝູ່ເພື່ອນ</u>ຂອງທ່ານເຄີຍບອກທ່ານບໍ່ວ່າ ທ່ານຄວນ ຫຼຸດຜ່ອນການດື່ມເຫຼົ້າ ຫຼື ໃຊ້ຢາເສບຕິດ?	☐	☐
6. ທ່ານເຄີຍ<u>ມີບັນຫາ</u>ເດືອດຮ້ອນ<u>ໃນ</u>ຂະນະທີ່ທ່ານນຳໃຊ້ເຫຼົ້າ ຫຼື ຢາເສບຕິດ ບໍ່?	☐	☐

ແຈ້ງການສຳລັບເຈົ້າໜ້າທີ່ຄລີນິກ ແລະ ວ່າດ້ວຍບັນທຶກດ້ານການແພດ:
ຂໍ້ມູນທີ່ບັນທຶກຢູ່ໃນໜ້ານີ້ອາດໄດ້ຮັບການປົກປ້ອງໂດຍກົດລະບຽບພິເສດວ່າດ້ວຍການຮັກສາຄວາມລັບແຫ່ງຣັຖບານກາງ (42 CFR Part 2), ຊຶ່ງຫ້າມການເປີດເຜີຍຂໍ້ມູນນີ້ ເວັ້ນແຕ່ວ່າຈະໄດ້ຮັບການຍິນຍອມເປັນລາຍລັກອັກສອນສະເພາະ. ການອະນຸຍາດໂດຍທົ່ວໄປສຳລັບການເປີດເຜີຍຂໍ້ມູນທາງການແພດແມ່ນ**ບໍ່**ພຽງພໍ.

ຜະລິດຊ້ຳໃໝ່ດ້ວຍການອະນຸຍາດຈາກ ສູນຄົ້ນຄວ້າວິໃຈດ້ານການຕິດສານເສບຕິດສຳລັບວັຍໜຸ່ມ
(Center for Adolescent Substance Abuse Research: CeASAR, ໂຮງໝໍເດັກແຫ່ງບອສຕັນ (Children’s Hospital Boston).
ການຜະລິດຊ້ຳຂອງ CRAFFT ໄດ້ຜະລິດຂຶ້ນດ້ວຍການສະໜັບສະໜູນຈາກ Massachusetts Behavioral Health Partnership.

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Вопросы Скрининга CRAFFT

Пожалуйста ответьте честно на все вопросы; мы гарантируем конфиденциальность ваших ответов.

Часть A

За последние 12 месяцев, делали ли вы следующее:	**Нет**	**Да**
1. Употребляли алкоголь (более нескольких глотков)?	☐	☐
2. Курили марихуану или гашиш?	☐	☐
3. Употребляли что-нибудь другое, чтобы получить «кайф»? “ что-нибудь другое” включает запрещенные наркотики, сильнодействующие лекарства (по рецепту и без рецепта) и вещества, которые можно нюхать и “вдыхать”.	☐	☐

Если вы ответили НЕТ на ВСЕ вопросы (A1, A2, A3) ответьте только на **B1** ниже, и не продолжайте далее.

Если вы ответили Да на Любой из вопросов (A1, A2, A3), ответьте на Вопросы **B1 - B6** ниже.

Часть B

	Нет	**Да**
1. Вы когда-нибудь садились в **МАШИНУ**, за рулем которой находился человек (включая вас) в состоянии алкогольного опьянения, под действием наркотиков или “под кайфом”?	☐	☐
2. Вы когда-нибудь употребляли алкоголь или наркотики для того, чтобы **РАССЛАБИТЬСЯ**, самоутвердиться или “вписаться”?	☐	☐
3. Вы когда-нибудь употребляли алкогольные напитки или наркотики без друзей, **В ОДИНОЧКУ?**	☐	☐
4. Вы когда-нибудь **ЗАБЫВАЕТЕ** то, что делали под влиянием алкогольных напитков или наркотиков?	☐	☐
5. Ваши родственники или **ДРУЗЬЯ** когда-нибудь говорили вам, что вам нужно меньше пить или употреблять меньше наркотиков?	☐	☐
6. Вы когда-нибудь попадали в **НЕПРИЯТНОСТИ**, находясь под влиянием алкогольных напитков или наркотиков?	☐	☐

Конфиденциальность:

Вышеизложенная информация может быть защищена специальными федеральными законами о конфиденциальности (42 CFR Часть 2), которые запрещают разглашение данной информации без письменного согласия субъектов персональных данных. Общее разрешение на разглашение медицинской информации НЕ является достаточным.

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Las Preguntas CARLOS (CRAFFT)

Por favor responda a todas las preguntas con la mayor sinceridad posible;
sus respuestas serán tratadas de forma confidencial

Parte A

Durante los últimos doce meses:

	No	Sí
1. ¿Ha consumido bebidas alcohólicas (más de unos pocos sorbos)?	☐	☐
2. ¿Ha fumado marihuana o probado hachís?	☐	☐
3. ¿Ha usado algún otro tipo de sustancias que alteren su estado de ánimo o de conciencia? El término "algún otro tipo" se refiere a drogas ilícitas, medicamentos de venta libre o de venta con receta médica, así como a sustancias inhalables que alteren su estado mental.	☐	☐

Si respondió con un NO las tres primeras preguntas (A1, A2, A3), pase ahora a la pregunta **B1**

Si respondió con un SÍ a CUALQUIERA de las tres primeras preguntas (A1, A2, A3), pase ahora a las preguntas **B1 a B6**

Parte B (CARLOS)

	No	Sí
1. ¿Ha viajado, alguna vez, en un **CARRO** o vehículo conducido por una persona (o usted mismo/a) que haya consumido alcohol, drogas o sustancias psicoactivas?	☐	☐
2. ¿Le han sugerido, alguna vez, sus **AMIGOS o su familia** que disminuya el consumo de alcohol, drogas o sustancias psicoactivas?	☐	☐
3. ¿Ha usado, alguna vez, bebidas alcohólicas, drogas o sustancias psicoactivas para **RELAJARSE**, para sentirse mejor consigo mismo o para integrarse a un grupo?	☐	☐
4. ¿Se ha metido, alguna vez, en **LÍOS** o problemas al tomar alcohol, drogas o sustancias psicoactivas?	☐	☐
5. ¿Se le ha **OLVIDADO,** alguna vez, lo que hizo mientras consumía alcohol, drogas o sustancias psicoactivas?	☐	☐
6. ¿Alguna vez ha consumido, alcohol, drogas o alguna sustancia psicoactiva mientras estaba **SOLO** o SOLA, sin compañía?	☐	☐

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Câu hỏi sàng lọc CRAFFT

Xin hãy trả lời trung thực tất cả các câu hỏi; câu trả lời sẽ được giữ bí mật.

Phần A

Trong vòng 12 THÁNG QUA, quý vị có:	**Không**	**Có**
1. Uống chút rượu nào không (hơn một vài ngụm)?	☐	☐
2. Hút chút cần sa hoặc hashish nào không?	☐	☐
3. Dùng bất kỳ chất gì khác để hưng phấn?	☐	☐

"bất kỳ chất gì khác" gồm thuốc trái phép, thuốc không kê toa và có kê toa, và những thứ quý vị hít hoặc "hút"

Nếu quý vị trả lời KHÔNG với TẤT CẢ câu hỏi (A1, A2, A3) chỉ trả lời **câu B1** dưới đây, sau đó DỪNG.

Nếu quý vị trả lời CÓ với BẤT KỲ câu nào (A1, A2, A3) trả lời câu **B1 đến B6** dưới đây.

Phần B	**Không**	**Có**
1. Bạn có bao giờ đi trên một XE HƠI (**CAR**) do một người lái (kể cả bạn) đang "hưng phấn" hoặc đã sử dụng rượu hay ma túy?	☐	☐
2. Có bao giờ bạn sử dụng rượu hoặc ma túy để THƯ GIÃN (**RELAX**), để cảm thấy dễ chịu hơn và cảm thấy thoải mái hơn/hòa nhập hơn với bạn bè?	☐	☐
3. Có bao giờ bạn sử dụng rượu hoặc ma túy khi bạn MỘT MÌNH (**ALONE**)?	☐	☐
4. Có bao giờ bạn QUÊN (**FORGET**) những việc đã làm khi sử dụng rượu hoặc ma túy?	☐	☐
5. Có bao giờ gia đình hoặc BẠN BÈ (**FRIENDS**) nói với bạn rằng bạn cần giảm uống rượu hoặc giảm dùng ma túy?	☐	☐
6. Bạn đã bao giờ gặp RẮC RỐI (**TROUBLE**) trong khi bạn sử dụng rượu hoặc ma túy?	☐	☐

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Behavioral Health Screening Tools for Consideration to Add to NextGen
AHC/CHCN (last updated 11/26/12)

ADULT

	Screening Tool	Availability in public domain	
		Need Permission? Yes/No	**Fees**
	ANSA (Adult Needs and Assessment)	No	Free
	EPDS (Edinburg Postnatal Depression Scale)	No	Free
	MDQ (Mood Disorder Questionnaire)	No	Free
	MINI (screening range of Dxs)	original MINI 6.0- Yes*	One time processing fee for Clinicians: $19.95
		NYC modified version- No	Free
SUBSTANCE USE	**AUDIT** (Alcohol Use Disorders Identification Test)	No	Free
	CAGE-AID	No	Free
	MAST (Michigan Alcoholism Screening Test)	No	Free
	MAST-G (Michigan Alcoholism Screen Test- Geriatrics)	No	Free
	4Ps Plus (Perinatal SUDs)	Yes*	Fee based on number of women screened annually
ANXIETY DISORDERS	**GAD-7** (Generalized Anxiety Disorder 7-item)	No	Free
TRAUMA	**PCL-C** (PTSD Checklist- Civilian Version)	No	Free
INSOMNIA	**PSQI 9** (Pittsburgh Sleep Quality Index)	Yes*	Free
PAIN	**BPI** (Brief Pain Inventory)	Yes*	Free
	MPI (Multidimensional Pain Inventory)	No	Free
SOMATIC	**PHQ-15** (Patient Health Questionnaire 15-Item)	No	Free
FUNCTIONAL IMPAIRMENT	**Quality of Life Scale**	No	Free
COGNITIVE IMPAIRMENT	**Mini-Cog**	No	Free
	MoCA (Montreal Cognitive Assessment)	No	Free

PEDIATRICS

	Screening Tool	Availability in public domain	
		Need Permission? Yes/No	**Fees**
CHILD DEVELOPMENT	**ASQ-3** (Ages and Stages Third Edition)	Yes*	ASQ-3 Questionnaire: $225 ASQ-SE Questionnaire: $175
	ASQ SE (Ages and Stages Social Emotional)		
	M-CHAT (Modified Checklist for Autism-Toddlers)	No	Free
	Peds Sxs Checklist (Pediatric Symptom Checklist)	No	Free
ADHD	**Vanderbilt** (for parent)	No	Free
	CANS (Child Adolescent Needs and Strengths)	No	Free

*currently in process of obtaining more details about permission

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Applying the Substance Abuse Confidentiality Regulations 42 CFR Part 2

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

**** These Frequently Asked Questions (FAQs) are for information purposes only and are not intended as legal advice. Specific questions regarding compliance with federal law should be referred to your legal counsel. State laws may also apply.***

In 2010, the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) and the HHS Office of the National Coordinator (ONC) published FAQs "Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)." The 2010 FAQs are available at http://www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf.

Q1. When a patient has signed a consent form allowing disclosure to multiple parties, can the patient revoke consent for disclosure to one or more of those parties while leaving the rest of the consent in force?

A1. Yes. Under 42 CFR Part 2 (hereafter referred to as "Part 2"), a patient can revoke consent to one or more parties named in a multi-party consent form while leaving the rest of the consent in effect. In a non-Health Information Exchange (HIE)[1] environment, this can be accomplished simply by the Part 2 program indicating on the consent form or in the patient's record that consent has been revoked with respect to one or more named parties. In an HIE environment, the revocation with respect to one or more parties should be clearly communicated to the Health Information Organization (HIO)[2] as well as noted in the patient's record by the Part 2 program.

To ensure compliance with consent requirements, an HIO should have policies and procedures in place for implementing patient decisions to give and revoke consent. Once a patient has revoked a Part 2 consent with respect to one or more parties, that revocation should be immediately communicated to the HIO by the entity obtaining the patient's revocation so that it implements the revocation decision and no longer transmits the Part 2 program's protected patient information to those one or more parties. Part 2 permits a patient to revoke consent orally [42 CFR §2.31(a)(8),(c)(8)]. While oral revocations must be honored under Part 2, SAMHSA recommends the entity obtaining the revocation get it in writing and/or document the revocation in the patient's record. Part 2 prohibits a program from making a disclosure on the basis of a consent which it knows has been revoked. A program however is entitled to act in reliance on a signed consent prior to a revocation, and such disclosure would not be improper [42 CFR § 2.31(c)(3) and § 2.31(a)(8)]. SAMHSA recommends that a revocation be communicated as soon as practicable to entities relying on such consent.

We note that the requirements of the HIPAA Privacy Rule must also be considered. For information on HIPAA, see the HHS Health Information Privacy website at: http://www.hhs.gov/ocr/privacy/index.html or http://www.samhsa.gov/HealthPrivacy/docs/SAMHSAPart2-HIPAAComparison2004.pdf

[1] Health Information Exchange ("HIE") is a generic term that refers to a number of methods and mechanisms through which information can be exchanged electronically

[2] As used in these FAQs, the term "HIO" means an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Q2. Does a consent form allowing for a program to disclose Part 2 information remain in effect when the *disclosing* program merges with another or undergoes corporate restructuring?

A2. Whether a consent form remains in effect when a program merges with another program or undergoes corporate restructuring depends on how the entity making the disclosure is identified on the consent form.

Under Section 2.31(a)(1), the *disclosing entity* can be listed by "specific name or general designation." If a particular program is designated by specific name as the entity permitted to make the disclosure, then the consent form would no longer be valid if the program's name is changed (following a merger or restructuring or for another reason) since the new entity is not identified as the same one that was listed on the consent form. If the disclosing entity is listed by a general designation, such as "any drug or alcohol treatment program that is affiliated with the XYZ HIO," then that consent would continue to be valid if the program making the disclosure merges or undergoes corporate restructuring, assuming the new merged program is also an HIO-affiliated member.

Note that section 2.19 sets forth the requirements when a Part 2 program is discontinued or taken over or acquired by another program, as opposed to just undergoing a name change or restructuring. This section provides that a discontinued program or one acquired by another program must purge patient identifying information from its records or destroy the records unless the patient consents to the transfer of his or her records, except to the extent that there is a legal requirement that records be retained.

In cases where a *recipient* organization has undergone a name change, whether or not a new consent form is needed depends upon the specific designation made on the original consent. Section 2.31(a)(2) allows for specification of either the name or title of the individual or the name or the organization to which the disclosure is to be made. Therefore, an organizational name change alone may not necessitate a new consent.

Q3. May a Part 2 program disclose patient information to providers of "on-call coverage" pursuant to a Qualified Service Organization Agreement (QSOA)?

A3. Yes. 42 CFR § 2.11 defines "Qualified Service Organization (QSO)" and lists the types of services that a QSO provides, and further references Qualified Service Organization Agreements (QSOA). Medical services are included on that list and thus a Part 2 program can enter into a QSOA with providers of "on-call coverage."

A QSOA is a two-way agreement between a Part 2 program and the entity providing the service, in this case the provider of on-call coverage. The QSOA authorizes communication between those two parties, however the Part 2 program should only disclose information to the QSO that is necessary for the QSO to perform its duties under the QSOA. Also, the QSOA does not permit a QSO to redisclose information to a third party unless that third party is a contract agent of the QSO, helping them provide services described in the QSOA, and only as long as the agent only further discloses the information back to the QSO or to the Part 2 program from which the information originated. For additional information, see FAQ number 10 of the 2010 FAQs published by SAMHSA and the ONC at:
http://www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf

Thus, if a QSOA exists between a Part 2 program and an HIO for services rendered to the program by the HIO, the QSOA would not allow the HIO to redisclose that information to a third party like providers of "on-call coverage." For an HIO to redisclose Part 2 information to providers of "on-call coverage" that are not part of the Part 2 program, a consent form that allows the HIO to make the redisclosures to the providers of "on-call coverage" would be needed.

Since "on-call coverage" arrangements are fluid and the identity of the health care provider who is providing the on-call coverage might not be known, the designation of the recipient could be "the health care provider who is providing on-call coverage for the ABC treatment program." By designating the recipient as the "on-call coverage provider", the requirement that the recipient's name or title be listed would be met. Consent for disclosures to providers of on-call coverage can be included in the same consent form used for other disclosures of patient information if the program so chooses.

An HIO can also redisclose Part 2 information without patient consent to providers of "on-call coverage" who are part of the Part 2 program or of an entity having direct administrative control over the program, as long as the on-call providers need the information in connection with their duties that arise out the provision of diagnosis, treatment or referral for treatment services [42 CFR § 2.12(c)(3)].

Q4. Can a single Part 2 consent form be used to authorize patient information to be exchanged through an HIO's system for different purposes, such as treatment, payment, disease management and/or quality improvement?

A4. Yes, Part 2 allows the use of a single consent form authorizing the disclosure of Part 2 patient information to different recipients for different purposes. However, Part 2 also requires a consent form to specify the kind and amount of information that can be disclosed to each of the recipients named in the consent. The amount of information to be disclosed "must be limited to that information which is necessary to carry out the purpose of the disclosure" [42 C.F.R. §2.13(a)]. This will vary depending on the different purposes for which different recipients are being allowed access to the information made available through an HIE. Thus the consent form would have to be structured to make it clear what information may be given to which recipients, and for which purposes. The HIE system must also be designed to limit the different recipients' access through the HIE to only the kind and amount of patient information each needs to fulfill the specific purpose for which they are being allowed access.

Q5. Does Part 2 permit a healthcare provider to disclose information without consent when there is an immediate threat to the health or safety of an individual or the public?

A5. Part 2 permits the disclosure of information under certain circumstances without consent during a medical emergency or in other limited situations. If a Part 2 program (or a healthcare provider that has received Part 2 patient information) believes that there is an immediate threat to the health or safety of any individual, there are steps described below that the Part 2 program or healthcare provider can take in such a situation:

Notifications to medical personnel in a medical emergency: A Part 2 program can make disclosures to medical personnel if there is a determination that a medical emergency exists, i.e., there is a situation that poses an immediate threat to the health of any individual and requires immediate medical intervention [42 CFR §2.51(a)]. Information disclosed to the medical personnel who are treating such a medical emergency may be redisclosed by such personnel for treatment purposes as needed. For additional information regarding disclosures during a medical emergency, see FAQs numbered 7, 8, and 9 below.

Notifications to law enforcement: Law enforcement agencies can be notified if an immediate threat to the health or safety of an individual exists due to a crime on program premises or against program personnel. A Part 2 program is permitted to report the crime or attempted crime to a law enforcement agency or to seek its assistance [42 CFR §2.12(c)(5)]. Part 2 permits a program to disclose information regarding the circumstances of such incident, including the suspect's name, address, last known whereabouts, and status as a patient in the program.

Immediate threats to health or safety that do not involve medical emergencies or crimes on programs premises or against program personnel: Part 2 programs and health care providers and HIOs who have received Part 2 patient information, can make reports to law enforcement about an immediate threat to the health or safety of an individual or the public *if patient-identifying information is not disclosed*. Immediate threats to health or safety that do not involve a medical emergency or crimes (e.g., a fire) are not addressed in the regulations. Programs should evaluate those circumstances individually.

Reports of child abuse and neglect: The restrictions on disclosure do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or

local authorities. However, Part 2 restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect [42 CFR § 2.12(c)(6)]. Also, a court order under Part 2 may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment if, among other reasons, the disclosure is necessary to protect against an existing threat of life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect [42 CFR § 2.63(a)(1)].

Court ordered disclosures: Under the regulations, Part 2 programs or "any person having a legally recognized interest in the disclosure which is sought" may apply to a court for an order authorizing disclosure of protected patient information [42 CFR § 2.64]. Thus, if there is an existing threat to life or serious bodily injury, a Part 2 program or "any person having a legally recognized interest in the disclosure which is sought" can apply for a court order to disclose information.

Q6. Under what circumstances can information disclosed pursuant to Part 2 be redisclosed?

A6. Once Part 2 information has been initially disclosed (with or without patient consent), no redisclosure is permitted without the patient's express consent to redisclose or unless otherwise permitted under Part 2.

Disclosures made *with* patient consent must be accompanied by a statement notifying the recipient that Part 2 redisclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

When disclosures are made *without* patient consent under the following circumstances, limited redisclosures without obtaining the patient's consent: also permitted patient, such as medical emergencies [42 CFR § 2.51], child abuse reporting [42 CFR § 2.12(c)(6)], crimes on program premises or against program personnel [42 CFR § 2.12(c)(5)], and court ordered disclosures when procedures and criteria are met [42 CFR §§ 2.61-2.67].

When disclosures are made under the following circumstances the recipient is prohibited from redisclosing the information without consent, except under the following restricted circumstances:

Research – Researchers who receive patient identifying information are prohibited from redisclosing the patient-identifying information to anyone except back to the program [42 CFR § 2.52(b)].

Audits and Evaluations – Part 2 permits disclosures to persons and organizations authorized to conduct audits and evaluation activities, but imposes limitations by requiring any person or organization conducting the audit or evaluation to agree in writing that it will redisclose patient identifying information only (1) back to the program, or (2) pursuant to a court order to investigate or prosecute the program (not a patient), or (3) to a government agency that is overseeing a Medicare or Medicaid audit or evaluation [42 CFR § 2.53(c)(d)].

Qualified Service Organization Agreements (QSOAs) – Part 2 requires the QSO to agree in writing that in receiving, storing, processing, or otherwise dealing with any information from the program about patients, it is fully bound by Part 2, it will resist, in judicial proceedings if necessary, any efforts to obtain access to information pertaining to patients except as permitted by Part 2, and will use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information [42 CFR § 2.11]. In addition, QSOAs may allow disclosure in certain circumstances.

Authorizing Court Orders -- When information is disclosed pursuant to an authorizing court order, Part 2 requires that steps be taken to protect patient confidentiality. In a civil case, Part 2 requires that the court order authorizing a disclosure include measures necessary to limit disclosure for the patient's protection, which could include sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered [42 CFR § 2.64(e)(3)]. In a criminal case, such order must limit disclosure to those law enforcement and prosecutorial officials who are responsible for or are conducting the investigation or prosecution, and must limit their use of the record to cases involving extremely serious crimes or suspected crimes. For additional information regarding the contents of court orders authorizing disclosure, see 42 CFR § 2.65(e).

Q7. How can a Part 2 program ensure that it will be notified that a health care provider invoked the medical emergency exception and gained access to protected Part 2 information?

A7. The Part 2 regulations at 42 CFR §2.51 specify that when a disclosure is made in connection with a medical emergency, the *Part 2 program* (emphasis added) must document in the patient's record the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency [42 CFR § 2.51(c)]. See previous FAQs, and specifically, Number 30 of the 2010 FAQs. SAMHSA recommends that HIE data systems be designed to ensure that the Part 2 program is notified when a disclosure occurs and Part 2 records are released pursuant to a medical emergency. To promote compliance, SAMHSA recommends that the notification include all the information that the Part 2 program is required to document in the patient's records (e.g., date and time of disclosure, the nature of the emergency, etc.). Similarly, SAMHSA recommends that the information about emergency disclosures be kept in the HIO's electronic system and protected using appropriate safeguards.

Before a Part 2 program enters into an affiliation with an HIO, it should consider whether the HIO system has the capability to comply with all Part 2 requirements, including the capacity to notify the Part 2 program when its records have been disclosed pursuant to a medical emergency. For additional information regarding disclosures during a medical emergency, see the FAQs numbered 5, 8, and 9.

Q8. What categories of health care professionals are considered "medical personnel" for the purpose of obtaining information during a medical emergency?

A8. Part 2 allows patient identifying information to be disclosed to medical personnel in a medical emergency [42 CFR § 2.51]. Part 2 does not define the term "medical personnel" but merely provides that information can be given to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention. It is up to the health care provider or facility treating the emergency to determine the existence of a medical emergency and which personnel are needed to address the medical emergency. The name of the medical personnel to whom the disclosure was made, their affiliation with any health care facility, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the medical emergency must be documented in the patient's records by the Part 2 program disclosing them [42 CFR §2.51(c)]. Additional information about disclosures in medical emergencies is found in FAQs numbered 5, 7, and 9.

Q9. Can the Part 2 medical emergency exception be invoked to head off a potential medical emergency such as a potential drug interaction?

A9. If a health care provider treating an individual determines that a medical emergency exists as defined in Part 2, i.e., "a condition which poses an immediate threat to the health of any individual [not just the patient], and which requires immediate medical intervention," and in treating the medical emergency the health care provider needs information about potential drug interactions,

then that information and any other information contained in the Part 2 record that the treating health care provider determines he or she needs to treat the medical emergency can be disclosed. If no such determination exists, SAMHSA recommends trying to obtain consent from the patient.

If a health care provider is treating a patient in a non-emergency situation and the health care provider is concerned about a potential drug interaction, in an HIE environment, an HIO may only disclose a Part 2 program patient's records to a health care provider if the patient signs a consent form releasing the Part 2 record to the health care provider. Such a consent form may already exist if the patient previously signed a Part 2 consent form allowing the HIO to disclose Part 2 information to HIO affiliated health care providers and the provider seeking access is listed as a recipient on that form.

A health care provider who is concerned about a potential drug interaction and treating a patient in a non-emergency situation can also gain access to a Part 2 program patient's record if the health care provider has signed a QSOA with the patient's Part 2 program (and the information is limited to what is needed for the provider to provide services to the Part 2 program) or obtains patient consent.

In a non-emergency situation, if the health care provider concerned about a potential drug interaction is part of the Part 2 program (or of an entity that has direct administrative control over the program), he or she can gain access to the Part 2 patient's record without consent if the health care provider needs the information to treat the patient. 42 CFR § 2.12(c)(3) does not restrict communications between and among such personnel who have a need for the information in connection with their duties arising out of the provision of diagnosis, treatment or referral for treatment services.

It should be noted that concern alone about potential drug interaction may not be sufficient to meet the standard of a medical emergency. Thus, based on the circumstances of the presenting situation, SAMHSA recommends that health care providers should obtain consent from the patient where feasible.

Q10. Do all primary care providers who prescribe controlled substances to treat substance use disorders meet the definition of a "program" under Part 2?

A10. No. Not every primary care provider who prescribes controlled substances meets the definition of a "program" or part of a "program" under Part 2. For providers to be considered "programs" covered by the Part 2 regulations, they must be both "federally-assisted" and meet the definition of a program under 42 CFR Part § 2.11 Physicians who prescribe controlled substances to treat substance use disorders are DEA-licensed and thus meet the test for federal assistance [42 CFR Part §2.12(b)(2)]. Nevertheless, the regulations establish additional criteria to meet the definition of a "program":

1. If a provider is *not* a general medical care facility, then the provider meets Part 2's definition of a "program" if it is an individual or entity that holds itself out as providing, *and* provides alcohol or drug abuse diagnosis, treatment or referral for treatment.

2. If the provider is an identified unit within a general medical care facility, it is a "program" if it holds itself out as providing, *and* provides, alcohol or drug abuse diagnosis, treatment or referral for treatment.

3. If the provider consists of medical personnel or other staff in a general medical care facility, it is a program if its primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment *and* is identified as such specialized medical personnel or other staff within the general medical care facility.

In addition, in explaining Part 2's applicability and coverage, § 2.12(e)(1) states that "coverage includes, but is not limited to, employee assistance programs, programs within general hospitals, school-based programs and private practitioners who hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment or referral for treatment" [42 CFR Part § 2.12(e)(1)].

Accordingly, primary care providers who do not work in general medical care facilities meet Part 2's definition of a program if their principal practice consists of providing alcohol or drug abuse diagnosis, treatment or referral for treatment, *and* they hold themselves out as providing the same. If their principal practice consists of providing alcohol or drug abuse diagnosis, treatment or referral for treatment, but they do not hold themselves out as providing those services, then it is likely that they would not meet the definition of a program. The phrase "holds itself out" is not defined in the regulations, but could mean a number of things, including but not limited to state licensing procedures, advertising or the posting of notices in the offices, certifications in addiction medicine, listings in registries, internet statements, consultation activities for non-"program" practitioners, information presented to patients or their families, or any activity that would lead one to reasonably conclude that the provider is providing or provides alcohol or drug abuse diagnosis, treatment or referral for treatment.

Further, while the term "general medical care facility" is not defined in the definitions section of 42 CFR 2.11, hospitals, trauma centers, or federally qualified health centers would generally be considered "general medical care" facilities. Therefore, primary care providers who work in such facilities would only meet Part 2's definition of a program if 1) they work in an identified unit within such general medical care facility that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment, or 2) the primary function of the provider is alcohol or drug abuse diagnosis, treatment or referral for treatment and they are identified as providers of such services. In order for a program in a general medical care facility to share information with other parts or units within the general medical care facility, administrative controls must be in place to protect Part 2 information if it is shared.

In addition, a practice comprised of primary care providers could be considered a "general medical facility." As such, only an identified unit within that general medical care facility which holds itself out as providing *and* provides alcohol or drug abuse diagnosis, treatment or referral for treatment would be considered a "program" under the definition in the Part 2 regulations. Medical personnel or staff within that facility whose primary function is the provision of those services and who are identified as such providers would also qualify as a "program" under the definition in the Part 2 regulations. Other units or practitioners within that general medical care facility would not meet the definition of a Part 2 program unless such units or practitioners also hold themselves out as providing *and* provide alcohol or drug abuse diagnosis, treatment or referral for treatment.

Q11. Is information generated by the provision of SBIRT (Screening, Brief Intervention and Referral to Treatment) services covered by Part 2?

A11. Screening, Brief Intervention and Referral to Treatment (SBIRT) is a cluster of activities designed to identify people who engage in risky substance use or who might meet the criteria for a formal substance use disorder. Clinical findings indicate that the overwhelming majority of individuals screened in a general medical setting do not have a substance use disorder and do not need substance use disorder treatment.

The determination whether patient information acquired when conducting SBIRT services is subject to Part 2 depends on whether the entity conducting the SBIRT activities is a federally-assisted "program" as defined in the regulations. If the entity conducting SBIRT services is not a federally-assisted program, then the SBIRT services and patient records generated by such services would not be covered under 42 CFR Part 2, although HIPAA and state laws may apply. However, if the entity or unit within a general medical care facility conducting the SBIRT services is a federally-assisted program under Part 2, then the SBIRT patient records would be subject to Part 2 regulations.

See FAQ Number 10 of these FAQs for a discussion of the definition of a program under 42 CFR Part 2.

Q12. What is Part 2's relationship to State laws?

A12. 42 CFR § 2.20, states that "no State law may authorize or compel any disclosure prohibited by these [Part 2] regulations." However, States may impose additional confidentiality protections. Thus, § 2.20 provides that, "If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law."

Q. 13. Would a logon or splash page notification on an HIO's portal that contains the Part 2 notice prohibiting redisclosure be sufficient to meet Part 2's requirement that disclosures made with patient consent be accompanied by such a statement?

A13. No. Part 2 requires each disclosure made with written patient consent to be accompanied by a written statement that the information disclosed is protected by federal law and that the recipient cannot make any further disclosure of it unless permitted by the regulations (42 CFR § 2.32). A logon page is the page where a user logs onto a computer system; a splash page is an introductory page to a web site. A logon or splash page notification on a HIO's portal including the statement as required by § 2.32 would not be sufficient notification regarding prohibitions on redisclosure since it would not accompany a specific disclosure. The notification must be tied to the Part 2 information being disclosed in order to ensure that the recipient of that information knows that specific information is protected by Part 2 and cannot be redisclosed except as authorized by the express written consent of the person to whom it pertains or as otherwise permitted by Part 2.

Q 14. If a Part 2 program has signed QSOAs with two service providers, can those services providers redisclose Part 2 information to each other?

A14. No. A QSOA is a two-way agreement between a Part 2 program and the entity providing the service, for example a lab. The QSOA authorizes communication only between the Part 2 program and QSO. The QSO, in this case the lab, would not be allowed to redisclose lab results about the Part 2 program's patient to another QSO such as an HIO, even if the HIO has also signed a QSOA with the Part 2 program. In order for the lab to redisclose Part 2 patient information to the HIO, it would need the patient's signed Part 2 consent or be otherwise permitted by Part 2. One consent form could both authorize the Part 2 program to disclose information to the lab, and authorize the lab to redisclose Part 2 information to the HIO. Once the HIO obtains the lab results it could, through the QSOA it signed with the Part 2 program, send those results to the Part 2 program, assuming that was a service described in the QSOA.

Q15. If an HIO has a QSOA with a Part 2 program and a patient signs a consent allowing a HIO affiliated provider to gain access to the patient's records through the HIO, does that patient consent allow the HIO to disclose the Part 2 information?

A15. Yes, as long the consent form signed conforms to the requirements of Part 2. (See previously issued FAQ number 11 published by SAMHSA and ONC in 2010 for a list of the required

elements of a patient consent under Part 2: http://www.samhsa.gov/healthprivacy/docs/EHR-FAQs.pdf). A QSOA does not allow a QSO such as an HIO to redisclose Part 2 information to a third party, except to a contract agent of the HIO if it needs to do so in order to provide the service(s) described in the QSO. However, if a patient signs a consent form authorizing the HIO, which has received the disclosed information from the Part 2 program, to redisclose the Part 2 information to a HIO affiliated member, then the Part 2 information can be redisclosed by the HIO.

Part 2's consent provision requires that a consent form include the "specific name or general designation of the program or person permitted to make the disclosure" [42 CFR Part 2, § 2.31(a)(1)]. In the case where Part 2 information is made available to an HIO, whether through a QSOA or written patient consent, the consent form allowing the HIO to redisclose the Part 2 information must identify by name or general designation the Part 2 program(s) as the entity permitted to make the disclosure of the Part 2 information. This is because, while the HIO is redisclosing the Part 2 information, the disclosing entity remains the Part 2 program. The consent can also name the HIO as a redisclosing party.

As noted above, the disclosing Part 2 program may be identified either by its specific name or by "general designation". Language such as "all programs in which the patient has been enrolled as an alcohol or drug abuse patient" would be an acceptable general designation.

Q16. Under Part 2, can an HIO or HIO affiliated member use a consent form that generally designates the entities permitted to make disclosures of Part 2 information, and refers to the HIO's website for a list of those disclosing entities?

A16. Yes, the consent form can refer to the HIO's website for the list of entities permitted to make disclosures if the *disclosing entity* is identified by a "general designation" in the consent form as permitted under Part 2. Part 2's consent provisions allow either the "name or general designation of the program or person permitted to make the disclosure" to be specified on the consent form. Because a general designation is permitted, if such general designation is used, then the specific names of those disclosing entities do not need to be included on the consent form and patients can be referred to the HIO's website for a list of those entities.

This is in contrast to Part 2's consent provision regarding *recipients* of Part 2 data. 42 CFR §2.31(a)(2) requires that a consent form include "the name or title of the individual or the name of the organization to which disclosure is to be made." Thus, as was previously noted in previously issued FAQ number 18 published by SAMHSA and ONC in 2010 **(**http://www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf**),** Part 2 consents cannot refer patients to the HIO's website for a list of potential recipients of their data but rather must identify within the consent all the HIO affiliated members by name or title that are potential recipients of the Part 2 data. Therefore, a new consent form (e.g. by the additional Part 2 program or the HIO) would be required when a new recipient of the information is added.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

Screening for Depression

Medicare | PREVENTIVE SERVICES

ICN 907799 June 2012

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Table of Contents

The Centers for Medicare & Medicaid Services (CMS) recognizes the crucial role that health care providers play in educating Medicare beneficiaries about potentially life-saving preventive services and screenings, and in providing these services. While Medicare pays for a variety of preventive benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare beneficiaries understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life. This booklet can help you communicate with your beneficiaries about Medicare-covered screening for depression in adults, as well as assist you in correctly billing for these services.

Overview

Among persons older than 65 years, one in six individuals suffers from depression. Depression in older adults is estimated to occur in 25 percent of those with other illnesses, including:

- Cancer,
- Arthritis,
- Stroke,
- Chronic lung disease, and
- Cardiovascular disease.

Removal of Barriers to Preventive Services Under the Affordable Care Act

Medicare waives the coinsurance or copayment and deductible for those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population, and that are appropriate for the individual.

Older adults have the highest risk of suicide of all age groups. These beneficiaries are important in the primary care setting because 50 to 75 percent of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39 percent were seen during the week prior to their death. Symptoms of major depression that beneficiaries feel nearly every day include, but are not limited to:

- Feeling sad or empty,
- Less interest in daily activities,
- Weight loss or gain when not dieting,
- Less ability to think or concentrate,
- Tearfulness,
- Feelings of worthlessness, and
- Thoughts of death or suicide.

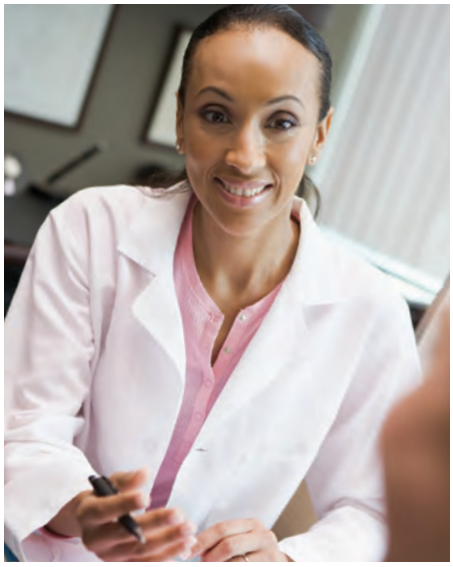
Stand Alone Benefit

The screening for depression in adults benefit covered by Medicare is a stand alone billable service. It is a separate service from the Initial Preventive Physical Examination (IPPE) or the Annual Wellness Visit (AWV), although it can be provided at the same time as the IPPE or AWV.

Coverage Information

Effective for dates of service on or after October 14, 2011, Medicare Part B covers **annual** (i.e., at least 11 months after the most recent screening for depression) screening up to 15 minutes for depression screening for Medicare beneficiaries in primary care settings when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. At a minimum level, staff-assisted supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care setting who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment.

Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting.



Screening for depression is non-covered when performed more than one time in a 12-month period (i.e., at least 11 months after the most recent screening for depression). In addition, self-help materials, telephone calls, and web-based counseling are not paid separately by Medicare and are not part of this national coverage determination.

Primary Care Setting Defined

For purposes of this covered service, a primary care setting is defined as one in which there is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with beneficiaries, and

practicing in the context of family and community. CMS does not consider the following as primary care settings under this definition:

- Ambulatory surgical centers,
- Emergency departments,
- Hospices,
- Independent diagnostic testing facilities,
- Inpatient hospital settings,
- Inpatient rehabilitation facilities, and
- Skilled nursing facilities.

Medicare covers screening for depression when services are furnished in the following places of service:

- An office,
- An outpatient hospital,
- An independent clinic, or
- A state or local public health clinic.

Frequency

When calculating frequency to determine the annual period, 11 full months must elapse following the month in which the last annual depression screening took place.

EXAMPLE: A beneficiary gets a screening for depression in January 2012. The count starts February 2012. The beneficiary may get another screening for depression in January 2013.

Coinsurance or Copayment and Deductible

The beneficiary pays nothing (no coinsurance or copayment and no Medicare Part B deductible) for this screening service if conditions of coverage are met. However, if a beneficiary sees a non-participating physician, there could be a charge.

Documentation

Medical records must document that all coverage requirements are met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) code, listed in Table 1, to report screening for depression in adults.

Table 1. HCPCS Code for Screening for Depression in Adults

HCPCS Code	Code Descriptor
G0444	Annual depression screening, 15 minutes

Diagnosis Requirements

Although you must report a diagnosis code on the claim, Medicare does not require a specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code for screening for depression in adults. Contact your local Medicare Contractor for further guidance.

Coming Soon!
International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)

For more information, visit http://www.cms.gov/Medicare/Coding/ICD10 on the CMS website.

Billing Requirements

Billing and Coding Requirements When Submitting Professional Claims

When you submit professional claims to carriers or A/B Medicare Administrative Contractors (MACs), report the appropriate HCPCS code and the corresponding ICD-9-CM diagnosis code

in the X12 837-P (Professional) electronic claim format. You must also include Place of Service (POS) codes on all professional claims, to indicate where you provided the service. For more information on POS codes, visit http://www.cms.gov/Medicare/Coding/place-of-service-codes on the CMS website.

NOTE: If you qualify for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, you may use Form CMS-1500 to submit these claims on paper. All providers must use Form CMS-1500, version 08-05, when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html on the CMS website.

Electronic Claims Requirements

ASCA requires providers to submit claims to Medicare electronically, with limited exceptions. For more information about the electronic formats, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims.html on the CMS website.

Billing and Coding Requirements When Submitting Institutional Claims

When you submit institutional claims to Fiscal Intermediaries (FIs) or A/B MACs, report the appropriate HCPCS code, revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837-I (Institutional) electronic claim format.

NOTE: If an institution qualifies for an exception to the ASCA requirement, it may use Form CMS-1450 to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html on the CMS website.

Types of Bill (TOBs) for Institutional Claims

The FI or A/B MAC pays for screening for depression in adults when submitted on the following TOBs, listed in Table 2. For further guidance on the appropriate revenue code, contact your local Medicare Contractor.

Table 2. Facility Types and TOBs for Screening for Depression in Adults

Facility Type	TOB
Hospital Outpatient	13X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	77X
Critical Access Hospital (CAH)	85X

Additional Billing Instructions for FQHCs and RHCs

The professional component of preventive services is within the scope of covered FQHC or RHC services. The professional component is a physician's interpretation of the results of an examination. For instructions on billing the professional component, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1039.pdf on the CMS website.

The technical component is services rendered outside the scope of the physician's interpretation of the results of an examination. If you perform technical components or services, not within the scope of covered FQHC or RHC services, in association with professional components, how you bill depends on whether the FQHC or RHC is independent or provider-based:

- **For Provider-Based FQHCs or RHCs:** Bill the technical component of the service on the TOB for the base provider and submit to the FI or A/B MAC in the 837-I format. For more information on billing instructions for provider-based FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website and choose the appropriate chapter based on your facility type.
- **For Independent FQHCs or RHCs:** Bill the technical component of the service to the carrier or A/B MAC in the 837-P format. For more information on billing instructions for independent FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf on the CMS website.


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

Form Approved
OMB No. 0938-0626

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Authorization

☐ Revision to Current Authorization

☐ Check here if EFT payment is being made to

Payment Information

Professional Claims

When you bill your carrier or A/B MAC, Medicare pays for screening for depression in adults under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all screenings for depression.

Providers Must Use EFT

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data, or revalidating enrollment must use Electronic Funds Transfer (EFT) to get payments. For more information about EFT, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EFT.html on the CMS website.

Institutional Claims

When you bill your FI or A/B MAC, Medicare payment for screening for depression in adults depends on the type of facility providing the service. Table 3 lists the type of payment that facilities get.

Table 3. Facility Payment Methods for Screening for Depression in Adults

Facility Type	Basis of Payment
Hospital Outpatient*	Outpatient Prospective Payment System (OPPS)
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

* Medicare pays Maryland hospitals for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

Reasons for Claim Denial

Medicare may deny coverage of screening for depression in adults in several situations, including:

- The beneficiary got more than one screening for depression in the last 12 months.
- The beneficiary got the screening for depression outside of the primary care setting.

You may find specific payment decision information on the Remittance Advice (RA). The RA includes Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. For the most current listing of these codes, visit http://www.wpc-edi.com/reference on the Internet. You can obtain additional information about claims from your carrier, FI, or A/B MAC.

Medicare Contractor Contact Information

For carrier, FI, or A/B MAC contact information, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

RA Information

For more information about the RA, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html on the CMS website.

Resources

For more information about screening for depression in adults, refer to the resources listed in Tables 4 and 5. For educational products for Medicare Fee-For-Service health care professionals and their staff, information on coverage, coding, billing, payment, and claim filing procedures, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html on the CMS website, or scan the Quick Response (QR) code to the right with your mobile device.

Table 4. Provider Resources

Resource	Website
CMS Beneficiary Notices Initiative (BNI)	http://www.cms.gov/Medicare/Medicare-General-Information/BNI
"CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf
"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 190	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
Medicare Learning Network (MLN) Matters® Article MM7637, "Screening for Depression in Adults"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7637.pdf
"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.9	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf
Medicare Preventive Services General Information	http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo

Table 4. Provider Resources (cont.)

Resource	Website
MLN Guided Pathways to Medicare Resources	The MLN Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about preventive services, refer to the "Coverage of Preventive Services" section in the "MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.
MLN Matters® Articles Related to Medicare-covered Preventive Benefits	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf
MPFS	http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched
OPPS	http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalOutpatientPPS
USPSTF Screening for Depression in Adults Recommendations	For a summary of the USPSTF written recommendations on screening for depression in adults, visit http://www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm on the Internet.

Table 5. Beneficiary Resources

Resource	Website/Contact Information
Manage Your Health – Preventive Services	http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx
"Medicare & You: Stay Healthy with Medicare's Preventive Benefits" Video	http://www.youtube.com/watch?v=mBCF0V4R4A0&feature=relmfu
Medicare Beneficiary Help Line and Website	Telephone: Toll-Free: 1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: 1-877-486-2048 Website: http://www.medicare.gov
Medicare Depression Screenings	http://www.medicare.gov/navigation/manage-your-health/preventive-services/depression-screenings.aspx
"Publications for Medicare Beneficiaries"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf

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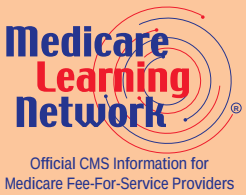

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo on the CMS website.

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Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

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¿Cuál es mi Puntaje de Experiencias Infantiles Adversas (ACE)?

Antes de cumplir 18 años:

1. Alguno de sus padres u otros adultos en su casa **con frecuencia o con mucha frecuencia**…
   La/o ofendían, la/o insultaban, la/o menospreciaban, o la/o humillaban?
   o
   Actuaban de tal forma que temía que le fueran a lastimar físicamente?
   Si No Si la respuesta es SI anote 1_____
2. Alguno de sus padres u otros adultos en su casa **con frecuencia o con mucha frecuencia**…
   La/o empujaban, la/o jalaban, la/o cacheteaban, o le aventaban cosas?_
   o
   Alguna vez la/o golpearon con tanta fuerza que le dejaron marcas o la/o lastimaron?__
   Si No Si la respuesta es SI anote 1_____
3. Algún adulto o alguna otra persona por lo menos 5 años mayor que usted **alguna vez**…
   La/o tocó o acarició indebidamente o le dejo que le tocara el cuerpo de alguna forma sexual?
   o
   Intentó tener relaciones sexuales orales, anales o vaginales con usted?
   Si No Si la respuesta es SI anote 1_____
4. Se sentia usted **con frecuencia o con mucha frecuencia** que…
   Nadie en su familia la/o quería o pensaba que usted era especial o importante? o
   En su familia no se cuidaban unos a los otros, no sentían que tenían una relación cercana, o no se apoyaban unos a los otros?__
   Si No Si la respuesta es SI anote 1_____
5. Se sentía usted con **frecuencia o con mucha frecuencia** que…
   No tenía suficiente comida, tenía que usar ropa sucia, o no tenía nadie que lo protegiera?
   o
   Sus padres estaban demasiado borrachos o drogados para cuidarla/o o llevarla/o al medico si es que lo necesitaba?
   Si No Si la respuesta es SI anote 1_____
6. Alguna vez perdió un padre o una madre biológico(a) debido a divorcio, abandono, o alguna otra razón?
   Si No Si la respuesta es SI anote 1_____
7. Fue su madre o madrastra:
   Con **frecuencia o con mucha frecuencia** la/o empujaban, jalaban, golpeaban, o aventaban cosas? o
   A veces, con frecuencia, o con mucha frecuencia le pegaban, la/o mordían, la/o daban puñetazos, o la/o golpeaban con algún objeto duro? o
   Alguna vez la/o golpearon durante varios minutos seguidos o la amenazaron con una pistola o un cuchillo?
   Si No Si la respuesta es SI anote 1_____
8. Vivió usted con alguien que era borracho o alcohólico, o que usaba drogas?
   Si No Si la respuesta es SI anote 1_____
9. Algún miembro de su familia sufría de depresión o enfermedad mental, o alguien en su familia trató de suicidarse?
   Si No Si la respuesta es SI anote 1_____
10. Algún miembro de su familia fue a la cárcel?
    Si No Si la respuesta es SI anote 1_____

Ahora sume las respuestas en que anoto "SI."_____
Esta es su Puntaje de Experiencias Infantiles Adversas (ACE)

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SBIRT

A Resource Toolkit for Behavioral Health Providers to Begin the Conversation with Federally Qualified Healthcare Centers

Table of Contents

The Opportunity

This guide is written for Behavioral Health Providers seeking to engage their local FQHC/CHC to begin the conversation on implementing SBIRT. Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Partnering in an SBIRT project provides the opportunity to begin the early step toward a model of service integration. SBIRT is part of a larger shift toward a public health model for addressing problems related to behavioral health (Mental Health, Substance Abuse, Co-occurring). In the future, substance abuse treatment, mental health, primary care, and related services will be increasingly integrated in an effort to reach more people and provide them with a more seamless recovery-oriented system of care. As the shift occurs behavioral health professionals will be called upon to work collaboratively with primary care and other settings where services such as SBIRT and medication-assisted treatment are being offered (NFATTC Addiction Messenger, 2010).

The Affordable Health Care for America Act - HR 3962 will have a profound effect on the funding and delivery of behavioral health services. On the horizon, the expected increase in Medicaid enrollment will challenge the service delivery system. As an example, the mission of the public health departments is to provide public health models. Thus, states may be shifting primary care services from county public health units to Federally Qualified Healthcare Centers (FQHCs) and/or Community Health Centers (CHCs). According the National Association of Community Health Centers, “Spread across 50 states and all U.S. territories, there are 1,250 Community Health Centers that provide vital primary care to 20 million Americans with limited financial resources” (p. 1). It is clear that a momentum is building toward health/behavioral health integration as a method to improve outcomes and efficiency. Payment methods, fee structure, and the sharing of health information are only a small example of the complexities involved as the provisions of the act unfold over the next several years. The development of an integrated model provides the opportunity of mutually beneficial relationship that reduces the treatment cost for the FQHC by addressing patients’ behavioral health needs while increasing the number of referred to the behavioral health provider.

The Panel

Experts from the state and federal government, health, behavioral health, and education were consulted in the creation of this guide. We would like to thank the following individuals for their contributions to this guide:

- **Edward Bernstein MD: Professor and Vice Chair for Academic Affairs Department of Emergency Medicine Boston University School of Medicine, Professor Community Health Sciences and Director of the BNI-ART Institute, Boston University School of Public Health**

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  Darran M. Duchene: Section Chief, Substance Abuse Services Project Director, Access to Recovery Program Project Director, BRITE Program State Methadone Authority Substance Abuse/Mental Health Program Office

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- **Raul Gordillo, Psy.D., C.A.P., C.M.H.P: Behavioral Health Supervisor Elderly and Veterans Services**

- **Robert W. Hazlett, Ph.D., CAC, CCS: Department of Children & Families (Florida)**

- **J. Aaron Johnson: Department of Family Medicine, Medical Center of Central Georgia & Mercer University School of Medicine**

- **Neil Kaltenecker: Executive Director, The Georgia Council On Substance Abuse**

- **Pam Peterson-Baston, MPA, CAP, CPP: Solutions of Substance, Inc.**

- **Pam Waters: Director Southern Coast Addiction Technology Transfer Center**

Why Should I Partner with my Local FQHC?

What is an FQHC?

A **Federally Qualified Health Center** (**FQHC**) is a reimbursement designation referring to several health programs funded under the Health Center Consolidation Act (Section 330 of the Public Health Service Act). Health Centers Consolidation Act of 1996 brought four programs under section 330 of the PHS Act:

- "Neighborhood Health Centers" funded in 1964.
- Congressional authorization of Community Health Centers and Migrant Health Centers: sections 329 and 330 of the Public Health Service Act.
- Authorization of Health Care for the Homeless Program (1987)
- Public Housing Primary Care Programs (1990)

FQHCs:

- Are located in or serve a high need community (designated Medically Underserved Area or Population). FQHC locator: **http://findahealthcenter.hrsa.gov/Search_HCC.aspx**
- Governed by a community board composed of a majority (51% or more) of health center patients who represent the population served.
- Provide comprehensive primary health care services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.
- Provides medical, mental health and dental care to all regardless on their ability to pay -uninsured or underinsured
- Provides services through all the life cycles-prenatal, pediatric, adult and geriatrics.
- Provides enabling services such as pharmacy, transportation, prenatal and family care services, case management and other referrals to other basic needs agency
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

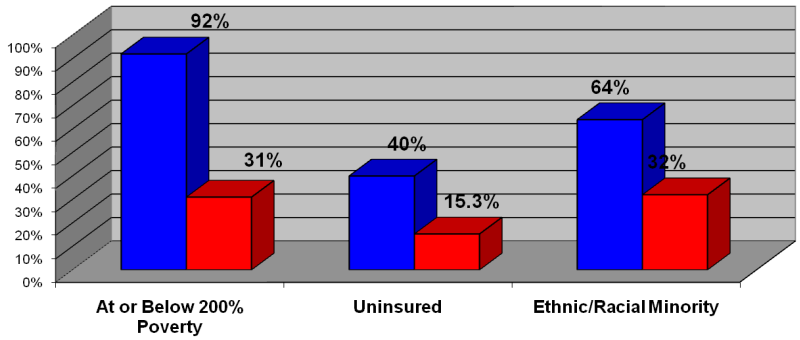
Wikipedia links:

- http://en.wikipedia.org/wiki/FQHC
- Health Center Consolidation Act
- Public Health Service Act). Health programs funded include:
- Community Health Centers
- Medically Underserved Area/Populations (MUA or MUP).
- Migrant Health Centers
- Health Care for the Homeless Programs
- Public Housing Primary Care Programs

Why pick an FQHC? (adapted from Lardiere, (2011): http://www.nachc.com/about-our-health-centers.cfm)

Many of the people you serve may be eligible or already receiving services through a local FQHC. According to the Bureau of Primary Health Care, In 2009, the health center program made the following impact (Lardiere, 2011).

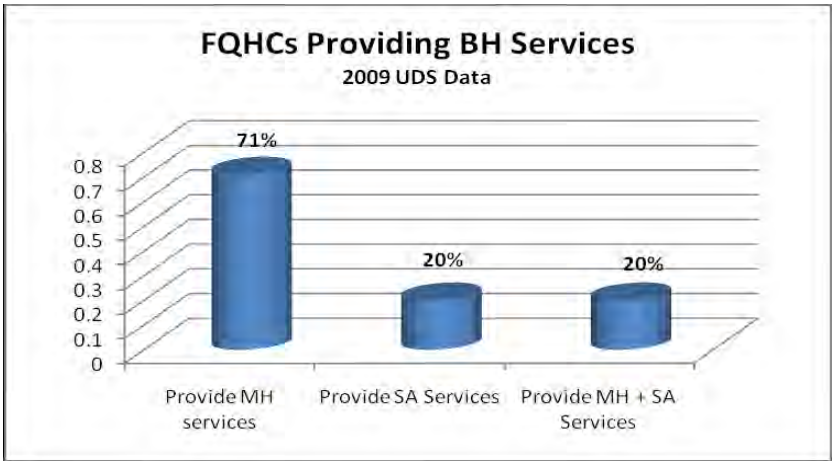
Served 18.8 million patients
92% below 200% poverty
71% below 100% poverty
38% uninsured
1,018,000 homeless individuals
865,000 migrant/seasonal farmworker
165,000 residents of public housing



Provided 74 million patient visits
1,131 grantees - half of which are located in rural areas
7,900+ service sites

Employed more than 123,000 staff
9,100 physicians
5,800 nurse practitioners, physicians assistants, and certified nurse midwives

- 70% of Health Centers Currently Provide Behavioral Health Services.
- 90% of Health Centers Screen for Depression
- 61% Screen for Substance Abuse
- ***However, only 20% of FQHCs provide substance abuse treatment***.



How do I find my local FQHC?
FQHC locator website: **http://findahealthcenter.hrsa.gov/Search_HCC.aspx**

Find a Champion

A good strategy in approaching your local FQHC is finding a person that has the clout and/or credibility to advocate implementing SBIRT. They may be appointed leaders such as elected officials, board members, or executive directors. Or, they may be assumed leaders such as physicians, patients, or consumer rights advocates who know everyone in the community and have the confidence of the community. "Champions are credible community members—whether appointed or assumed leaders—whom you can count upon to speak enthusiastically in support of your program".

Utilizing Champions

With the right amount of ongoing cultivation, champions can help you …

- recruit new members or volunteers
- raise resources
- increase public awareness
- make formal and informal presentations
- spread word-of-mouth recognition
- serve as board or advisory council members
- widen your organization's web of support
- open doors to new relationships for you

How to identify a champion:

To make a list of potential champions, do a group brainstorm of all the key leaders and potential champions in your community.

- Talk to other Behavioral Health Providers in your area to identify local champions.
- Talk to an FQHC that has already successfully implemented SBIRT.
- Recruit a local physician that speaks the language of FQHCs.

Use Six Degrees of Separation:

Inform everyone in your network that you are trying to connect with someone who is a champion for the issues the SBIRT addresses; you will usually find someone who knows someone who knows your target.

Close the Deal:

Design a clear message that lets the potential champion know what your organization is doing for the community and why it is important. If someone who is already involved with your organization knows the key leader you want to approach, have them make the "ask" for that person's support and participation.

Build a Champion for Your Cause

In order for someone to become a true SBIRT champion, you will need to convince the individual of the benefit they will derive from becoming involved in your initiative. Then, you need to give that person a meaningful way to contribute. Determine how SBIRT overlaps with the goals of your potential champions.
* adapted from the Corporation for National & Community Service, 2011

SBIRT Outreach:
Talking Points for Behavioral Health Providers

The talking points are intended to aid the behavioral health provider's initial talks/negotiations with FQHCs. The talking points offer salient arguments that will appeal to FQHC's based on interviews with Primary Care Administrators and Behavioral Health SBIRT Providers. The Optional items may be used but are dependent on the operation practices of the FQHC, the service model of your agency, and/or your choice of integration models (see integration models).

- As a healthcare provider you are already screening for behavioral health issues. If you add a few questions you can bill another Medicaid code. No extra forms needed.

    1. ***(Optional)*** The screening can be provided while patient are awaiting consultation permitting your physicians access to the SBIRT screening results prior to the actual doctor-patient consultation

- Health improvements reduce the costs of treating your patients. SBIRT is an evidence based model that has recognized health improvement benefits.

- Once the screening is complete our agency can take it from there, no extra staff time or resources needed.

    1. If a Behavioral Health Problem is identified the patient can be referred to our agency for treatment or prevention/education activities.

        - There are many models of practice integration we can discuss to seamlessly integrate the referral process with little to no disruption to your current practices

- What can our agency do for you?

    1. Our staff are trained to provide evidence based prevention and treatment of behavioral health issues. We can offer a cost effective method to integrate behavioral health issues into your treatment practice.

    2. We can provide feedback to your physicians resulting in health improvement that reduce treatment cost

    3. The services are at little to no cost to you or your patients

    4. ***(Optional)*** We can work in a single integrated health record. Eliminating the need for additional forms or technology training for your staff as well as immediate access to pertinent treatment information.

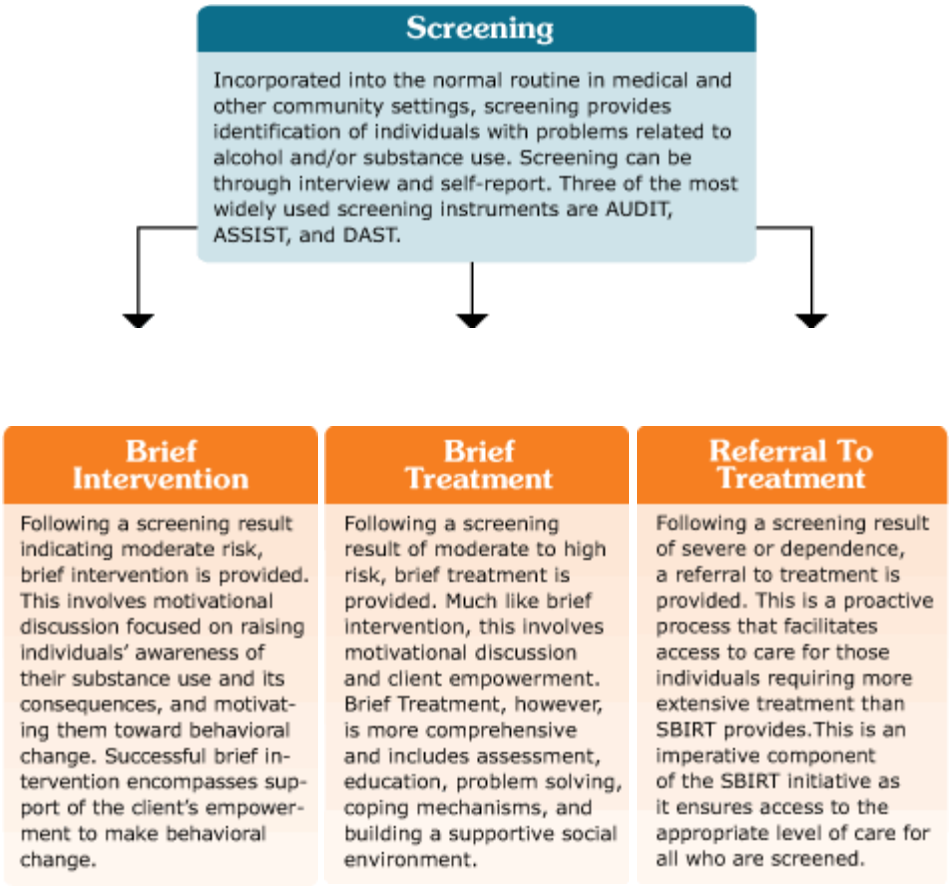
    5. ***(Optional)*** The prevention, education, or intervention service can be provided while the client is waiting for primary care services

Brief Intervention and Treatment

What is it?

As defined by the Substance Abuse and Mental Health Services Administration, SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

- *Screening* quickly assesses for the presence of risky substance use, follows positive screens with further assessment of problem use, and identifies the appropriate level of treatment.
- *Brief intervention* focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- *Referral to treatment* provides those identified as needing more extensive treatment with access to specialty care. SAMHSA Treatment Locator: findtreatment.samhsa.gov/



Adapted from: http://www.sbirt.samhsa.gov/core_comp/index.htm

Brief Intervention: Definition & Resources

Brief intervention comprises a single session, or sometimes multiple sessions, of motivational discussion focused on increasing insight and awareness regarding substance use and motivation toward behavioral change. Brief intervention can be used as a stand-alone treatment for those at-risk, as well as a vehicle for engaging those in need of more intensive specialized care.

- A practice to identify real or potential substance use problems and to motivate an individual to do something about it.
- Non-confrontational, short health counseling technique.
- Not a quick fix treatment.

Manuals and Training

1. Motivational Interviewing http://motivationalinterview.org/

2. (American College of Surgeons Committee on Trauma (COT): Screening and Brief Intervention Training for Trauma Care Providers: http://www.mayatech.com/cti/sbitrain07/

3. Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide http://www.sbirt.samhsa.gov/documents/SBIRT_guide_Sep07.pdf

4. Alcohol Screening and Brief Intervention Curriculum: http://www.bu.edu/act/mdalcoholtraining/index.html

   Free web-based training curriculum geared toward generalist clinicians and developed by the Boston Medical Center.

5. Brief Counseling for Marijuana Dependence: A Manual for Treating Adults: http://kap.samhsa.gov/products/brochures/pdfs/bmdc.pdf

6. National Institute on Alcohol Abuse and Alcoholism Helping Patients Who Drink Too Much: A Clinician's Guide: http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm

7. Ensuring Solutions to Alcohol Problems SBI Implementation Guide for Hospitals: http://www.ensuringsolutions.org/resources/resources_show.htm?doc_id=503275&cat_id=2005

8. BNI ART Institute http://www.ed.bmc.org/sbirt/

Referral to Treatment

Patients identified as needing more extensive treatment than what can be offered through an SBIRT program, referral to a specialized treatment provider may be necessary. Referral to treatment is an integral component of the SBIRT process and necessitates strong collaboration between the SBIRT team and substance abuse treatment providers in the community. Some useful links to treatment resources are provided below.

1. Florida Alcohol and Drug Abuse Association Treatment locator: http://www.fadaa.org/search.cfm

2. Buprenorphine Physician/Treatment Locator: buprenorphine.samhsa.gov/bwns_locator/

3. SAMHSA Treatment Locator: findtreatment.samhsa.gov/

Coding for SBI Reimbursement

Important Medicare Information: SAMHSA is working with the Centers for Medicare and Medicaid Services (CMS) to educate practitioners about the importance of SBIRT coverage and the Medicare billing rules around these services. In the case of Medicare, SBIRT services are defined as alcohol and/or substance (other than tobacco) abuse **structured assessment** (e.g., AUDIT, DAST) and brief intervention. Medicare may not pay for screening services unless specifically required by statute.

The American Medical Association has approved two codes (based on time devoted to the service): 99408 and 99409. Use of these codes requires documentation in the clinical record.

Services provided under codes 99408 or 99409 are separate and distinct from all other Evaluation & Management (E/M) services performed during the same clinical session (ie, date of service). (Modifier -25, indicating an additional separate and distinct E/M service during the same clinical session, may be coded for some health plans.)

A physician or other qualified health professional uses a validated screening instrument (such as the AUDIT or DAST). An intervention is performed when indicated by the score on the screening instrument. The instrument used and the nature of the intervention are recorded in the clinical documentation for the encounter. If an intervention is not required based on the result of the screening, the work effort of performing the survey is included in the selection of the appropriate E/M service. If an intervention is required based on the screening result, the intervention is conducted. Code 99408 is the most likely service level for most patients.

The Centers for Medicare & Medicaid Services created codes for reporting comparable services for Medicare fee-for-service schedule (FFS) patients.

More information can be found at the Medicare Learning Network: http://www.cms.gov/MLNgeninfo/.

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	$48.00

(reprinted from http://www.samhsa.gov/prevention/SBIRT/index.aspx)

About the Project

This guide was created as product of:

In partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment's (CSAT's) Partners for Recovery (PFR) and Addiction Technology Transfer Center (ATTC) Network, an Advanced Leadership Institute was developed. This intense leadership preparation program was designed to cultivate the development of future addiction leaders. A nine month graduate-level leadership program sought to garner the momentum generated by the PFR/ATTC Network Leadership Institute and further the professional development of a select group of leaders. It created an opportunity for participants to take their knowledge, skills, and expertise to the next level where local, state, and national systems change initiatives will be effected.

The PFR/ATTC Network Advanced Leadership Institute was launch in January 2011 with two pilots: Kansas City, Missouri and Washington, DC area.

CORE ELEMENTS

At each pilot site, Associates experienced an extensive set of development experiences, including the core elements of:

- Various assessments based on individual analysis, as well as input from others
- Leadership instruction though an intensive four-day leader development Immersion session
- Team coaching
- A personally relevant professional support network
- Structured knowledge and skill application, along with reflection
- Personal health, revitalization and self-care
- Continued program instruction by means of a Booster session
- System development through relevant application team projects
- Supplemental resource support (Web-based resources and tools)

THE PROJECT TEAM

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CFBHN's Network strives to maximize revenues and improve access to services, as well as the quality of those services, provided by both the individual agencies and throughout the system of care. CFBHN's administrative office in Tampa, Florida maintains departments for program development, quality management, contracting, finance and accounting, billing, management information systems, purchasing and resource management functions, and provider services.

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Director of Development
Penfield Christian Homes, Inc
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Penfield Christian Homes is a Christian recovery program for reclaiming the lives of adult men suffering from addiction to drugs and alcohol. Penfield has been in operation for over thirty years, helping approximately 900 men a year find freedom from addiction and live happy, productive lives through our unique, Christ-centered approach. The men are taught to apply, through the power of Jesus Christ, Biblical principles as expressed in the Twelve Steps of Alcoholics Anonymous. At Penfield Christian Homes, these principles are referred to as Twelve Steps for Successful Christian Living. The ministry of Penfield is rooted in the belief that recovery from the addictive use of alcohol and drugs can be achieved through a personal faith in Jesus Christ.

Laureen Pagel, Ph.D., MS, CAP, CPP, CMHP
CEO
Sutton Place Behavioral Health
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Sutton Place Behavioral Health is a private, not-for-profit agency which is available to provide psychiatric treatment, mental health counseling and substance abuse services for residents of Nassau County, Florida. Sutton Place is dedicated to ensuring that individuals and families receive quality services that are well coordinated, individualized, and cost effective while overall, helping form a system of care that meets the total behavioral health needs of the community we serve. We strive to continually improve the quality of health care we provide and respond to changing community behavioral health needs in collaboration with other community health providers, including private clinicians, family service agencies and other key stakeholders.

Appendices

I. Resources

II. Model Memorandum of Understanding

III. SBIRT: Extended Health Care Questionnaire

Resources

SBIRT

- http://www.adp.cahwnet.gov/SBI/screening.shtml
- http://www.samhsa.gov/prevention/SBIRT/index.aspx

Substance Abuse and Mental Health Services Administration SBIRT Website

- http://www.sbirt.samhsa.gov/index.htm

NIAAA Alcohol Alert on Screening for Alcohol and Alcohol Related Problems

- http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm
  The Alcohol Alert (2005) from the National Institute on Alcohol Abuse and Alcoholism focuses on the use of routine alcohol screening in a variety of medical settings.

NFATTC

- *SBIRT: Part 1 - why screen and intervene?*.
  from http://www.nattc.org/regcenters/index_northwestfrontier.asp
- *Part 2 – breaking the model down*
  from http://www.nattc.org/regcenters/index_northwestfrontier.asp
- *Part 3 – taking it to the field* (13), 9.
  from http://www.nattc.org/regcenters/index_northwestfrontier.asp

NIDAMed

- http://drugabuse.gov/nidamed/

  NIDA Resource Guide: Screening for Drug Use in General Medical Settings
- http://www.nida.nih.gov/nidamed/resguide/

State SBIRT Websites

- Colorado http://www.improvinghealthcolorado.org/about_faqs.php
- Oregon site http://www.sbirtoregon.org/index.php
- Pennsylvania www.ireta.org/sbirt/
- Massachusetts www.mass.gov
- Texas www.utexas.edu/research/cswr/nida/researchProjects/sbirt.html
- Washington www1.dshs.wa.gov/rda/projects/wasbirt.shtm

Project ASSERT

- http://www.ed.bmc.org/assert/assert.htm
- http://sbirt.samhsa.gov/grantees/state.htm

Resources: continued

ACEP project

- http://acepeducation.org/sbi/

SAMHSA's SBIRT Cooperative Agreements

SBIRT Coding for Reimbursement

- www.ireta.org/sbirt/pdf/SBIRT**BillingManual**20100217.doc

- www.sbirt.samhsa.gov/SBIRT/documents/SBIRT_Coding_Chart2.pdf
  SAMHSA's downloadable coding chart

- www.dhfs.state.wi.us/Medicaid/updates/2007/2007-09att16d.htm
  Medicare/Medicaid Health and Behavior Assessment and Intervention Codes

- www.cms.hhs.gov/mlnmattersarticles/downloads/MM5878.pdf
  www.cms.hhs.gov/transmittals/downloads/R1433CP.pdf
  Smoking and Tobacco Use Cessation Counseling Billing Code Update to Medicare

- www.ensuringsolutions.org/resources/resources_show.htm?doc_id=385233
  Ensuring Solutions SBI Reimbursement Guide: Everything You Need to Know to Conduct SBI and Get Paid for It:

FQHCs

- **http://findahealthcenter.hrsa.gov/Search_HCC.aspx**
- **http://www.nachc.com/**

- Lardiere, M., R. (2011). *Federally qualified healthcare centers*. http://www.nachc.com/about-our-health-centers.cfm
- National Association of Community Health Centers (2011). *About our health centers*. http://www.nachc.com/about-our-health-centers.cfm

Primary Care / Behavioral Health Integration

- http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf
- http://www.thenationalcouncil.org/cs/tools_tips

MEMORANDUM OF UNDERSTANDING
BETWEEN

_____

AND

_____

This memorandum of understanding has been developed to establish a collaborative agreement between _____ and_____ Screening Brief Intervention, Referral and Treatment (SBIRT) Initiative in an effort to integrate medical, behavioral health support services.

PURPOSE: This memorandum of understanding serves the following purposes:

- To maximize resources; facilitating effective service integration between _____and_____

- To offer comprehensive screening and support patients; improving their health outcomes

CONSUMER ELIGIBILITY:

_____ persons that meet the follow criteria:

- _____
- _____
- _____

ACTIVITIES:

Screening and Assessment

_____ staff will provide health screening and/or assessments to _____patients. Screening will be offered on a voluntary basis.

Follow-up

If a patient exibits behavioral health risk and/or symptoms as determined through the screening and assessment process, _____ staff will provide appropriate follow-up. Follow-up may include, but not be limited to, information and referral, brief educational intervention and post discharge follow-up as appropriate.

Communication Plan

On an ongoing and as needed basis, _____ and _____ staff will communicate with one another regarding the initiative and patient progress. This communication can be initiated by either party and will be conducted to ensure continuity of care. Furthermore, both agencies will ensure that they keep each other informed of updated relevant consumer information.

Both agencies will obtain the appropriate signed consent from consumers to share protected health information across agencies in an effort to provide continuity of consumer care and HIPAA compliance.

LIAISONS:

_____ _____

_____ _____

_____ _____

This memorandum can be updated, revised, amended and/or terminated at the request of either agency.

SIGNATURE

_____ _____

Date

_____ _____

Date

Health Care Agency's Logo

Extended Health Care Questionnaire

We are aware that even a small amount of alcohol or use of prescription and/or over the counter medications, as well as illicit drugs, can effect the treatment that the doctor will prescribe for you, or may interfere with medications that he/she may prescribe. Therefore the questions below are to assist the doctor in providing the best care possible and your participation in completing this questionnaire is greatly appreciated.

On average how many days per week do you drink alcohol? _____

On a typical day when you drink, how many drinks do you have? _____

What is the maximum number of drinks you had on any given day in the past month? _____

In the last year have you tried to cut down on the drugs or medications that you use?

Yes _____ No _____

In the past year have you used prescription or other drugs more than you meant to?

Yes _____ No _____

During the past month have you often been bothered by feeling down, depressed or hopeless?

Yes _____ No _____

During the past month have you ever been bothered by little interest or pleasure doing things?
Yes _____ No _____

(Please circle answer) **Date of Birth: __/__/_____**

Race: W AA Asian Indian Native Hawaiian/Pacific Islander Other _____

Are you Hispanic or Latino? Yes No (If yes, please circle one below)
Cuban, Puerto Rico, Central America, Mexican
Dominican, South American, Other _____

Age ____ Gender: M F Print Name: _____

Are you a Veteran? Yes No **Last 4 digits of SS# ___ ___ ___ ___**

Are you a family member of a Veteran? Yes No

Quick Guide

For Clinicians

Based on TIP 24

A Guide to Substance Abuse Services for Primary Care Clinicians

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

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Alcohol Screening and Brief Intervention

A guide for public health practitioners

American Public Health Association

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Written by Anara Guard and Laurie Rosenblum, Health and Human Development Programs, Education Development Center, Inc.

Project Coordinator: Mighty Fine, American Public Health Association

We appreciate the contributions of Dan Hungerford, Centers for Disease Control and Prevention.

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Overview of SBI and This Manual

Screening and brief intervention (SBI) is a structured set of questions designed to identify individuals at risk for alcohol use problems, followed by a brief discussion between an individual and a service provider, with referral to specialized treatment as needed. Screening asks several questions to determine whether individuals are misusing alcohol—that is, are they drinking too much, too often, or experiencing harm from their drinking. The provider evaluates the answers and then shares the results and their significance with the individual.

Brief interventions are counseling sessions that last 5 to 15 minutes. Their purpose is to increase the person's awareness of his or her alcohol use and its consequences and then motivate the person to either reduce risky drinking or seek treatment, if needed. The provider works with the person on willingness and readiness to change his or her drinking behavior.

Screening and brief intervention:

- **is designed for use by service providers who do not specialize in addiction treatment**
- **uses motivational approaches based on how ready the person is to change behavior**
- **gives feedback and suggestions respectfully in the form of useful information, without judgment or accusations**
- **has been shown by research to be effective in reducing alcohol use and alcohol-related adverse consequences, including injury**

The purpose of this manual is to provide public health professionals, such as health educators and community health workers, with the information, skills, and tools needed to conduct SBI so that they can help at-risk drinkers reduce their alcohol use to a safe amount or stop drinking. Using this effective intervention to reduce risky drinking can help improve the health of individuals and communities by preventing the range of negative outcomes associated with excessive alcohol use: injuries and deaths, including from motor vehicle crashes; social problems, such as violence; physical and mental illnesses; and employment, relationship, and financial problems.

This manual provides background information and practical steps for conducting SBI in a variety of public health settings, including trauma centers, emergency departments, other clinical settings, home visits, and public events. The manual provides brief descriptions of the problems associated with alcohol misuse, types of alcohol use, value of a public health approach in addressing alcohol problems, history and effectiveness of SBI, and key issues in screening and brief intervention. Guidance is given on choosing a screening tool and conducting screening. The four main steps in conducting brief interventions are described, including the purpose of each step, what to do, and suggestions for what to say. Also included is information on the most commonly used screening tools, a handout for clients, and a list of additional resources.

Alcohol Problems and Their Impact

The Numbers and Impact

Alcohol is the most commonly used drug in the United States and a leading cause of illness and death.[1] Nearly 3 out of 10 American adults drink in a risky way, ranging from occasional binge drinking to daily heavy drinking.[2] "Binge drinking" is defined as five or more drinks within two hours for men and four or more drinks within two hours for women on at least one day in the past 30 days.[3] "Heavy drinking" means consuming five or more drinks on the same occasion on each of five or more days in the past 30 days.

Results from the 2006 National Survey on Drug Use and Health[4] show that alcohol misuse is a problem across the lifespan. It increases during late adolescence, reaching a peak between the ages of 21 and 25 with 46.1% of this age group engaging in binge drinking. Binge drinking and heavy alcohol use then decrease over the adult years. Driving under the influence of alcohol increases to a peak of 27.3% of all young people ages 21-25, and then decreases with increasing age. Each year an average of 3.5 million people ages 12 to 20 have an alcohol use disorder (abuse or dependence).[5]

Risky drinking can have a negative impact on many areas of life. In addition to its impact on individuals' general health and personal life, alcohol use is a factor in many injuries, including 40-50% of fatal motor vehicle crashes, 60-70% of homicides, 40% of suicides, 60% of fatal burn injuries, 60% of drownings, and 40% of fatal falls.[6] According to the National Highway Traffic Safety Administration (NHTSA), there were 17,602 deaths in 2006 caused by alcohol-related motor vehicle crashes, which is more than 41% of all motor vehicle crash deaths.[7] Of these deaths, 13,470 involved a driver or motorcycle rider whose blood alcohol concentration (BAC) exceeded the legal limit.

Types of Alcohol Use

Many different terms are used to describe drinking behavior, and there is no absolute consensus on which ones to use. "Abstaining" usually means drinking no alcohol at all. However, in some studies, it can mean drinking 12 or fewer drinks per year and not drinking over daily or weekly maximum limits. "Low risk" use usually refers to drinking within recommended guidelines and is not likely to cause problems.

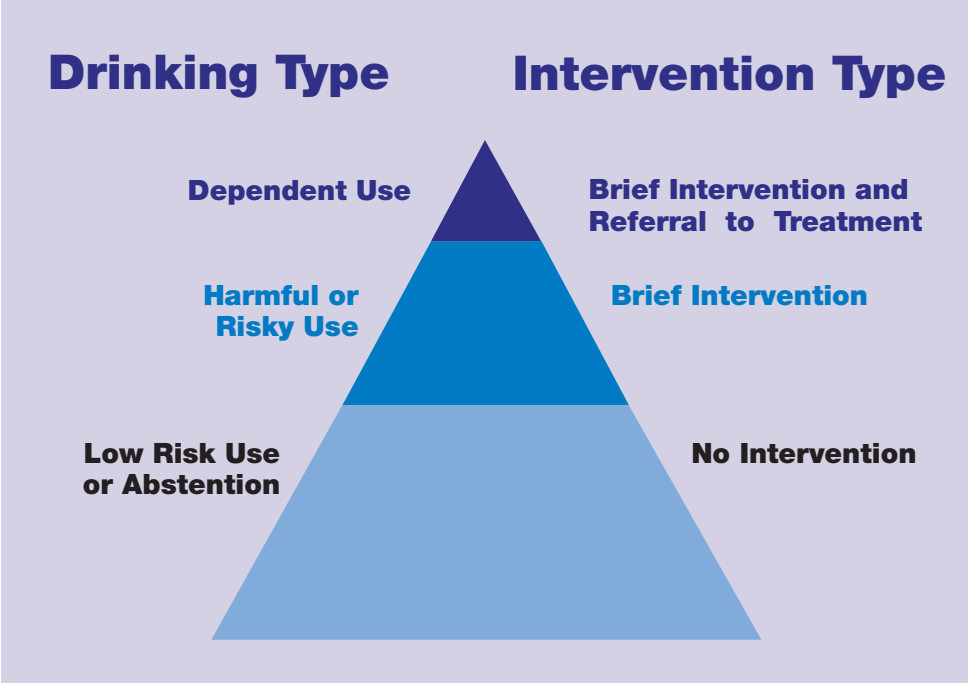
The terms "risky use" and "harmful drinking" refer to drinking amounts that ***increase the risk of causing*** serious problems and amounts that ***actually cause*** serious problems. These problems include motor vehicle crashes, physical health and/or mental health problems, violence, injuries, unsafe sex, and serious issues in areas of life such as work, school, family, social relationships, and finances. Some literature also uses the term "hazardous drinking" for drinking that runs the risk of causing serious problems.

"Alcohol dependence" means the person is physically dependent on alcohol. Diagnosis generally requires three or more of these symptoms within a 12-month period:

- **A great deal of time spent in obtaining, using, or recovering from use of alcohol**
- **Difficulty controlling drinking, i.e. persistent desire to drink or unsuccessful attempts to cut down on drinking**
- **Physical withdrawal symptoms when alcohol use is stopped or decreased, or drinking to relieve withdrawal symptoms**
- **Tolerance: increased amounts of alcohol are required to achieve the same effects**

- **Giving up or reducing important activities because of alcohol use**
- **Drinking more or longer than intended**
- **Continued use despite recurrent psychological or physical problems.**[8]

The pyramid below shows the percentage of the U.S. population that makes up each of the main types of alcohol use described above. Although many people think of treatment as the remedy for alcohol problems, there are six times as many people who have alcohol problems as there are alcoholics or alcohol-dependent people. Efforts to address only those with dependence miss the vast majority of people with alcohol problems. An individuals' alcohol use may change over time as they age and as their life circumstances change. This is why it is important to assess individuals for alcohol use on a regular basis throughout their lifetime.



Source: Substance Abuse and Mental Health Services Administration. (2006) Results from the 2005 National Survey on Drug Use and Health: National findings Rockville (MD): Office of Applied Studies

To determine the most appropriate intervention, it is also important to look at the person's pattern of drinking. Some people drink very large amounts regularly and have developed increased tolerance for alcohol but may not display significant problems. However, excessive drinking over the long term can lead to chronic health problems, such as liver damage, certain types of cancer, and mental health problems. Other people binge drink, consuming large amounts on particular occasions but not more than recommended amounts on a regular basis.

Since SBI is most effective in addressing risky and harmful drinking, this manual primarily focuses on these behaviors. Low-risk drinking is also addressed since a brief intervention following a screening is a good opportunity to educate low-risk drinkers about risky drinking so that they will maintain their drinking at a safe level. Treatment of alcohol dependence is done most effectively through longer term interventions, so it is not discussed in this manual other than to refer individuals to other forms of treatment.

Why a Community-Based Public Health Response to Risky Drinking

Risky drinking can result in problems that create costs for the individual drinkers, their families and entire communities. Communities are affected financially by the increase in health care, public safety, and social service costs, and emotionally by the increase in illness, disability, and death. SBI can help reduce these costs and improve the health of communities.

Many people who have an alcohol use disorder do not seek treatment, often because they do not realize they have a problem.[9] Other individuals may not have a diagnosable disorder but may be at risk for alcohol-related problems. Health care settings provide a good opportunity to address alcohol problems, but some people do not have access to regular health care. And even among those who do, their drinking problems may not be detected if no one asks or when their symptoms are attributed to another cause, such as stress or aging.

SBI can take place in many settings beyond health care. If community-based public health professionals, such as health educators and community health workers, were trained in SBI and screened their clients, more risky drinkers who currently are not reached by the health care system and are untreated would receive brief interventions. The National Highway Traffic Safety Administration is also exploring the workplace as a setting to reach people who may be at risk but are not seeing health care providers.

Background and Effectiveness of SBI

Background on SBI

The first research studies of SBI were conducted more than 40 years ago. However, it was not until effective assessments of alcohol use were developed in the 1980s that SBI became a useful public health strategy for addressing alcohol misuse.

Early screening tools, such as the Michigan Alcohol Screening Test (MAST) and the Cut-down, Annoyed, Guilty Eye-Opener (CAGE), were developed to detect alcohol dependence and refer to treatment. Swedish research showed that more systematic screening along with brief interventions in primary care settings could reach large numbers of at-risk drinkers and help them reduce their alcohol use.[10] These findings led the World Health Organization (WHO) to start a program in 1981 to develop an internationally valid screening tool and study the effectiveness of brief interventions for at-risk drinkers.[11] The result was the Alcohol Use Disorders Identification Test (AUDIT)[12] and the first study of effectiveness of brief intervention across different countries.[13] The WHO program then expanded to study ways to implement SBI in primary care settings and to develop national plans to integrate SBI into the health care systems of developed and developing nations.[14]

Currently, there are large-scale SBI programs in Brazil, South Africa, Europe and the U.S. The Substance Abuse and Mental Health Services Administration (SAMHSA), through its Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, conducts science-based demonstration projects across the country that assess and disseminate information on new SBI methods.

Effectiveness of SBI

Several systematic reviews have shown that SBI is effective:

- **in helping at-risk drinkers. Drinkers who are alcohol dependent typically need more intensive treatment.**
- **in helping both men and women, including pregnant women.**
- **with a wide age range, including adolescents, adults, and older adults.**
- **in both primary care and emergency department settings.**

Since at-risk drinkers make up a large percentage of all drinkers, SBI can have a very significant impact on improving the health of the population as a whole. Large numbers of people can be helped to reduce risky drinking or to maintain their drinking at safe levels by just one or a few brief meetings with a provider.

A key review published in 2002, showed small decreases in hazardous drinking 6 to 12 months after SBI among people who had not sought alcohol treatment. Among people who did seek treatment, SBI was as successful as the more intensive types of treatment.[15]

A 2004 review of SBI demonstrated the effectiveness of brief interventions in adult primary care.[16] The U.S. Preventive Services Task Force found that 6 to 12 months after brief counseling (up to 15 minutes and at least one follow-up contact), the participants had decreased their average number of drinks per week by anywhere from 13% to 34%. The percentage of participants drinking at safe or moderate levels was 10 % to 19% greater than among those who did not receive the brief

intervention. The brief interventions were effective with people from 17 to 70 years old. Based on this review, the U.S. Preventive Services Task Force wrote a recommendation statement supporting the use of brief interventions in adult primary care.[17] An article in 2004 showed similar positive outcomes for SBI in primary care among both men and women.[18] A review in 2002 covering individuals ages 12 to 70 recommended SBI for use in emergency departments.[19]

A recent report on findings from SAMHSA's SBIRT program[20] also shows that large numbers of people who are at risk of developing serious alcohol problems can be identified through screening. The combination of screening, brief intervention, and referral to treatment can decrease the frequency and severity of alcohol use and increase the percentage of people who obtain the specialized treatment they need.

The cost-effectiveness of SBI has been shown in several countries.[21] SBI does not require investments in extensive training, expensive instruments or lengthy amounts of time to conduct. One study in physician offices showed that SBI not only led to significant decreases in alcohol use but also to a decrease in hospital days and emergency department visits.[22] The cost of the intervention was $205 per person; it saved $712 in health care costs. This means that for every dollar spent, $4.30 was saved in future health care costs. The cost benefit increased dramatically (from 4.3 to 39) when factoring in reductions in motor vehicle crashes and legal costs.

Cost effectiveness varies depending on how SBI is used. Emergency departments and trauma centers, which have a higher proportion of patients with alcohol use problems than the general health care system, have found SBI to be very cost effective. One study of trauma patients in emergency departments and hospitals found a net savings of $89 in health care costs alone per patient screened and $330 for each patient offered an intervention.[23] The number and length of sessions per client also significantly affect the cost.

SBI in the Context of a Public Health Approach

The effectiveness of SBI in helping individuals reduce their drinking can be increased when SBI is carried out in communities that are using public health strategies to address alcohol problems in a comprehensive way. This comprehensive approach includes community education for the general public and for merchants who sell alcohol; development and enforcement of laws and policies that affect the price, availability, and advertising of alcohol; collaboration among organizations and coalition building to address issues related to alcohol use; health insurance coverage for SBI; and ready access to alternative activities, such as alcohol-free recreation programs, dances, and drop-in centers.

Screening and Brief Intervention:
What You Need to Know

Screening

Screening is used to identify anyone who is at risk of having a specific health condition. However, it does not provide a diagnosis. Screening for alcohol misuse assesses whether an individual may have an alcohol use disorder or is at risk of experiencing problems from alcohol use. Screening is followed by brief intervention targeted toward at-risk drinkers rather than those who are dependent on alcohol. Many at-risk drinkers still have enough control over their drinking that they can cut down or quit with just the help from a brief intervention. However, if further help is needed, you should be prepared to make appropriate referrals.

Screening can be conducted by a variety of different public health professionals in many community-based settings, including your office, during home visits, or at public events such as health fairs. It can be offered through face-to-face interview or as a self-administered paper or computer-based questionnaire. If a self-administered instrument is used, it is more efficient for the client to complete it before meeting with you, perhaps in a waiting room. However, if the issue of alcohol use comes up during your meeting, it can be useful to conduct the screening right then. It is important to start by asking if the person would be willing to answer some questions to help discuss his or her alcohol use.

There are many different alcohol screening tools available. Some are designed for specific populations, such as adolescents or pregnant women. Some are available in other languages in addition to English. The tools also vary in whether they ask about alcohol use patterns such as amount and frequency, alcohol-related problems, or both. Another way these tools differ is in the number of questions they ask and the amount of time they take to administer and score. (See pages 11–14 for a chart of widely used tools.)

The maximum amount that people should drink to be within guidelines for safe consumption is shown in the table below. To stay within the daily and weekly limits may require non-drinking days each week.

NIAAA Guidelines: How Much Is Too Much?[24]

	Drinks Per Week	Drinks Per Occasion
Men	More than 14	More than 4
Women	More than 7	More than 3
Age 65+	More than 7	More than 3

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Some people should not drink alcohol at all. They include:

- **Children and adolescents (people under age 21)**
- **People who cannot keep their drinking to a moderate level**
- **Women who are pregnant, planning to become pregnant, or breastfeeding**
- **People who take prescription or over-the-counter medications that can interact with alcohol**
- **People who have a health condition that can be made worse by alcohol**
- **People who are or will be driving, operating machinery, or doing other activities that require alertness, coordination, or skill**

Brief Intervention

A brief intervention consists of one or more time-limited conversations between an at-risk drinker and a practitioner. The goals are to 1) help the drinker increase awareness of his or her alcohol use and its consequences and 2) encourage the person to create a plan to change his or her drinking behavior to stay within safe limits. The conversations are typically 5-15 minutes, although they can last up to 30-60 minutes for as many as four sessions.

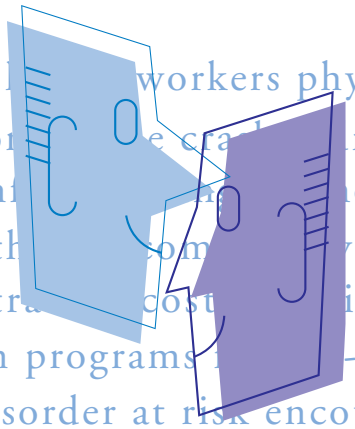
Your role in a brief intervention is to: [25]

1) Provide information and feedback empathetically about screening results, the link between drinking and the problems it can cause, guidelines for lower-risk alcohol use, and ways to reduce or stop drinking.

2) Understand the client's view of drinking and increase his or her motivation to change. This approach encourages clients to think about and discuss what they like and dislike about their drinking, how drinking may have contributed to their current problems, and how they might want to change their drinking behavior and risks. Engage clients in a discussion that helps them come to their own decisions about drinking.

3) Provide clear and respectful advice, without judgment or blame, about the need to decrease risk by cutting down or quitting drinking and avoiding high-risk situations. Explore different options by listening to the person's concerns and clarifying his or her strengths, resources, and past successes. The best result is for clients to develop their own goals and a realistic plan of action to achieve them based on how ready they are to change. The plan may involve reducing drinking somewhat or quitting altogether.

Resistance to change is a common response. In order to change a behavior, a person must accept that there is a problem and a need to change. Brief intervention can help significantly in this process. However, keep in mind that it is not your role as a provider to change the client or determine what he or she should do. It is your role to engage the client in exploring his or her drinking behavior and the problems it causes by providing information, asking questions, expressing concerns, and providing encouragement.



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reening emergency departments alcohol-free recreation programs face-to-face interview
ief intervention home visits health fairs alcohol use disorder at risk encouragement he
cohol dependence binge drinking heavy drinking harmful drinking alcohol dependent

How to Do SBI

Before You Begin...

There are several important steps to take before you start providing SBI. They include:

- **Choosing a screening tool**
- **Clarifying logistics of the setting(s) in which you will be conducting SBI, including making sure that systems for maintaining privacy and confidentiality are in place**
- **Compiling a current list of organizations and providers for referrals to services**
- **Practicing screening and brief intervention**

Choosing a Screening Tool

The rationale for SBI (as opposed to alcohol treatment) is to identify problems early. Therefore, screening instruments should identify hazardous drinking, i.e., drinking at a level that is associated with increased risk of harm. For most audiences and settings, the Alcohol Use Disorders Identification Test (AUDIT), or a two-part question that asks about frequency and amount of consumption, will be sufficient[26]. For special populations and languages, consult the chart on pages 11-14.

There are many screening tools available. The charts on pages 11-14 can help you choose an instrument appropriate for your specific situation and needs. It briefly describes some tools that are in wide use, are readily available, and can be used in a variety of settings.

To prepare for using a tool, consider the following issues:

- **What are the key characteristics of your target population, e.g., age, racial/ethnic background, inner city or rural location?**
- **Do you need the questionnaire in languages other than English? Which ones?**
- **How much time do you have for administering and scoring the tool?**
- **Do you want a tool that must be administered by a staff person or that the client can complete on his or her own?**

The number of questions in a screening tool is important to consider. Questionnaires that are too long may be unrealistic to use, and tools that are very short (e.g., just one to two questions) may not provide enough information. Instruments with 4–10 items are usually more useful than shorter ones because they provide more points from which to start the discussion in a brief intervention.

Screening can be made more efficient by doing it in two steps: Ask all clients a question about binge drinking, e.g., "How many times in the last month (or other period of time) have you had X or more drinks at a time?" (X = 5 drinks for men under 65, 4 drinks for women under 65, and 3 drinks for men and women 65 and older.) With anyone who gives a response other than "none", continue with questions from one of the screening tools. Answers to these questions will help inform the discussion that is at the heart of a brief intervention.

Commonly Used Screening Tools

The following charts briefly describe characteristics of some of the tools in widest use[1] that have been validated in various settings and with general and specialized populations. Some of these tools are designed to detect alcoholism, while others detect risky drinking or harmful drinking. We encourage you to compare several tools before selecting one or more for use in your practice.

The charts begin with the instruments designed for the broadest range of audiences, followed by those for more specialized audiences. The column "Who Gives" the tool indicates whether the tool is administered by a staff person (Staff), which often means orally, or is completed by the client on his or her own (Self) on paper or a computer. The column headed "Populations" includes populations with whom the screening tool has been validated in research studies.

AUDIT: Alcohol Use Disorders Identification Test

Audience	# Questions	Time *Take*	*Score*	Who Gives *Staff*	*Self*	Cost	Languages *Spanish*	*Other*
Adults Adolescents	10	2 min.	1 min	x	x	No	x	x

Populations	Notes
General and: Blacks, Hispanics, incarcerated, college students, women	Shorter versions such as the AUDIT-C available Training manual and video available

Developed for WHO in 1992 **http://www.projectcork.org/clinical_tools/html/AUDIT.html**

ASSIST: Alcohol, Smoking, and Substance Involvement Screening Test

	# Questions	Time *Take*	*Score*	Who Gives *Staff*	*Self*	Cost	Languages *Spanish*	*Other*
Adults	8 (multiple items each)	10 min.	< 2 min.	x		No	x	x

Populations	Notes
Cross-cultural, tested in 7 countries	Manual and guide available

Developed for WHO in 2000 **http://www.who.int/substance_abuse/activities/assist/en/index.html**

Alcohol Screening.org

[1] We have excluded instruments that are long (i.e., more than a dozen questions), time-consuming to deliver, or expensive.

	# Questions	Time *Take* *Score*	Who Gives *Staff* *Self*		Languages *Spanish* *Other*
Adults	13	4 min. 1 min.	x	No	

Populations	Notes
General	Combines AUDIT with consumption questions Answers are normed to others of similar age and gender; offers recommendations of steps to take Can be added to websites of other organizations

Developed by Join Together, Boston University School of Public Health in 2001 **http://www.alcoholscreening.org**

CAGE: Cut down, Annoyed, Guilty, Eye-Opener

	# Questions	Time *Take* *Score*	Who Gives *Staff* *Self*		Languages *Spanish* *Other*
Adults Adolescents (ages 16+)	4	<1 min. <1min.	x x	No	x x

Populations	Notes
General and Latinos	Focuses on symptoms of dependence. Can be combined with a question about binge drinking for more effective use in SBI.

Developed in 1984 **http://www.projectcork.org/clinical_tools/html/CAGE.html**

CRAFFT: Car, Relax, Alone, Friends, Forget, Trouble

Audience	# Questions	Time *Take* *Score*	Who Gives *Staff* *Self*	Cost	Languages *Spanish* *Other*
Adolescents (ages 14-18)	6	3 min. <1 min	x x	No	

Populations	Notes
American Indian/Alaska Native; inner city, suburban youth	

Developed by John Knight, Children's Hospital, Boston, MA in 1999 **http://www.slp3d2.com/rwj_1027/ and www.ceasar-boston.org**

S-MAST: Short Michigan Alcohol Screening Test

Audience	# Questions	Time *Take* *Score*	Who Gives *Staff* *Self*	Cost	Languages *Spanish* *Other*
Adults Adolescents	13	5 min. 2 min.	x x	No	

Populations	Notes
General and rural, primary care patients, mentally ill	Geriatric version also available Detects abusive and dependent drinkers

Developed in 1975; in the public domain **http://projectcork.org/clinical_tools/html/ShortMAST.html**

RAPS: Rapid Alcohol Problems Screen [also known as RAPS4]

Audience	# Questions	Time *Take* *Score*	Who Gives *Staff* *Self*	Cost	Languages *Spanish* *Other*
Adults	4	1 min. < 1 min.	x	No	x

Populations	Notes
White, Black, Hispanic; in emergency departments	

Developed by the Public Health Institute, Alcohol Research Group in 2000 **http://adai.washington.edu/instruments/pdf/Rapid_Alcohol_Problems_Screen_201.pdf**

T-ACE Tolerance, Annoyed, Cut Down, Eye Opener

Audience	# Questions	Time *Take* *Score*	Who Gives *Staff* *Self*	Cost	Languages *Spanish* *Other*
Adults	4	<1 min. <1 min.	x	No	x

Populations	Notes
Black inner city women	Intended for pregnant women only Adapted from CAGE

Developed in 1989 **http://www.projectcork.org/clinical_tools/html/T-ACE.html**

TWEAK: Tolerance, Worried Eye-Opener, Amnesia, Cut Down

Audience	# Questions	Time *Take*	*Score*	Who Gives *Staff*	*Self*	Cost	Languages *Spanish*	*Other*
Adults	5	< 2 min.	1 min.	x	x	No		x

Populations	Notes
Pregnant women, Black, White, Hispanic, inner city, rural	Combines questions from MAST, CAGE, and T-ACE The level of at-risk drinking identified in this instrument is greater than the currently accepted definition of one drink per day. Practitioners should be aware of this when selecting this instrument.

Developed by Marcia Russell, Prevention Research Center, in 1994 **http://www.prev.org/research_russell_tweak.html**

For additional information on screening tools:

National Institute on Alcohol Abuse and Alcoholism. (2003). Assessing alcohol problems: A guide for clinicians and researchers. 2nd edition. **http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/index.htm**

Project CORK. **http://www.projectcork.org/clinical_tools/**

University of Washington Alcohol and Drug Abuse Institute. Substance Use Screening & Assessment Instruments Database. **http://lib.adai.washington.edu/instruments/**

Dealing with Logistics for Conducting Screening

This section describes issues to address when administering screening and ensuring privacy and confidentiality for three common settings in community-based public health.

Individual Sessions in a Provider's Office

- ***Administering screening:*** Screening can be done before the session in a waiting area on paper or on computer. Or, it can be done during the session orally or on paper. In either case, be sure to allow time to score and review the results.
- ***Privacy:*** Use of an office usually ensures privacy if the sound does not carry beyond that room.

Home Visits

- ***Administering screening:*** It is most efficient to conduct the screening and brief intervention in the same visit unless the screening tool you are using takes more than a few minutes to score. In that case, score and review the results between visits.
- ***Privacy:*** There may be other people present in the home who can overhear the screening and brief intervention. You should discuss this matter with the client and determine whether it is a problem, and if so, how to handle it.

Public Events, such as Health Fairs

- ***Administering screening:*** Public events can attract large numbers of people, but do not allow for much follow-up. The screening and brief intervention should be done one right after the other. A briefer screening tool is usually preferable in this setting. If the screening is done before the person meets with you, be sure to allow time to score and review the results.
- ***Privacy:*** Other people will most likely be present at your booth or table, so a separate space should be set up nearby where brief interventions, and screening if it is done orally, can be conducted in private.

In all of these settings, providers are usually covered by the confidentiality regulations of their parent organization regardless of the setting. If they are not covered, then a procedure must be established so that any information shared and recorded is kept confidential. Especially with home visits and public events, this procedure must ensure a way of keeping any written information related to the client from being accessible to other people until it reaches secure files in the organization.

Compiling a Referral List

Before conducting SBI, compile a list of alcohol treatment services in your community. You might include outpatient counseling, day treatment, residential and detoxification programs, mental health programs that deal with alcohol problems, and self-help groups like Alcoholics Anonymous. Include the phone number, address, contact person, and a brief description of the services offered. Make copies of this list to have available at all SBI sessions and plan to update it regularly.

Practicing SBI

After you have read the section "Conducting SBI," practice conducting screenings and brief interventions. A useful way to practice is through role plays with your colleagues in which you act out how SBI might take place in your setting. It is helpful to also have at least one person to observe and provide feedback about the role play.

Consider practicing these situations:

- **The setting is an office, home visit, or public event**
- **The client screens positive and is high risk, low risk, or potentially alcohol dependent**
- **The client is very, somewhat, or not at all ready to change his or her drinking habits**

After each role play, spend several minutes discussing how it went. Each actor might say how it felt to play that role. Then discuss what the provider said, the clarity of explanations, use of relevant information from the screening, the provider's interview style and rapport established with the client, and the outcome of the interview. Discuss what worked and what could be improved.

Conducting SBI

Now you are ready to begin screening clients to assess whether they may have an alcohol use disorder or are at risk of experiencing problems from alcohol use. Asking screening questions can help discover hidden problems and provide an opportunity for education. Screening is valuable in identifying which clients may need an intervention to address their risky drinking. Keep in mind the importance of screening all your clients rather than assuming that you can tell whether or not an individual has an alcohol problem.

When you are screening for amount and frequency of alcohol use, it can be helpful to use pictures of standard drinks. You should explain that, ***on average, men should have no more than two drinks per day, and women and people over age 65 should have no more than one drink per day.***

If the results of screening show the need for brief intervention, there are four steps to follow.[27]

The steps are listed on pages 17–20.

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STEP 1

Raise the Subject

Key components:

1. Be respectful
2. Obtain permission from the client to discuss his or her alcohol use
3. Avoid arguing or confronting the client. If the client does not want to discuss it, accept his or her decision. Don't push; it may build resistance to discussing it in the future with others who may also broach the topic.

Preparation:

- Review any information you may have about the client

Objectives	Actions	Questions/Comments
Establish rapport	Explain your role Avoid being judgmental Set the tone	It may be helpful to tell clients that you address this issue with all your clients so they don't feel singled out.
Raise the subject	Engage the client	*"Would it be okay to take a few minutes to talk about your drinking?"* **PAUSE** to listen for and respect the answer. *"Has anyone ever talked with you about your drinking?"* If yes, *"When? What were the results?"* Include this information with the current screening results.

This first step sets the tone for a successful brief intervention. Asking permission to discuss the subject formally lets the client know that his or her wishes and perceptions are central in the intervention.

Provide Feedback

Key components:

1. Review current drinking patterns
2. Make any connection between alcohol, other health problems (if applicable), and this visit

Preparation:

- Have a scored copy of the client's screening data
- Have a copy of the NIAAA drinking guidelines

Objectives	Actions	Questions/Comments
Review client's drinking patterns	Review screening data Express concern Be non-judgmental	*"From what I understand, you are drinking…* (state the amount). *We know that drinking above certain levels can cause problems such as…* (refer to present problems or to general increased risk of illness and injury in the future). *I am concerned about your drinking."*
Make any connection between alcohol use, other health problems (if applicable), and this visit with the provider	Discuss specific client issues that might be related to alcohol use, e.g., motor vehicle crash, hypertension	*What connection (if any) do you see between your drinking and this visit?* If client sees a connection, review what he or she has said. If client does not see a connection, then make one, if possible, using facts, e.g., motor vehicle crash. Don't strain to draw connections if the visit is unrelated to their alcohol misuse. *"We know that our reaction time decreases even with one or two drinks. Drinking at any level may impair our ability to react quickly when* (state activity, e.g., driving)."
Compare to NIAAA drinking guidelines	Show NIAAA guidelines specific to client's gender and age	*"These are considered the upper limits of low-risk drinking for your age and gender. By low risk we mean that you would be less likely to experience illness or injury if you stayed within these guidelines."*

Linking the visit to their drinking (if a connection seems to exist) and comparing the clients' drinking patterns to national guidelines are useful ways to motivate clients to think about their drinking patterns and consider making changes.

Enhance Motivation

Key components:

1. Assess readiness to change
2. Help client see discrepancies or differences between his or her present behavior and concerns
3. Listen reflectively
4. Ask open-ended questions

Clients often have mixed feelings about making changes. Helping clients see the difference between their present behavior and their concerns may tip the scale toward being more ready to change. Reflective listening is a way to check what clients mean by a statement and to help clarify it.

Preparation: Have a copy of the Readiness to Change Ruler

Objectives	Actions	Questions/Comments
Assess readiness to change	Show Readiness Ruler (see copy below) Have client show where he or she is on a scale of 1-10 in terms of readiness to change	*"On a scale from 1-10, with 1 being not at all ready and 10 being very ready, how ready are you to change any aspect of your drinking?"*
Help client see difference between his or her behavior and concerns	Identify areas to discuss Use reflective listening	**If client says:** Two or more on the scale, ask *"Why did you choose that number and not a lower one?"* The goal of asking this question is to decrease resistance and have the clients state in their own words reasons they might be ready to change. One or unwilling to change, ask, *"what would make your drinking a problem for you?* Or, *"How important would it be for you to prevent (fill in a negative result) from happening?"* Or, *"Have you ever done anything you wished you hadnt while drinking?'* Discuss why the client drinks and the drawbacks to drinking. Ask, *"What would it take to make changing your drinking habits more important to you?"* Restate what you think the client meant by his or her statement. For example, in the context of discussing drinking less when with friends, the statement *"It's difficult,"* may be followed by, *"So it's difficult because you're worried about what your friends think,"* delivered with downward intonation to invite response.

Readiness Ruler

Not ready **Very ready**

1 2 3 4 5 6 7 8 9 10

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Negotiate and Advise

Key components:

1. Discuss options and a plan for how to cut back on drinking and/or reduce harm
2. Give advice
3. Provide drinking agreement and handout

Preparation:

- Have a blank copy of a drinking agreement (but remember that the goal is not to produce signed agreements as a measure of success)
- Have a copy of the handout from the appendices of this manual

Objectives	Actions	Questions/Comments
Negotiate goal and build self-efficacy (confidence in one's ability to change)	Assist client to identify a goal from a variety of options Avoid being argumentative	'Repeat what client said in Step 3 and say, *"What's the next step?"* or *"What are your options?* [see below] *Where do you want to go from here?"* Ask about other times the client has successfully made a change, e.g., quit smoking, improved eating habits.
Give advice, with the client's permission	Provide options for the client to consider Deliver sound advice/education Provide strategies to help reduce harm	Options can include: cut back on how often I drink; cut back on how much I drink on days when I do drink; never drink and drive; a trial period of not drinking; stop drinking entirely; get help from someone with my drinking; do nothing.
Summarize	Provide a drinking agreement (see next page) for the client to take home, if they are amenable Help client clarify goals to pursue Provide handout	*"This is what I have heard you say…Here is a drinking agreement that can reinforce your new drinking goals. This is really an agreement between you and yourself."* Suggest follow-up for drinking level/pattern with an appropriate person, and provide any contact information necessary. Thank the client for his or her time and willingness to talk. Express optimism in his or her intent to make changes.

Summary

You should assist the client in exploring a variety of options. However, the client is the decision-maker and should ultimately be responsible for choosing a plan.

Drinking Agreement

Date: _____

I, _____, agree to the following drinking limit:

Number of drinks per week: _____

Number of drinks per occasion: _____

Client signature: _____

Remember: It is never a good idea to drink and drive.

Follow-Up

Follow-up is contact between a provider and client to check on how the client is doing with the steps planned in the brief intervention. The goal is to discuss with the client what he or she has done and to help with any barriers to carrying out the steps. If the client needs further help, you can schedule another visit or a make a referral to other services for evaluation and treatment.

Many programs do not have the capacity to offer follow-up to clients after screening and brief intervention. If follow-up is part of your program (say, for chronic conditions) it may be feasible to do SBI follow-up as well.

Either you or the client can initiate the follow-up contact. You may want to decide at the first meeting who will initiate so that you can give the client any necessary contact information. The decision should be based on the individual's needs and ability to initiate. If you are seeing the client on a regular basis, the follow-up can take place in future sessions as needed.

In some situations, such as at health fairs, it may not be possible for the follow-up to be provided by the same person who conducted the brief intervention. In these cases, you need to consider before the brief intervention whether you will recommend that follow-up be done with another provider in your organization, with the individual's primary care provider or counselor if he or she has one, or with someone else you suggest.

Making Referrals

There are several types of situations with SBI where a referral to other services may be needed. If there is indication that the person may be alcohol dependent, he or she should be given a referral for further diagnosis and specialized treatment. Some people in at-risk categories may be best served with a referral to other sources of help, including:

- **People with a history of alcohol or drug dependence**
- **People with past or current serious mental illness**
- **People who have not been able to reach their goals with brief counseling alone**

Additional Strategies

Additional Ways to Motivate Change[28]

Below are several strategies that can help to motivate change in brief interventions.

Refrain from Directly Countering Statements of Resistance

For example, the client may say "How can I have a drinking problem when I drink less than all my friends?" You can respond without insisting that they have a problem but instead inviting further discussion.

Restate Positive or Motivating Statements

For example, if a client says, "You know, now that you mention it, I feel like I have been overdoing it a little with my drinking lately," you could say, "You don't need me to tell you you've been drinking a little too much lately, you've noticed yourself." This serves to reinforce the patient's motivation even if his or her statement is a relatively weak one. If the client says, "I guess I might have to cut down," you could restate this as, "It sounds like you've been thinking about changing your drinking habits."

Other Helpful Hints

- **Encourage clients to think about previous times when they have cut back on their drinking or about other changes they have made, such as quitting smoking.**
- **Praise clients for their willingness to discuss such a personal topic, as well as their willingness to consider change.**
- **Treat the client as an active participant in the intervention.**

Addressing Common Problems[29]

Below are two common problems that may occur during a brief intervention and suggestions for dealing with them.

Refusal to Identify Oneself along the Readiness Ruler

When this happens, it is often a problem with understanding the numbers on the ruler.

1. **Describe what the numbers mean.**
2. **If this doesn't help, try these questions instead of using the ruler. Ask, "What would make your drinking a problem for you?" "How important is it for you to change any aspect of your drinking?"**
3. **Discuss the client's reasons for and against drinking.**

Not Ready to Change Drinking Patterns to Stay within Safe Limits

Advise the client that the best recommendation is to cut back to safe drinking limits, but that any step in that direction is a good start. The client's current goal is then written on the drinking agreement. Suggest that if the client would like to talk further about this issue, he or she can contact his or her primary care provider or an alcohol or mental health counselor.

Responding to Clients Whose Screening Results Show Low Risk[30]

When discussing screening results with clients who show low risk for alcohol use problems, you will probably want to use a briefer approach than the four steps outlined above. Below is a sample script that you can modify to fit each client

Explain the Results of the Screening

Example: "I have looked over your answers about your alcohol use. From your answers it appears that you are at low risk of experiencing alcohol-related problems if you continue to drink moderately (abstain)."

Educate Clients about Low-Risk Levels and the Value of Staying Within Them

Example: "If you do drink, remember that you should not consume more than two drinks a day (one if the client is a woman or over age 65). That means one bottle of beer, one glass of wine, and one shot of liquor. And, make sure you don't drink at least two days out of every week, even in small amounts. People who drink within these limits are much less likely to have problems related to alcohol like car crashes, injuries, high blood pressure (tailor to the one or a few problems relevant to the client, your role, and the setting)."

Congratulate Clients for Following the Guidelines

Example: "So, keep up the good work, and continue to keep drinking below or within the low-risk guidelines."

Conclusion

Now that you have learned the value of SBI, the basic steps, and how to get started, you can use the tools in this guide to conduct SBI in your settings and consult the resources listed for additional help if you need it. Using these tools, you can have a significant impact on the lives of risky drinkers and their families, friends, and communities.

HANDOUT

Drinking Agreement

Date: _____

I, _____, agree to the following drinking limit:

Number of drinks per week: _____

Number of drinks per occasion: _____

Client signature: _____

Remember: It is never a good idea to drink and drive.

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What is a Standard Drink?

1 standard drink equals: 1.5 oz. of liquor (e.g., whiskey, vodka, gin), **12 oz. beer, 5 oz. wine**

Moderate Drinking

Men	Up to 2 drinks per day
Women	Up to 1 drink per day
Age 65+	Up to 1 drink per day

How Much Is Too Much?

If you drink more than this, you are at risk for alcohol-related illness and/or injury. You need to stay within the limits per week AND per day. To stay within the daily and weekly limits may require non-drinking days each week.

	Drinks Per Week	Drinks Per Occasion
Men	More than 14	More than 4
Women	More than 7	More than 3
Age 65+	More than 7	More than 3

Resources

Anderson, P., Aromaa, S., Rosenbloom, D., & Enos, G. (2008). *Screening and Brief Intervention: Making a Public Health Difference.* Boston, MA: Join Together.

Babor, T. F., & Higgins-Biddle, J. C. (2001). *Brief intervention for hazardous and harmful drinking: A manual for use in primary care.* World Health Organization. **http://libdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf**

The BACCHUS Network. (2007). *Screening and brief intervention toolkit for college and university campuses.* Denver, CO: The BACCHUS Network. **http://www.nhtsa.gov/people/injury/alcohol/StopImpaired/3672Toolkit/pages/contents.html**

Emergency Nurses Association. (2008). *SBIRT alcohol screening toolkit.* Des Plaines, IL: Emergency Nurses Association. Includes training manual, video, and PowerPoint presentation. **http://www.ena.org/ipinstitute/SBIRT/ToolKit/toolkit.asp**

Field, C., Hungerford, D., & Dunn, C. (2005). Brief motivational interventions: An introduction. The Journal of Trauma, Injury, Infection, and Critical Care 59, S21-S26. **http://www.cdc.gov/ncipc/Spotlight/JrnTraumaSupl.htm**

National Highway Traffic Safety Administration. (2006.) Alcohol Screening Planner. Communications Campaigns and Tools. **p://www.stopimpaireddriving.org/planners/Alcohol_Screening06/planner/index.cfm**

Saitz, R., & Galanter, M. (Eds.). (2007). *Alcohol/drug screening and brief intervention: Advances in evidence-based practice.* Binghamton, NY: Haworth Medical Press.

Screening, Brief Intervention, Referral, and Treatment (SBIRT). Substance Abuse and Mental Health Services Administration (SAMHSA). Comprehensive source for SBIRT information. Includes training manuals, online resources, links to organizations and publications, and list of references. **http://sbirt.samhsa.gov**

Substance Abuse and Mental Health Services Administration (SAMHSA). (2007). *Alcohol screening and brief intervention (SBI) for trauma patients: Committee on Trauma quick guide.* **http://sbirt.samhsa.gov/documents/SBIRT_guide_Sep07.pdf**

Substance Use Screening & Assessment Instruments Database. Alcohol and Drug Abuse Institute, University of Washington. (Updated every month). Helps clinicians and researchers find instruments for screening and assessment of substance use. **http://lib.adai.washington.edu/instruments**

Practitioner Training

Helping Patients Who Drink Too Much: A Clinician's Guide. National Institute on Alcohol Abuse and Alcoholism (NIAAA). Updated 2005 edition. NIH Publication No. 05-3769. NIAAA-funded guide to screening and brief intervention for primary care and mental health clinicians. **http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm**

Video Cases: Helping People Who Drink Too Much. National Institute on Alcohol Abuse and Alcoholism (NIAAA). Companion material to *Helping Patients Who Drink Too Much: A Clinician's Guide.* Four 10-minute video cases showing brief interventions with four drinkers at different levels of severity and readiness to change. Also included are interactive learning exercises and a 17-minute tutorial with animated graphics. Free CME/CE credits. **http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/VideoCases.htm**

Brief Interventions for Alcohol Use. Alcohol CME. 2004-2006. NIAAA-funded online continuing education course on using brief interventions to address alcohol problems in primary care settings. For physicians and other healthcare professionals, counselors, and substance abuse workers. CEUs available. **http://www1.alcoholcme.com/PageReq?id=1:8029**

Alcohol Screening and Brief Intervention Curriculum. Alcohol Clinical Training (ACT). 2007. Free online curriculum for generalist physicians and educators that teaches skills for addressing alcohol problems in primary care settings (including screening and brief intervention) and emphasizes cross-cultural efficacy. **http://www.bu.edu/act/index.htmlessing**

Referral Resources

Find Substance and Mental Health Treatment. Substance Abuse and Mental Health Services Administration (SAMHSA). Helps locate treatment services and provides links to other resources. **http://www.samhsa.gov/treatment/index.aspx**

Alcoholics Anonymous (AA) Web site provides listings for local AA support groups. http://www.aa.org

References

1. U.S. Secretary of Health and Human Services. (1997). *Ninth special report to the U.S. Congress on alcohol and health.* (NIH Publication no. 97-4017.) Washington, DC: U.S. Government Printing Office.

2. NIAAA Alcohol Education Project. (2004). Standardized SBIRT Curriculum. Retrieved May 15, 2008 from http://www.ed.bmc.org/sbirt/scope.php

3. Dawson, D. A., Grant, B. F., & Li, T-K. (2005). Quantifying the risks associated with exceeding recommended drinking limits. *Alcoholism: Clinical and Experimental Research* 29(5), 902-908.

4. SAMHSA. (2007). *Results from the 2006 National Survey on Drug Use and Health: National Findings.* Retrieved May 27, 2008 from http://www.oas.samhsa.gov/NSDUH/2k6NSDUH/2k6results.cfm#3.1

5. SAMHSA. (2008, June). *Underage alcohol use: Findings from the 2002-2006 National Surveys on Drug Use and Health.* Retrieved July 1, 2008 from http://oas.samhsa.gov/underage2k8/Cover.htm

6. D'Onofrio, G., & Degutis, L. C. (2002, June). Preventive care in the emergency department: Screening and brief intervention for alcohol problems in the emergency department: A systematic review. *Academy of Emergency Medicine 9*(6), 627-638.

7. U.S. Department of Transportation, National Highway Transportation Safety Administration. (2007, July). Traffic safety facts: 2006 traffic safety annual assessment—A preview. Retrieved May 26, 2008 from http://www-nrd.nhtsa.dot.gov/Pubs/810791.PDF

8. American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders, Fourth edition. Washington DC: APA.

9. SAMHSA Bulletin. (2008, March 5). SAMHSA to provide $3.75 million to train medical residents in SBIRT techniques. Retrieved May 15, 2008 from http://www-nrd.nhtsa.dot.gov/Pubs/810791.PDF http://www.samhsa.gov/newsroom/advisories/0803041505.aspx

10. Kristenson, H., Ohlin, H., Hulten-Nosslin, B., Trell, E., & Hood, B. (1983). Identification and intervention of heavy drinking in middle aged men: Results and follow-up of 24-60 months of long-term study with randomized controls. *Alcoholism: Clinical and Experimental Research 7,* 203-209.

11. Babor, T. F., de la Fuente, J. R., Saunders, J., & Grant, M. (1989). *AUDIT The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care.* WHO/MNH/DAT 89.4. Geneva: World Health Organization.

12. Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction 88*, 791-804.

13. WHO Brief Intervention Study Group. (1996). A cross national trial of brief intervention with heavy drinkers. *American Journal of Public Health 86*, 948-955.

14. Babor, T. F., de la Fuente, J. R., Saunders, J., & Grant, M. (1989). *AUDIT The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care.* WHO/MNH/DAT 89.4. Geneva: World Health Organization.

15. Moyer, A., Finney, J.W., Swearingen, C.E., & Vergun, P. (2002, March). Brief interventions for alcohol problems: A meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction 97*(3), 279-292.

16. Whitlock, E. P., Polen, M. R., Green, C. A., Orleans, T., & Klein, J. (2004). Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine 140*(7), 557-568.

17. U.S. Preventive Services Task Force. (2004). Screening and behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: Recommendation statement. *Annals of Internal Medicine 140*(7), 554-556.

18. Ballesteros, J., González-Pinto, A., Querejeta, I., & Arino, J. (2004). Brief interventions for hazardous drinkers delivered in primary care are equally effective in men and women. *Addiction 99*(1), 103-108.

19. D'Onofrio, G, & Degutis, L. C. (2002, June) Preventive care in the emergency department: Screening and brief intervention for alcohol problems in the emergency department: A systematic review. *Academic Emergency Medicine 9*(6), 627-638.

20. SAMHSA News (2008, March/April). Screening works: Update from the field. Retrieved May 26, 2008 from http://www.samhsa.gov/SAMHSA_News/VolumeXVI_2/article1.htm

21. Babor, T. F. et al. (2007). Screening, brief intervention, and referral to treatment (SBIRT): Toward a public health approach to the management of substance abuse. In R. Saitz & M. Galanter (Eds.), *Alcohol/drug screening and brief intervention: Advances in evidence-based practice* (pp. 7-30). Binghamton, NY: The Haworth Press.

22. Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Staauffacher, E. A., & Barry, K. L. (2002). Brief physician advice for problem drinkers: Long-term efficacy and cost-benefit analysis. *Alcoholism: Clinical and Experimental Research 26*(1), 36-43.

23. Gentilello, L. M., Ebel, B. D., Wickizer, T. M., Salkever, D. S., & Rivara, F. P. (2005). Alcohol interventions for trauma patients treated in emergency departments and hospitals: A cost benefit analysis. *Annals of Surgery 241*(4), 541-550.

24. National Institute on Alcohol Abuse and Alcoholism. (Updated 2005). *Helping patients who drink too much: A clinician's guide.* Retrieved May 21, 2008 from http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

25. ENA Injury Prevention Institute. (2008). *Reducing patient at-risk drinking: A SBIRT implementation toolkit for the emergency department setting.* Des Plaines, IL: Emergency Nurses Association.

26. Vinson, D.C., Kruse, R.L., Seale, J.P. (2007). Simplifying alcohol assessment: two questions to identify alcohol use disorders. *Alcoholism: Clinical and Experimental Research 31*(8):1392-8.

27. Adapted from D'Onofrio, G., Pantalon, M. V., Degutis, L. C., Fiellin, D.A., & O'Connor, P. G. (2005). Screening and brief intervention for unhealthy alcohol use in the ED. Retrieved May 20, 2008 from http://acepeducation.org/sbi/media/bni_manual.pdf

28. Adapted from D'Onofrio, G., Pantalon, M. V., Degutis, L. C., Fiellin, D.A., & O'Connor, P. G. (2005). Screening and brief intervention for unhealthy alcohol use in the ED. Retrieved May 20, 2008 from http://acepeducation.org/sbi/media/bni_manual.pdf

29. Adapted from D'Onofrio, G., Pantalon, M. V., Degutis, L. C., Fiellin, D.A., & O'Connor, P. G. (2005). Screening and brief intervention for unhealthy alcohol use in the ED. Retrieved May 20, 2008 from http://acepeducation.org/sbi/media/bni_manual.pdf

30. Adapted from Babor, T. F., & Higgins-Biddle, J. C. (2001). *Brief intervention for hazardous and harmful drinking: A manual for use in primary care.* Geneva: World Health Organization. Retrieved May 15, 2008 from http://libdoc.who.int/hq/2001/WHO_MSD_MSB_0.16b.pdf

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for both Alcohol and Drug Use				
ASSIST **(Alcohol, Smoking, and Substance Involvement Screening Test)**	The ASSIST provides information about: the substances people have used in their lifetime; those used in the past three months; problems related to substance use; risk of current or future harm; dependence; and injection drug use. **Comments:** The ASSIST collects information regarding use of tobacco, alcohol, cannabis, cocaine, amphetamine type stimulants, sedatives, hallucinogens, inhalants, opioids, and other drugs. **Administration Time:** 10 min **Scoring Time**: 5 min **Training:** Recommended but not required; a guidance document is available free of charge. **Language:** English, Spanish, & 4 other languages. Translation directions provided	General population; primary and other health care settings worldwide Focus: Recent and Past Drug and Alcohol Use **Comments:** Prenatal care providers may prefer this instrument as it collects substance use information they are required to collect on all pregnant women (Code of Virginia §54.1-2403.1)	Clinician Administered Interview Computer administered format available	**Available in the public domain.** Can be downloaded from the internet at: http://www.who.int/substance_abuse/activities/assist/en **FREE**: The scale is printed in the manual and can be downloaded for free from the WHO web site. The document may be freely reviewed, abstracted, reproduced, and translated, in part or in whole but it may not be sold or used in conjunction with commercial purposes. Program on Substance Abuse World Health Organization 1211 Geneva, Switzerland email: Publications@who.int

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Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for both Alcohol and Drug Use				
4P's	The 4Ps (Parents, Partners, Past and Pregnancy) was developed for use with pregnant women and women of child bearing age. The tool has 4 questions intended to facilitate discussion **Comments:** Recommended for use by medical & non-medical providers **Administration Time:** 2 min **Scoring Time:** < 1 min **Training**: Brief training recommended but not required **Language:** English	Pregnant women and women of child bearing age **Focus**: Recent and past drug and alcohol use	Clinician administered: intended to facilitate discussion regarding substance use	**Available in the public domain** http://www.dbhds.virginia.gov/documents/screener-4Ps.pdf Developed by Hope Ewing
5Ps	The 5 Ps is actually a 6 question tool. It is the 4Ps plus an additional question on peers and on smoking **Comments:** recommended for use by both medical & non-medical providers **Administration Time:** 2 -3 min **Scoring Time:** < 1 min **Training:** Brief training recommended but not required **Language:** English	Pregnant women and women of child bearing age **Focus**: Recent and past drug and alcohol use as well as tobacco	Clinician administered: intended to facilitate discussion regarding substance use	**Available in the public domain** The 5Ps was adapted by the Massachusetts Institute for Health and Recovery in 1999 from Dr. Hope Ewing's 4Ps (1990). The attached version includes guidance from the Louisiana Office of Addictive Behaviors. http://www.dhh.louisiana.gov/offices/publications/pubs-23/5PsPrenatal%20Screen%20and%20INstructions.doc

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for both Alcohol and Drug Use				
Virginia Behavioral Health Risks Screening Tool	The **Virginia Behavioral Health Risks Screening Tool** incorporates the 5 P'S, the Quantity/Frequency of tobacco use, the 3 item anxiety scale from the Edinburgh Postpartum Depression Scale and a question regarding the woman's experience with violence. The Virginia Behavioral Health Risks tool was adapted from the Institute of Health and Recovery (IHR) High Risk Screening tool. **Comments:** The IHR tool is currently used in 32 community health centers in Massachusetts & is in the process of being validated. It is available in Spanish. **Administration Time**: 3-5 min **Scoring Time**: approx 2 min **Training**: recommended but not required. **Language**: English	Pregnant women, women of child bearing age and adolescent females The **Virginia tool** can be used with pregnant women and women of child bearing age but recommends different follow-up screens if the woman expresses concern about her emotional health.	Clinician administered or self administered Intended to facilitate discussion regarding substance use, domestic violence and depression	**Available in the public domain** http://www.dbhds.virginia.gov/documents/scrn-pw-VAHighRiskTool-provider.pdf http://www.dbhds.virginia.gov/documents/scrn-pw-VAHighRiskTool-patient.pdf http://www.dbhds.virginia.gov/documents/scrn-pw-VAHighRiskTool-providerbackground.pdf For more information contact Martha Kurgans, Women's Services Coordinator Department of Behavioral Health and Developmental Services (DBHDS) Martha.kurgans@dbhds.virginia.gov Ph: 804-371-2184 The **IHR 5 P'S** was developed through funding by the Maternal and Child Health Bureau for the ASAP Project. http://www.mhqp.org/guidelines/perinatalPDF/IHRIntegratedScreeningTool.pdf For more information, please contact: Enid Watson, M. Div. Director, Screening and Early Identification Projects Institute for Health & Recovery 349 Broadway Cambridge, MA 02139 enidwatson@healthrecovery.org Ph: 617-661-3991 Fax 617-661-7277

				Toll Free: 1-866-705-2807
Instrument	**Description**	**Primary Population Focus**	**Format**	**Availability and Source**
Screening Instruments for both Alcohol and Drug Use				
4Ps Plus	The 4 P's Plus© is a revised version of the 4Ps tool and includes additional questions regarding mental health, domestic violence and substance us This screen has been tested and validated and effectively identifies pregnant women at highest risk for substance use during pregnancy. **Comments:** recommended for use by medical & non-medical providers **Administration Time:** 3 to 5 min. **Scoring Time:** approx 2 min **Training:** Technical Assistance & training available through NTI Upstream Solutions/ Children's Research Triangle **Language:** English or Spanish	Pregnant women Women of childbearing age **Focus:** Recent and Past Drug and Alcohol Use, domestic violence & depression	Clinician administered Intended to facilitate discussion regarding substance use, domestic violence and depression	**Copyrighted:** For permission and rights to use this tool, contact Dr. Ira Chasnoff at: ichasnoff@aol.com Ira Chasnoff NTI Upstream /Children's Research Triangle 180 North Michigan Avenue Suite 710 Chicago, IL 60601 P: 312.726.4011 Fax: 312.726.4021 email: info@ntiupstream.com

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for both Alcohol and Drug Use				
UNCOPE **(Used, Neglected, Cut Down, Objected, Preoccupied, Emotional Discomfort)**	The UNCOPE can be used in mental health and medical clinics, employee assistance counseling, marital and family counseling, child welfare services. It is not appropriate for evaluating persons arrested for driving under the influence, those presenting for treatment, or those being evaluated for any issue associated with substances. **Administration Time** < 1 min. **Scoring Time:** 1 min **Training:** not required **Language:** English	Adults receiving social service s; home visiting services Focus: Drug & Alcohol Use	Clinician Administered	**Available in the public domain.** Can be downloaded from the internet at: http://www.evinceassessment.com/UNCOPE_for_web.pdf) **FREE:** The UNCOPE is available free on the web and has been printed in various publications. The questions may be used free of charge for oral administration in any medical psychosocial, or clinical interview. Attribution to the developer is requested when citing the instrument The Change Companies 5221 Sigstrom Drive Carson City, NV 89706 tel: 888-889-8866 fax: 775-885-0643 email: info@changecompanies.net web: http://www.changecompanies.net.
Screening Instruments for Alcohol Use Only				
AUDIT **(Alcohol Use Disorder Identification Test)**	The AUDIT is a 10-item screening questionnaire designed to identify adults whose alcohol consumption has become hazardous or harmful to their health **Administration Time** < 2 min (10 minutes when incorporated into other aspects of medical exam.) **Scoring Time:** < 5 min **Training** Intended for use by trained health professionals or paraprofessionals **Language:** English	Adult men & women Focus: Alcohol Use	Clinician Administered Computer administered format available	**Available in the public domain.** Can be downloaded from the internet at: http://www.projectcork.org/clinical_tools/html/AUDIT.html **Portions available in the public domain :** The core questionnaire can be reproduced without permission. Test and manual are free; training module costs $75 and contains a videotape and manual World Health Organization Division of Mental Health & Prevention of Substance Abuse;CH-1211 Geneva 27, Switzerland email: Publications@who.int

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for Alcohol Use Only				
T-ACE **(Tolerance, Anger / Annoyance, Cut Down, Eye-Opener)**	The T-ACE is a four-item questionnaire developed for use with pregnant women. Positive results indicate need for further exploration of the subject's drinking. **Administration Time** can be administered by anyone, including non-professionals, in less than 1 minute. **Scoring Time:** 1 minute **Training** No special training is required **Language:** English	Pregnant women Focus: Alcohol Use	Clinician Administered	**Available in the public domain.** Can be downloaded from the internet at: http://www.projectcork.org/clinical_tools/html/T-ACE.html Permissions Department, Mosby, Inc. (a division of Elsevier) 6277 Sea Harbor Drive Orlando, FL Ph: 407-345-3994 web: http://www.us.elsevierhealth.com/
TWEAK **(Tolerance, Worry, Eye-Opener, Amnesia, Cut-Down)**	The TWEAK is a five-item scale originally developed to screen for risk drinking during pregnancy. The items are not gender specific, however, and the scale can be used with either women or men. **Administration Time:** 2 minutes **Scoring Time:** 1 minute **Training** No special training is required for the administration or scoring of this instrument. **Language:** English	Primary Focus: Alcohol Use	Pencil-and-paper / computerized self-administered / or in interview formats.	**Available in the public domain.** Can be downloaded from the internet: at: http://www.projectcork.org/clinical_tools/html/TWEAK.html Marcia Russell Prevention Research Center 1995 University Ave., Suite 450 Berkeley, CA 94704 Ph: 510-883-5703 email: russell@prev.org

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for Drug Use Only				
DAST-A **(Drug Abuse Screening Instrument)**	The DAST is a 20 item instrument for clinical and non-clinical screening to detect drug abuse or dependence disorders. It is most useful in settings in which seeking treatment for drug use problems is not the patient's stated goal. **Administration Time:** 5 minutes **Scoring Time:** 2 minutes **Training** No special training is required for the administration of this instrument. **Language**: English	Adult – drug use	Self-administered	**Available in the public domain.** Can be downloaded from the internet at: http://www.projectcork.org/clinical_tools/html/DAST.html Harvey A. Skinner Department of Behavioural Sciences University of Toronto 12 Queens Park, Crescent West McMurrich Building, 1st floor Toronto, ON M5S 1A8, Canada tel: 416-978-2040 email: harvey.skinner@utoronto.ca web: http://www.phs.utoronto.ca

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for Depression or Mental Health Concerns				
Edinburgh Postnatal Depression Scale (EPDS)	The EPDS is a 10 item tool developed to evaluate depression in childbearing women. It has been used - but not validated -for perinatal use. **Administration Time:** < 5 min. **Scoring Time:** 1 minute **Training:** Not required **Language:** Available in 20 languages	Primary Focus: pregnant & postpartum women who may be experiencing depression	Self-administered	**Available in the public domain.** English and Spanish versions can be downloaded from the internet at: http://www.aap.org/practicingsafety/module2.htm http://www.aap.org/practicingsafety/Toolkit_Resources/Module2/EPDS.pdf Conduct an internet search to obtain other languages. Edinburgh Postnatal Depression Scale (EPDS) J. L. Cox, J. M. Holden, R. Sagavsky From: British Journal of Psychiatry (1987), 150, 782-786
Beck Depression Scale (BDI-II)	The BDI -II is a 21 item tool developed to assess depression severity and allow for monitoring depression over time. It has good concurrent validity with measures of postpartum depression **Administration Time:** 5 min. **Training:** Review of manual and understanding of the DSM IV. **Language:** Available in Spanish and English	Primary Focus: General population of adults who may be experiencing depression	Clinician or self-administered The BDII uses diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).	**Copyrighted.** Information about ordering can be found at: http://pearsonassess.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8018-370 $49 for pkg. of 25 record forms $65 for manual

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for Depression and Mental Health Concerns				
CES –D Center for Epidemiological Studies	The CES-D is a 20 item self-report scale which measures the current level of depressive symptoms with an emphasis on depressed mood during the past week **Administration Time** 5-10 min. **Scoring Time:** estimated 5 min **Training:** not required **Language:** English & Spanish	General population	Self-administered	**Available in the public domain.** Can be downloaded from the internet at: www.depression-help-resource.com/cesd-depression-test.pdf
Abbreviated Patient Health Questionnaire PHQ-2	The PHQ-2 is a tool which consists of the first 2 questions of the PHQ-9 and is expected to be used as a conversational screen**.** A positive response to either question warrants the need for additional evaluation. The PHQ-9 can be used to provide a follow-up to PHQ-2 to determine if DSM-IV criteria for major depression diagnosis are met. **Administration Time**: 1 min. **Scoring** : estimated < 3 min **Training**: Instructions for use of the questionnaire. **Language**: English and Spanish	Primary Focus: General population of adults who may be experiencing depression and other mental health disorders	Clinician administered.	**Available in the public domain.** Available with acceptance of terms of use by Pfizer, Inc.. Can be downloaded from the internet at: www.commonwealthfund.org/usr_doc/PHQ2.pdf **NOTE:** The PHQ-2 is an abbreviated version of the PHQ-9 tool. http://www.docsfortots.org/documents/phqscreeningtool.pdf

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening Instruments for Depression and Mental Health Concerns				
Patient Health Questionnaire PHQ-9	The PHQ-9 is an abbreviated version of the Primary Care Evaluation of Mental Disorders **Administration Time:** 5-10 min **Scoring:** : estimated < 5min **Training:** DSM IV diagnosis codes. **Language:** English and Spanish	Primary Focus: General population of adults who may be experiencing depression and other mental health disorders	Clinician administered. The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).	**Available in the public domain.** Available with acceptance of terms of use. Can be downloaded from the internet at: www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/ http://www.dbhds.virginia.gov/documents/scrn-pw-PHQ-9-Eng.pdf http://www.dbhds.virginia.gov/documents/scrn-pw-PHQ-9-Span.pdf http://www.dbhds.virginia.gov/documents/scrn-pw-PHQ-9-Eng-Instructions.pdf
Screening for Intimate Partner Violence				
Abuse Assessment Screen(AAS)	Tool from the Family Violence Prevention Fund Addresses past, and current physical, emotional and sexual abuse as well as threats of abuse. **Administration Time:** estimated to be 5-10 min **Scoring**: estimated < 5min **Training:** not required **Language:** English and Spanish	Pregnant women	Clinician administered	**Available in the public domain.** Can be downloaded from the Virginia Department of Health/Project Radar website on Intimate Partner Violence: http://www.vahealth.org/Injury/projectradarva/index.htm http://www.dbhds.virginia.gov/documents/scrn-pw-AAS-Eng.pdf http://www.dbhds.virginia.gov/documents/scrn-pw-AAS-Span.pdf

Screening Instruments for Pregnant Women and Women of Childbearing Age
Substance Use, Mental Health and Intimate Partner Violence

Instrument	Description	Primary Population Focus	Format	Availability and Source
Screening for Intimate Partner Violence				
Women's Experience with Battering (WEB)	This 10 item tool operationalizes the experiences of battered women rather than the abusive behaviors they encounter.The tool demonstrated high internal consistency reliability, was significantly correlated with known-group status, exhibited good construct validity, and was not significantly correlated with a measure of social desirability. **Administration Time:** estimated to be 5-10 min **Scoring**: estimated < 5min **Training:** not required **Language:** English and Spanish Scoring procedures: Reverse score and then add the responses for all items. Range of scores is 10 to 60. A score of 20 or higher is a positive screening test for battering (Coker et al. 2002; Punukollu 2003).	women	Self Report	Developed by: Paige Hall Smith, Irene Tessaro, and Jo Anne Earp, 1995 http://www.dbhds.virginia.gov/documents/scrn-pw-WEB.pdf **http://www.dbhds.virginia.gov/documents/scrn-pw-WEB-Span.pdf**

"High Risk Screening: Addressing Perinatal Depression & Intimate Partner Violence When Screening for Substance Use

Why Include Screening for Perinatal Depression and Intimate Partner Violence?

Pregnant women are at greater risk to experience depression and/or be victims of domestic violence than non-pregnant women.

Substance use, mental health problems and domestic violence often occur together. Routinely screening all women for these risks at the same time and in a health context is the most efficient and productive approach for medical and other service providers who work with women. Even if a woman remains silent regarding one risk area she may be open to discussing problems in another area. Screening offers an opportunity to begin the conversation.

Screening Tools for Mental Health and Intimate Partner Violence

Screening tools are also available to assess perinatal depression and intimate partner violence. Screening for all 3 risks - substance use, perinatal depression and intimate partner violence - is considered "Best Practice" (ACOG, SAMHSA) and can take as little as 10 minutes. The more practice you get, the more comfortable and efficient you'll become screening for these "risks". For additional tools and more information see Screening Tools for Women of Childbearing Age.

Mental Health and Perinatal Depression Screening Tools

- Edinburgh Postnatal Depression screener
- PHQ 2 screener for depression
- PHQ 9 screener for depression

Intimate Partner Violence (IPV) Screening Tools

- Women's Experiences with Battery (WEB)
- Abuse Assessment Screen (AAS)

Integrated "High Risk" Screen (substance abuse, mental health & IPV)

- Virginia's Behavioral Health Risk Screening Tool (Background for tool)

Tips for Screening

Combining screenings into a "high risk" screening may be the easiest and most effective way to screen. Screening – whether for substance use, perinatal depression or intimate partner violence - involves similar principles and skills.

- Ask routinely
  - Integrate your questions with other routine inquiries
  - Use framing questions such as "because violence/substance use/depression is so common in so many people's lives, I now ask all women I see…." Or " I don't know if this is a problem for you, but many of the patients I see are dealing with personal problems that they are afraid or uncomfortable to bring up, so I've started asking all my patients/clients about these issues"
  - Screen all women – this takes the stigma out of the question and ensures you don't miss anyone who might have a problem

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    - Be non judgmental and validate their situation
    - Ask periodically – things change
- Advise
    - Educate women regarding the risks and their options
- Assess
    - Whether the woman, her unborn infant or other children are at risk for immediate harm.
    - How motivated the woman is to make needed changes.
- Assist and Arrange
    - You do not need to FIX the problem. Your role is to learn about resources in your community and to refer women where they can get the help they need.
    - Document your findings and activities
    - Remain involved. Your continued interest and support will make a significant difference.

Additional Information and Resources

Perinatal Depression

- *Postpartum Support Virginia:* http://postpartumva.org/index.html .
- *Depression during and after Pregnancy: a Resource for Women, Their Families, and Friends:* http://mchb.hrsa.gov/pregnancyandbeyond/depression
- *MedEd Postpartum Depression website*: http://www.mededppd.org

Intimate Partner Violence

- *Virginia Department of Health's Project RADAR*: http://www.vahealth.org/injury/projectradarva/index.htm
- American College Obstetrics & Gynecology Domestic Violence http://www.acog.org/publications/patient_education/bp083.cfm

To Locate Substance Use, Mental Health and Domestic Violence Services

Substance Use and Mental Health Services

Virginia's 40 community services boards (CSBs) provide publicly funded treatment and services to all Virginia residents who have a mental health, substance use and/or intellectual disability. To locate the CSB in your community go to http://www.dbhds.virginia.gov/SVC-CSBs2009.asp or http://vacsb.org/csb-bha.html

Private providers and local agencies may also provide services. To find additional services in your area dial 211.

Intimate Partner Violence Services

Virginia Family Violence and Sexual Assault Hotline 1- 800-838-8238
http://www.vadv.org/secProjects/fvsahotline.html

Reimbursement

Coverage for screening varies according amongst 3rd party providers. Virginia Medicaid, FAMIS and FAMIS MOMS programs cover substance use screenings but do not cover separate screenings for mental health or domestic violence. 3/2/2011

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