# Tools to Detect Common Mental Health and Substance Use Disorders: A Compendium and Review

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## Introduction

It is estimated that 50% of the most disabling disorders are psychiatric in nature; major depression, alcohol abuse, bipolar affective disorder, schizophrenia, and obsessive compulsive disorder (OCD) are among the 10 leading causes of disability worldwide (World Health Organization). Studies indicate that, when screened, more than 25% of primary care practice individuals will score positive for a probable mental illness or substance use disorder. Moreover, more than 50% of those individuals report having one or more chronic medical conditions that could reduce the ability of professionals to recognize their co-morbid psychiatric conditions. It has been demonstrated that without the use of validated screening tools, health care professionals typically identify less than 10% of their individuals as having a mental health or substance use disorder (US Institute of Medicine of the Academies).

One of the chief goals of the Preadmission Screening and Resident Review (PASRR) program is to ensure that all individuals who apply for admission to a Medicaid-certified nursing home are screened for these conditions (along with intellectual disabilities and related conditions), and – if any of these conditions is present – to recommend a set of individualized, disability-specific services to help the individual retain and improve functioning, and return as quickly as possible as to the community. PASRR consists of two levels:

1. At Level I, preliminary screens are intended to be quick investigations of whether an individual *might* have a relevant diagnosis; in other words, the screen should err on the side of finding "false positives" – individuals who later are found *not* to have a PASRR disability. The Code of Federal Regulations (CFR) gives little guidance about the sorts of data Level 1 screens should collect, leaving it up to states to decide.
2. At Level II, individuals who "test positive" at Level I are given in-depth, individualized evaluations to determine whether they do, in fact, have a PASRR disability; whether they would benefit from individualized services keyed to their specific needs (so-called "Specialized Services"), and what those services should be.

Given this context, this report has two goals:

1. To review a large number of screens that could be useful in clinical settings that require rapid, reliable screening for mental health and substance use disorders.
2. To survey the evidentiary base for including specific items (or types of items) in the PASRR Level 1 screen *or* in the Level II individualized evaluation.

To be eligible for inclusion in this review, screenings had to be:

1. Accepted measures within the mental health and medical field to assist in the identification of mental illness;
2. Easily accessed from the internet;
3. Available, when possible, from the public domain;
4. Written on a sixth to ninth grade level, to be usable by a range of screeners with varying levels of training;
5. Available in multiple languages;
6. Easily integrated within the context of a Level I screening session; and
7. Designed to be self-administered or administered and scored by a paraprofessional.

Screening instruments to detect specific mental health and substance use disorders have been in existence for over 55 years (e.g. Hamilton Depression Rating Scale, 1960). In general, older screenings have gradually been replaced by screenings that are more sophisticated in design, ones that can be self-administered, and many that can be found online. Prior to the 1990s, screenings were seen as "assessment scales" which ask individuals to rate the severity or frequency of various symptoms associated with, and indicative of, a particular disorder. There was a movement to expand existing assessment scales to include "symptom count instruments," which incorporate criteria in alignment with diagnostic requirements found in the Diagnostic and Statistical Manual of Mental Disorders (DSM). With few exceptions in the area of substance use disorders, the screening tools reviewed in this report are limited to those developed or modified since 1995.

Although all identified screening instruments discussed in this review have acceptable ratings with respect to reliability, validity, sensitivity and specificity, the screenings should not be viewed as diagnostic tools, nor should the results of these screenings be considered conclusive. Rather, when a person screens positive for a particular disorder, it should prompt further evaluation by a medical or mental health care professional. The focus of the subsequent evaluation is to confirm the diagnosis of the suspected condition, identify and diagnose a related condition, or determine that there is insufficient evidence for a mental or behavioral health diagnosis. In the event there is a confirmation of such a diagnosis, the health care professional should respond appropriately within defined standard of care guidelines.

The review that follows considers screens for depression, generalized anxiety disorder, post-traumatic stress disorder, bipolar disorder, schizophrenia and psychotic disorders, substance use disorders, and cognitive impairments. For each type of disorder, the characteristics of multiple screening instruments are summarized in a table. Readers who wish to see the screens themselves can consult the Appendix (each test has an associated number), and (with a few exceptions) click on the appropriate hyperlink in the last row of each table to jump directly to the tool.

## Depression

Depression is now considered among the top chronic diseases in America and often co-occurs with other major chronic diseases including diabetes; congestive heart failure; coronary artery disease; asthma and chronic obstructive pulmonary disease (Robert Wood Johnson Foundation's 2011 Research Synthesis Report on Mental Disorders and Medical Comorbidity). Table 1 lists the depression screening tools reviewed for this report, along with the relevant characteristics of each.

Although the BDI and Zung SDS continue to be used by many clinicians and have shown high reliability, the PHQ-9 has been endorsed by many organizations and professionals as the depression screen of choice. The PHQ-2 is a briefer, highly reliable instrument in the detection of depression but, when positive, provides no suggestion of severity. A positive screen on PHQ-2 should generate a PHQ-9 screening, which asks about suicidality and provides a severity rating.

It should also be noted that the PHQ-9 has been incorporated into comprehensive screenings that are designed to detect depression and other mental health disorders, e.g. the Patient Stress Questionnaire.

**Table 1: Screening Tools for Depression**

| Characteristics | Beck Depression Inventory (BDI) | Geriatric Depression Scale (GDS) | Patient Health Questionnaire (PHQ-2) | Patient Health Questionnaire (PHQ-9) | Zung Self-Assessment Depression Scale (Zung SDS) | Suicide Behaviors Questionnaire – Revised (SBQ-R) |
|---|---|---|---|---|---|---|
| **Year Released** | 1996 | 1986 | 2000 | 1999 | 1965/1997 | 1999 |
| **Target population** | Adult screen to identify depressive symptoms over the previous 2 weeks | Geriatric screen to identify symptoms of depression (no time-frame noted) | Adult screen to identify symptoms of depression during the past 2 weeks | Adult screen for depression, specific to symptoms experienced during the last 2 weeks | Adult screen for depressive symptoms over the past several days | Adult screen specific to detecting suicidality (present and during last 12 months); identifies likelihood of future suicidal behavior |
| **How administered** | Self-administered (assist as needed) | Initially designed to be administered in the context of a patient interview; also self-administered | Self-administered (assist as needed) | Self-administered (assist as needed) | Self-administered (assist if needed) | Self-administered (assist if needed) |
| **# questions** | 21 | 15 | 2 | 9 | 4 | 4 |
| **Response choices** | 4 options | Y/N format | 4 options | 4 options | 5 & 6 options | 5 & 6 options |
| **Avg time to complete** | <5 min | < 5 min | 30 secs | < 3 min | < 5 min | < 5 min |
| **Scoring time & complexity** | 3 min, simple | 3 min, simple | 30 secs, simple | < 2 min, simple | < 10 min, simple | < 10 min, simple |
| **In public domain** | N | Y | Y | Y | Y | Y |
| **Notes** | Includes question on self-harm | | Positive screen should always generate a PHQ-9 screening; no severity rating | | Screener should be directly supervised by a health care provider (on site); if screen is positive, individual should be immediately evaluated by a healthcare professional | If screen is positive, individual should be immediately evaluated by a healthcare professional. |
| **Test # in Appendix** | 1 (follow link) | 2 (follow link) | 3 (follow link) | 4 (follow link) | 5 (follow link) | 6 (follow link) |

## Generalized Anxiety Disorder

Due to its wide range of presentations, generalized anxiety disorder is often unrecognized or misdiagnosed as a physical condition. Consequently, approximately half of individuals with clinical anxiety disorders go untreated (Weisberg, et al. 2007). Individuals with generalized anxiety disorder often have multiple co-morbidities including migraine; rheumatoid arthritis; peptic ulcer disease; irritable bowel syndrome; coronary heart disease; hyperthyroidism; diabetes; asthma, and COPD (Culpepper, 2009). One in five persons with clinical levels of anxiety develops it after the age of 60 (Le Roux, et al., 2005).

Table 2 lists the GAD screening tools reviewed for this report, along with the relevant characteristics of each.

The GAD-7 is the most commonly used screening for generalized anxiety disorder. It has high reliability, is easy accessed, and provides an anxiety severity score that can be helpful in many settings. The GAD-7 is also embedded in the Patient Stress Questionnaire. The Severity Measure for Generalized Anxiety, created by the American Psychiatric Association, has promise as an emerging, self-administered screen for anxiety.

**Table 2: Screening Tools for Anxiety**

| Characteristics | Generalized Anxiety Disorder (GAD-7) | Geriatric Anxiety Disorder Inventory (GAI) | Severity Measure for Generalized Anxiety Disorder |
|---|---|---|---|
| **Year Released** | 1999 | 2007 | 2013 |
| **Target population** | Adult screen for generalized anxiety symptoms during the past 2 weeks | Geriatric screen for generalized anxiety symptoms | Adult screen for severity of generalized anxiety disorder |
| **How administered** | Self-administered (assist if needed) | Self-administered (assist as needed) | Self-administered (assist as needed) |
| **# questions** | 7 | 20 | 10 |
| **Response choices** | 4 options | Unknown | 5 options |
| **Avg time to complete** | < 5 min | < 5 min | < 5 min |
| **Scoring time & complexity** | 3 min, simple | Unknown | 3 min, simple |
| **In public domain** | Y | No, but available to licensed clinicians and academics free of charge | Y |
| **Notes** | Score has associated anxiety severity rating (none to minimal, mild, moderate, and severe); actions related to need for further assessment to confirm diagnosis and determine a standard of care intervention are available | The measurements of somatic symptoms within the instrument are limited in order to differentiate between symptoms of anxiety and medical conditions | Score provides a suspected severity rating (none, mild, moderate, severe, extreme) |
| **Test # in Appendix** | 7 (follow link) | Not available for preview | 8 (follow link) |

## Post-Traumatic Stress Disorder

PTSD is a serious, under-diagnosed, chronic psychiatric disorder that follows overwhelming stressful events, such as combat exposure, sexual assault, or a natural disaster. When screened in primary care settings, approximately 12-39% of individuals meet diagnostic criteria for PTSD, with a prevalence similar that that of depressive disorders (Leon, et al. 1995). In PTSD, symptomology is typically embedded in both psychiatric and medical comorbidities. Frequent psychiatric related comorbidities include substance abuse; generalized anxiety disorders and panic; mood disorders (major/minor depression and bipolar disorder) and personality disorders (Kessler, et al. 1995; Weisberg, et al. 2002).

Table 3 lists the PTSD screening tools reviewed for this report, along with the relevant characteristics of each.

Both the PC-PTSD screen and NSESSS are in the public domain and have received recognition for their reliability and accessibility. Other screens such as the Sprint are highly valued screenings for the detection of PTSD, but are designed to be given by mental health professionals. M3, a proprietary and multi-dimensional instrument identified in detail under the Bipolar Disorder section, also achieve an impressive 88% sensitivity and 76% specificity rating on its PTSD component.

**Table 3: Screening Tools for Post-Traumatic Stress Disorder (PTSD)**

| Characteristics | Primary Care PTSD Screen (PC-PTSD) | National Stressful Events Survey (NSESSS) | Short Post-Traumatic Stress Disorder Rating Interview (Sprint) |
|---|---|---|---|
| **Year Released** | 2003 | 2013 | 2001 |
| **Target population** | Adult screen for detection of PTSD in the general population | Adult screen for PTSD focused on symptoms over the prior 7 days | Adult screen focused on symptoms of PTSD over the prior 7 days |
| **How administered** | Self-administered (assist as needed) | Self-administered (assist as needed) | Self-administered (assist as needed) |
| **# questions** | 4 | 9 | 8 |
| **Response choices** | Y/N | 5 options | 5 options |
| **Avg time to complete** | < 2 min | < 5 min | 3-5 min |
| **Scoring time & complexity** | 1 min, simple | 1 min, simple | Unknown |
| **In public domain** | Y | Y | No; available to health care professionals through Duke University |
| **Notes** | | Emerging PTSD screen identified as Severity of Post-traumatic Stress Symptoms (Adult) through the American Psychiatric Association | |
| **Test # in Appendix** | 9 (follow link) | 10 (follow link) | Not available to view |

## Bipolar Disorder

Bipolar disorder is considered both chronic and disabling, with significant risk of mortality as the lifetime risk of suicide is 20 times that of the general population (Kesssler, et al. 2005; Osby, et al. 2001). While the typical individual with bipolar disorder is misdiagnosed for 7.5 years, greater than one-third of individuals with bipolar disorder have been misdiagnosed for more than 10 years and (Ghaemi, et al. 1999).

Table 4 lists the bipolar disorder screening tools reviewed for this report, along with the relevant characteristics of each.

The MDQ, ASRM, and the bipolar component of the M3 Clinician are all self-administered screens that receive above average psychometric ratings. Screens for bipolar disorder are often given subsequent to, or in conjunction with, depression screenings. Therefore, the use of the M3 is particularly helpful when conducting screens for multi-dimensional conditions. It is important to note that there are considerably more clinician-administered screens for Bipolar Disorder, e.g. Clinician-Administered Rating Scale for Mania (CARS-M) than self-administered instruments, possibly because individuals with bipolar disorder are often viewed as poor historians with respect to their manic and hypomanic states.

**Table 4: Screening Tools for Bipolar Disorder**

| Characteristics | Mood Disorder Questionnaire (MDQ) | Altmann Self-Rating Mania Scale (ASRM) | M3 Clinician |
|---|---|---|---|
| **Year Released** | 2000 | 1997 | 2007 |
| **Target population** | Adult screen for detection of Bipolar Spectrum Disorder (includes Bipolar I, Bipolar II and Bipolar NOS) | Adult screen for bipolar disorder; specifically assesses the presence and severity of manic symptoms | Adult screen for bipolar disorder |
| **How administered** | Self-administered (assist if needed) | Self-administered (assist if needed) | Self-administered (assist if needed) |
| **# questions** | 17 | 5 | 27 |
| **Response choices** | Yes/No | 5 options | 5 options |
| **Avg time to complete** | 5 min | 5 min | 5 min |
| **Scoring time & complexity** | < 3 min, simple | < 3 min, simple | Immediate electronic scoring, simple |
| **In public domain** | Y | Y | Proprietary screening; screenings for health care professionals are made available through subscription |
| **Notes** | | | Incorporated into multi-dimensional tool that also addresses depression, anxiety, PTSD, and alcohol use. M3 Clinician received NCQA approval as first screening tool endorsed for use in Patient-Centered Medical Home model of care (PCMH). |
| **Test # in Appendix** | 11 (follow link) | 12 (follow link) | 13 (follow link) |

## Schizophrenia and Psychotic Disorders

Schizophrenia and other psychotic disorders rank 22nd among causes for disability worldwide (World Health Organization, 1999). Although schizophrenia typically develops in the second and third decades of life, an emerging number of individuals (particularly women) are developing schizophrenia during their middle years and after age 65 (Palmer, et al. 2001). There is compelling evidence that substance abuse is frequently a co-occurring condition with psychotic disorders and that, in many instances, was well established prior to a person's onset of psychotic symptoms (Lambert, et.al.2005; Buhler, et al. 2002).

Table 5 lists the schizophrenia and psychosis screening tools reviewed for this report, along with the relevant characteristics of each.

Due to the nature of schizophrenia and psychotic disorders, there are no recommended self-administered screening tools. There are tools in the public domain, including those identified below, that provide assistance for professionals to assess individuals suspected of having schizophrenia or other psychotic disorders.

**Table 5: Screening Tools for Schizophrenia and Psychotic Disorders**

| Characteristics | Clinician-Rated Dimensions of Psychosis Severity | Brief Psychiatric Rating Scale (BPRS) |
|---|---|---|
| **Year Released** | 2013 | 1962 |
| **Target population** | Adult screen to measure severity of mental health symptoms across psychotic disorders, including delusions; hallucinations; disorganized speech; abnormal psychomotor behavior; negative symptoms (i.e., restricted emotional expression or avolition); impaired cognition; depression; and mania | Screening instrument used by clinicians for assessing positive, negative, and affective symptoms of individuals who have, or are suspected of having, schizophrenia or other psychotic disorders. Instrument designed to identify symptoms and/or assess admission to symptoms over the past 2-3 days |
| **How administered** | Clinician-administered | Clinician-administered |
| **# questions** | 8 areas covered | 18 areas covered |
| **Response choices** | 5 options on 0-4 scale (clinician-rated) | 8 options on 0-7 scale (clinician-rated) |
| **Avg time to complete** | Estimate of 20-30 min (conducted within course of interview) | Estimate of 20-30 min (conducted within course of interview) |
| **Scoring time & complexity** | Clinician rates patient on a five point scale (0= no symptoms, 1=equivocal, 2= present, but mild, 3=present and moderate, 4 = present and severe); complex -- results are weighed in relationship to other collected data and requires expertise in assessment of psychiatric disorders | Clinician rates individual on an eight point scale, ranging from no evidence to extremely severe; complex --- results are weighed in relationship to other collected data and requires expertise in assessment of psychiatric disorders |
| **In public domain** | Y | Y |
| **Notes** | Follow-up with individual is made on the basis of clinical judgement | Follow-up with individual is made on the basis of clinical judgment |
| **Test # in Appendix** | 14 (follow link) | 15 (follow link) |

## Substance Use Disorder

Substance use disorder, identified as public health's most prominent disorder, contributes to or causes more than 70 conditions that require hospitalization, complicating the treatment of most illnesses, prolonging hospital stays, increasing morbidity, and sharply increasing costs (National Center on Addiction and Substance Abuse, 2012). Globally, alcohol misuse is the fifth leading risk factor for premature death and disability; among people between the ages of 15-49, it is the first (Lim, et al, 2010).

Table 6 lists the substance use disorder screening tools reviewed for this report, along with the relevant characteristics of each.

There are numerous alcohol and drug screenings available that were not reviewed. The CAGE, AUDIT, and AUDIT-C, despite their age, are the alcohol screening tools most often used because of their brevity and strong reliability ratings. The AUDIT also provides a severity rating scale that may be helpful in determining immediate intervention strategies. The NIDA, which continues to be updated, has an on-line version for easy access. The NIDA has strong reliability and specificity.

The DAST-10 is a brief, well-established, and reliable screening tool to identify drug use. It also provides a severity rating that may be helpful in determining intervention strategies. The NIDA-Modified ASSIST V2.0 is an effective instrument with good sensitivity and specificity. It is often used following a positive score on the DAST-10.

**Table 6: Screening Tools for Substance Use Disorders**

| Characteristics | CAGE-Aid | Alcohol Use Disorder Identification Test-C (AUDIT-C) | Alcohol Use Disorder Identification Test (AUDIT) | NIDA – Quick Screen Test v1.0 | NIDA – Modified ASSIST v2.0 | Drug Abuse Screen Test (DAST-10) |
|---|---|---|---|---|---|---|
| **Year Released** | 1984 | 1982 | 1982 | 2009 (revised) | 2009 (revised) | 1982 |
| **Target population** | Adult screening to detect both alcohol and drug misuse particularly as they affect behavior | Adult screen to detect probable alcohol misuse | Adult screen to identify probably harmful and hazardous alcohol use | Adult screen to detect use of alcohol, tobacco products, prescription drugs for non-medical reasons, and illegal drugs during the previous 12 months | Adult screen to detect use of prescription drugs for non-medical reasons and/or illegal drug use | Adult and adolescent screen to detect drug use during the previous 12 months |
| **How administered** | Self-administered or interview with individual | Self-administered or interview with individual | Self-administered or interview with individual | Quick screen completed by face-to face interview | Self-administered (assist as needed) | Self-administered (assist as needed) |
| **# questions** | 4 | 3 to 5 | 10 | 4 (one per product) | 8 | 10 |
| **Response choices** | Yes/No | 3 to 5 options | 3 to 5 options | 5 options | Varied: Yes/No; 3 and 5 options | Yes/No |
| **Avg time to complete** | 1 min | < 3 min | 3 to 5 min | < 3 min | 5 to 10 min | < 8 min |
| **Scoring time & complexity** | < 1 min, simple | < 1 min, simple | 1 min, simple | < 3 min, simple | 5 min, some complexity | < 3 min, simple |
| **In public domain** | Y | Y | Y | Y | Y | Y |
| **Notes** | Positive score suggests further screening (AUDIT if alcohol, DAST-10 if drug) and/or clinical interview | | Has built-in alcohol severity scale corresponding to overall score (low risk, harmful/hazardous, probable dependence/abuse) | If threshold score is positive screen for alcohol misuse, NIDA Quick Screen transitions to a clinical approach to "assess, advise, assist, and arrange" for further intervention; if threshold score is a positive screen for tobacco, NIDA Quick Screen transitions to a clinical | Score provides a "substance involvement rating" and an associated risk category for drug abuse (lower risk, moderate risk and high risk) | Positive screen has built-in suspected drug use severity scales (no problem detected, low level, moderate level, substantial level, severe level) |

| Characteristics | CAGE-Aid | Alcohol Use Disorder Identification Test-C (AUDIT-C) | Alcohol Use Disorder Identification Test (AUDIT) | NIDA – Quick Screen Test v1.0 | NIDA – Modified ASSIST v2.0 | Drug Abuse Screen Test (DAST-10) |
|---|---|---|---|---|---|---|
| | | | | approach to address impact of use of product; if threshold score is positive for use of illegal drugs or prescription drugs for non-medical reasons, the screening transitions to the NIDA – Modified ASSIST V2.0 for further evaluation. | | |
| **Test # in Appendix** | 16 (follow link) | 17 (follow link) | 18 (follow link) | 19 (follow link) | 20 (follow link) | 21 (follow link) |

## Cognitive Impairments

Mild cognitive impairments (MCI) are common in adults with many mental and behavioral health disorders including major depression, bipolar disorder, anxiety, and substance abuse. In addition to co-morbidities with psychiatric disorders, MCI is associated with periods of illness, recovery from illness and surgery, and as a side effect to medication.

The Mini-Cog, a brief cognitive screening test, is widely accepted as a memory test that helps identify persons that might benefit from further evaluation to determine if dementia is present. Its ease of administration, brevity, reliability and sensitivity ratings have made it a screening of choice in many settings. It is considered to have the strongest components of the Mini-Mental Status Exam (MMSE) of any other cognitive screen (Borson, et al. 2005). It is also, to our knowledge, the only brief, publicly available mental status exam.

**Table 7: Characteristics of the Mini-Cog**

| Characteristics | Mini-Cog |
|---|---|
| **Year Released** | 2000 |
| **Target population** | Adult screening to detect for both alcohol and drug misuse particularly as it relates to alcohol and drug behavior |
| **How administered** | |
| **# questions** | 3 item recall screening instrument and a clock draw exercise |
| **Response choices** | Recall, with drawing test |
| **Avg time to complete** | 3 min |
| **Scoring time & complexity** | < 2 min, simple |
| **In public domain** | Y |
| **Notes** | Scoring ultimately falls into two categories (positive or negative for suspected cognitive impairment); positive scores should result in further evaluation by an medical professional using the Mini-Mental Status Exam (MMSE), a more advanced exam of cognitive function |
| **Test # in Appendix** | 22 (follow link) |

## Summary

This literature review focused on the identification and review of frequently used validated screening tools used to detect depression, bipolar disorder, anxiety, PTSD, substance use disorders, psychotic disorders, and mild cognitive impairment. For the purposes of this report, considerable emphasis was placed on whether the screening instrument can be easily accessed, is brief, can be self-administered, can be scored by a para-professional if needed, and can

theoretically be incorporated into, or augment, existing PASRR Level I screening or Level II evaluation tools.

The findings of this literature review indicate that widely available self-administered and clinician-assisted screening tools can effectively help evaluators to detect mental health and substance use disorders across numerous clinical settings. Research consistently demonstrates that such conditions frequently co-occur within individuals who are being treated for chronic and acute medical conditions.

The screening tools identified in this report are particularly well suited to augment an evaluation of an individual's mental health when a transition in care is anticipated or in process. Based on existing research, it is anticipated that the incorporation of selected evidence-based screenings into the PASRR Level I screening or Level II evaluation process will identify individuals that have a previously unrecognized or emerging diagnosable mental illness or substance use disorder.

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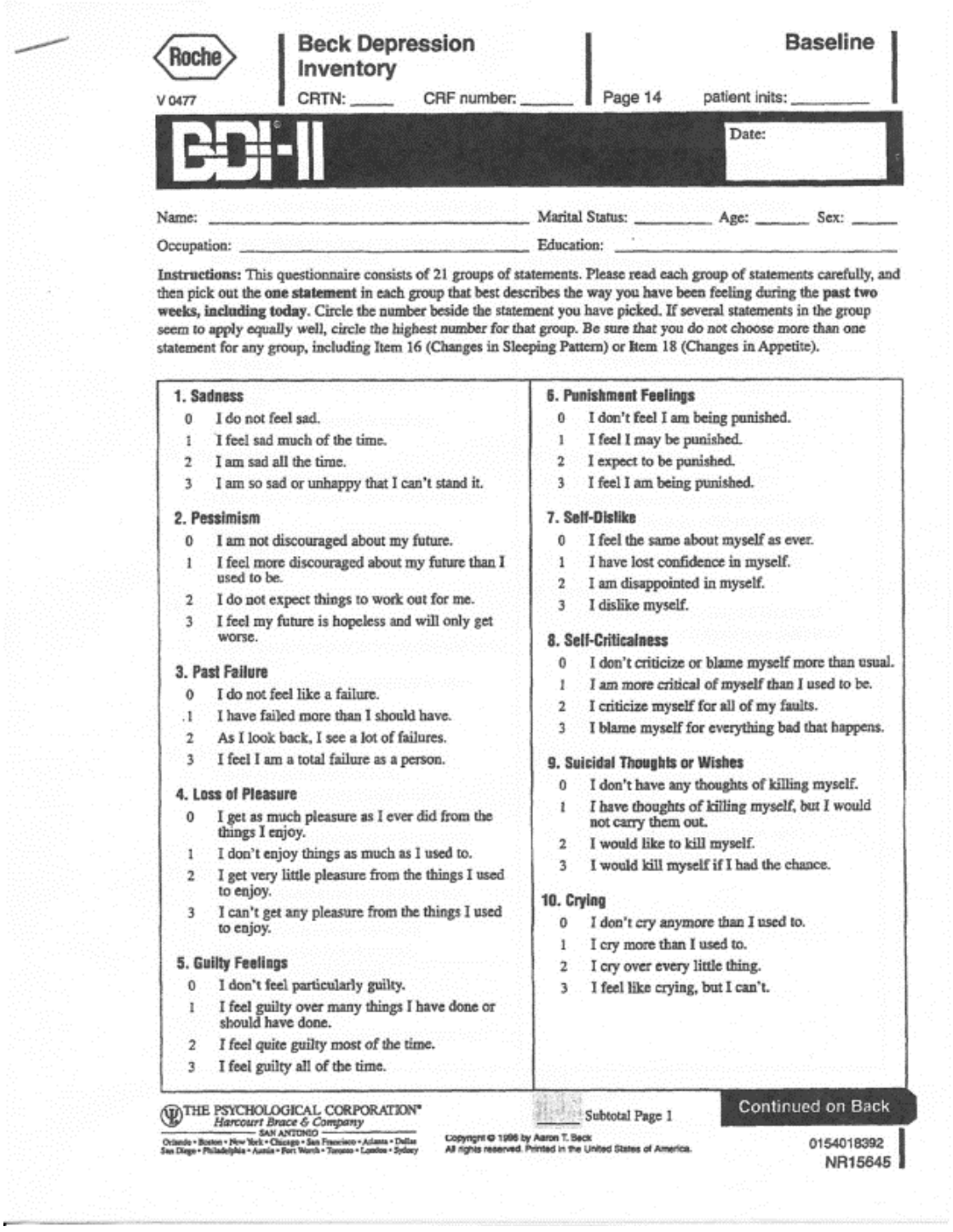
**Appendix: Tests Described in this Review**

**Test 1: Beck Depression Inventory**

(Note: *Not* in the public domain)



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**Beck Depression Inventory**

CRTN: _____ CRF number: _____

Page 14 patient inits: _____

**Baseline**

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

**Instructions:** This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

**1. Sadness**
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

**2. Pessimism**
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

**3. Past Failure**
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

**4. Loss of Pleasure**
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

**5. Guilty Feelings**
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

**6. Punishment Feelings**
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

**7. Self-Dislike**
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

**8. Self-Criticalness**
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

**9. Suicidal Thoughts or Wishes**
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

**10. Crying**
- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

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Continued on Back



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# Beck Depression Inventory

CRTN: _____ CRF number: _____ Page 15 patient inits: _____

Baseline

**11. Agitation**

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

**12. Loss of Interest**

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

**13. Indecisiveness**

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

**14. Worthlessness**

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

**15. Loss of Energy**

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

**16. Changes in Sleeping Pattern**

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

**17. Irritability**

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

**18. Changes in Appetite**

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2a My appetite is much less than before.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

**19. Concentration Difficulty**

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

**20. Tiredness or Fatigue**

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

**21. Loss of Interest in Sex**

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

3456789101112 ABCDE

_____ Subtotal Page 2
_____ Subtotal Page 1
_____ Total Score

NR15645

**Test 2: Geriatric Depression Scale**

## GERIATRIC DEPRESSION SCALE (SHORT VERSION)

Name: _____

Date of Assessment: _____ Completed By: _____

***Jerome A Yesavage Geriatric Depression Scale Psychopharmacology Bulletin (1988) 24:4;709-711***

**Instructions:**

- Each answer counts one point.
- Total score greater than five indicates probably depression.

**Issues:**
The GDS is a screening tool and not a diagnosis. Where a score of more than five is indicated, a more thorough clinical investigation should be undertaken.

Feher et al.[37] have concluded that the GDS is a generally valid measure of the mild-to moderate depressive symptoms in Alzheimer patients with mild-to moderate dementia.

***The right hand column shows test answers which are positive for depression***

| No: | Questions: | Answer: | Test Answers: |
|---|---|---|---|
| 1. | Are you basically satisfied with your life? | Yes / No | No |
| 2. | Have you dropped many of your activities or interests? | Yes / No | Yes |
| 3. | Do you feel that your life is empty? | Yes / No | Yes |
| 4. | Do you often get bored? | Yes / No | Yes |
| 5. | Are you in good spirits most of the time? | Yes / No | No |
| 6. | Are you afraid that something bad is going to happen to you? | Yes / No | Yes |
| 7. | Do you feel happy most of the time? | Yes / No | No |
| 8. | Do you feel helpless? | Yes / No | Yes |
| 9. | Do you prefer to stay at home, rather than go out and do things? | Yes / No | Yes |
| 10. | Do you feel that you have more problems with memory than most? | Yes / No | Yes |
| 11. | Do you think it is wonderful to be alive now? | Yes / No | No |
| 12. | Do you feel pretty worthless the way you are now? | Yes / No | Yes |
| 13. | Do you feel full of energy? | Yes / No | No |
| 14. | Do you feel that your situation is hopeless? | Yes / No | Yes |
| 15. | Do you think that most people are better off then you are? | Yes / No | Yes |
| | **Total Score** | | |

*When a score of more than five is indicated, a more thorough clinical investigation should be undertaken.*

**Test 3: PHQ-2**



## The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

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

STABLE RESOURCE TOOLKIT

## The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

### Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

### Scoring

A PHQ-2 score ranges from 0-6. The authors[1] identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

**Test 4: PHQ-9**

## 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 _____<br>Somewhat difficult _____<br>Very difficult _____<br>Extremely difficult _____ |



A2663B 10-04-2005

# 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 |

TABLE 1

**PHQ-9 Scores and Proposed Treatment Actions**

| PHQ-9 Score | Depression Severity | Proposed Treatment Actions |
|---|---|---|
| 1 to 4 | None | None |
| 5 to 9 | Mild | Watchful waiting; repeat PHQ-9 at follow-up |
| 10 to 14 | Moderate | Treatment plan, considering counseling, follow-up and/or pharmacotherapy |
| 15 to 19 | Moderately Severe | Immediate initiation of pharmacotherapy and/or psychotherapy |
| 20 to 27 | Severe | Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management |

**Test 5: Zung SDS**

## ZUNG SELF-RATING DEPRESSION SCALE

Patient's Initials

Date of Assessment

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

| **Make check mark (✓) in appropriate column.** | A little of the time | Some of the time | Good part of the time | Most of the time |
|---|---|---|---|---|
| 1. I feel down-hearted and blue | | | | |
| 2. Morning is when I feel the best | | | | |
| 3. I have crying spells or feel like it | | | | |
| 4. I have trouble sleeping at night | | | | |
| 5. I eat as much as I used to | | | | |
| 6. I still enjoy sex | | | | |
| 7. I notice that I am losing weight | | | | |
| 8. I have trouble with constipation | | | | |
| 9. My heart beats faster than usual | | | | |
| 10. I get tired for no reason | | | | |
| 11. My mind is as clear as it used to be | | | | |
| 12. I find it easy to do the things I used to | | | | |
| 13. I am restless and can't keep still | | | | |
| 14. I feel hopeful about the future | | | | |
| 15. I am more irritable than usual | | | | |
| 16. I find it easy to make decisions | | | | |
| 17. I feel that I am useful and needed | | | | |
| 18. My life is pretty full | | | | |
| 19. I feel that others would be better off if I were dead | | | | |
| 20. I still enjoy the things I used to do | | | | |

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-70.

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**Test 6: SBQ-R**

## SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

**Instructions:** Please check the number beside the statement or phrase that best applies to you.

**1. Have you ever thought about or attempted to kill yourself?** (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

**2. How often have you thought about killing yourself in the past year?** (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

**3. Have you ever told someone that you were going to commit suicide, or that you might do it?** (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

**4. How likely is it that you will attempt suicide someday?** (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

**Test 7: GAD-7**

## GAD-7 Anxiety

| Over the last two weeks, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to sleep 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 |

Column totals _____ + _____ + _____ + _____ =

*Total score* _____

If you checked any problems, how difficult have they 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: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

## Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

**Test 8: Severity Measure for Generalized Anxiety Disorder**

## Severity Measure for Generalized Anxiety Disorder—Adult

Name:_____ Age: _____ Sex: Male ❑ Female ❑ Date:_____

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

| | | | | | | | Clinician Use |
|---|---|---|---|---|---|---|---|
| | During **the PAST 7 DAYS**, I have... | Never | Occasionally | Half of the time | Most of the time | All of the time | Item score |
| 1. | felt moments of sudden terror, fear, or fright | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 2. | felt anxious, worried, or nervous | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 3. | had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 4. | felt a racing heart, sweaty, trouble breathing, faint, or shaky | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 5. | felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 6. | avoided, or did not approach or enter, situations about which I worry | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 7. | left situations early or participated only minimally due to worries | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 8. | spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 9. | sought reassurance from others due to worries | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 10. | needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people) | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| | | | | | | **Total/Partial Raw Score:** | |
| | | | | | | **Prorated Total Raw Score: (if 1-2 items left unanswered)** | |
| | | | | | | **Average Total Score:** | |

**Test 9: Primary Care PTSD Screen**

## 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

**Test 10: National Stressful Events Survey PTSD Short Scale**

## Severity of Posttraumatic Stress Symptoms—Adult*

*National Stressful Events Survey PTSD Short Scale (NSESSS)

Name:_____ Age:_____ Sex: Male ❑ Female ❑ Date:_____

Please list the traumatic event that you experienced: _____

Date of the traumatic event: _____

Instructions: People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

| | | | | | | | Clinician Use |
|---|---|---|---|---|---|---|---|
| | | Not at all | A little bit | Moderately | Quite a bit | Extremely | Item score |
| 1. | Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 2. | Feeling very emotionally upset when something reminded you of a stressful experience? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 3. | Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 4. | Thinking that a stressful event happened because you or someone else (who didn't directly harm you) did something wrong or didn't do everything possible to prevent it, or because of something about you? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 5. | Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 6. | Losing interest in activities you used to enjoy before having a stressful experience? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 7. | Being "super alert," on guard, or constantly on the lookout for danger? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 8. | Feeling jumpy or easily startled when you hear an unexpected noise? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| 9. | Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | |
| | | | | | | Total/Partial Raw Score: | |
| | | | | | | Prorated Total Raw Score: (if 1-2 items left unanswered) | |
| | | | | | | Average Total Score: | |

**Instructions to Clinicians**

The National Stressful Events Survey PTSD Short Scale (NSESSS) is a 9-item measure that assesses the severity of posttraumatic stress disorder in individuals age 18 and older following an extremely stressful event or experience. The measure was designed to be completed by an individual upon receiving a diagnosis of posttraumatic stress disorder (or clinically significant posttraumatic stress disorder symptoms) and thereafter, prior to follow-up visits with the clinician. Each item asks the individual receiving care to rate the severity of his or her posttraumatic stress disorder **during the past 7 days**.

**Scoring and Interpretation**

Each item on the measure is rated on a 5-point scale (0=Not at all; 1=A little bit; 2=Moderately; 3=Quite a bit, and 4=Extremely). The total score can range from 0 to 36 with higher scores indicating greater severity of posttraumatic stress disorder. The clinician is asked to review the score on each item of the measure during the clinical interview and indicate the raw score for each item in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score. In addition, the clinician is asked to calculate and use the **average total score**. The **average total score** reduces the overall score to a 5-point scale, which allows the clinician to think of the severity of the individual's posttraumatic stress disorder in terms of none (0), mild (1), moderate (2), severe (3), or extreme (4). The use of the average total score was found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials. The **average total score** is calculated by dividing the raw total score by number of items in the measure (i.e., 9).

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

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

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

**Frequency of Use**

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

**Test 11: Mood Disorder Questionnaire**

# 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? | ❍ | ❍ |

# 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.

**Test 12: Altmann Self-Rating Mania Scale (ASRM)**

## Altman Self-Rating Mania Scale (ASRM)

Name _____ Date _____

**Instructions:**

1. There are 5 statements groups on this questionnaire: read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

**Question 1**

- ☐ 0 I do not feel happier or more cheerful than usual.
- ☐ 1 I occasionally feel happier or more cheerful than usual.
- ☐ 2 I often feel happier or more cheerful than usual.
- ☐ 3 I feel happier or more cheerful than usual most of the time.
- ☐ 4 I feel happier or more cheerful than usual all of the time.

**Question 2**

- ☐ 0 I do not feel more self-confident than usual.
- ☐ 1 I occasionally feel more self-confident than usual.
- ☐ 2 I often feel more self-confident than usual.
- ☐ 3 I feel more self-confident than usual.
- ☐ 4 I feel extremely self-confident all of the time.

**Question 3**

- ☐ 0 I do not need less sleep than usual.
- ☐ 1 I occasionally need less sleep than usual.
- ☐ 2 I often need less sleep than usual.
- ☐ 3 I frequently need less sleep than usual.
- ☐ 4 I can go all day and night without any sleep and still not feel tired.

**Question 4**

- ☐ 0 I do not talk more than usual
- ☐ 1 I occasionally talk more than usual.
- ☐ 2 I often talk more than usual.
- ☐ 3 I frequently talk more than usual.
- ☐ 4 I talk constantly and cannot be interrupted

**Question 5**

- ☐ 0 I have not been more active (either socially, sexually, at work, home or school) than usual.
- ☐ 1 I have occasionally been more active than usual.
- ☐ 2 I have often been more active than usual
- ☐ 3 I have frequently been more active than usual.
- ☐ 4 I am constantly active or on the go all the time.

*Permission for use granted by EG Altman, MD*

**Test 13: M3 Clinician**

(Note: *Not* in public domain)

M3 Clinician

## The M3 Clinician Screen

Home

Over the last two weeks, have you noticed the following:

| | NOT AT ALL | RARELY | SOMETIMES | OFTEN | MOST OF THE TIME |
|---|---|---|---|---|---|
| 1. I feel sad, down in the dumps or unhappy | ○ | ○ | ○ | ○ | ○ |
| 2. I can't concentrate or focus | ○ | ○ | ○ | ○ | ○ |
| 3. Nothing seems to give me much pleasure | ○ | ○ | ○ | ○ | ○ |
| 4. I feel tired; have no energy | ○ | ○ | ○ | ○ | ○ |
| 5. I have had thoughts of suicide | ○ | ○ | ○ | ○ | ○ |
| 6. Changes in sleeping patterns: | | | | | |
| a. I have difficulty sleeping | ○ | ○ | ○ | ○ | ○ |
| b. I have been sleeping too much | ○ | ○ | ○ | ○ | ○ |
| 7. Changes in appetite: | | | | | |
| a. I have lost some appetite | ○ | ○ | ○ | ○ | ○ |
| b. I have been eating more | ○ | ○ | ○ | ○ | ○ |
| 8. I feel tense, anxious or can't sit still | ○ | ○ | ○ | ○ | ○ |
| 9. I feel worried or fearful | ○ | ○ | ○ | ○ | ○ |
| 10. I have attacks of anxiety or panic | ○ | ○ | ○ | ○ | ○ |
| 11. I worry about dying or losing control | ○ | ○ | ○ | ○ | ○ |
| 12. I am nervous or shaky in social situations | ○ | ○ | ○ | ○ | ○ |
| 13. I have nightmares or flashbacks | ○ | ○ | ○ | ○ | ○ |
| 14. I am jumpy or feel startled easily | ○ | ○ | ○ | ○ | ○ |
| 15. I avoid places that strongly remind me of a bad experience | ○ | ○ | ○ | ○ | ○ |
| 16. I feel dull, numb, or detached | ○ | ○ | ○ | ○ | ○ |
| 17. I can't get certain thoughts out of my mind | ○ | ○ | ○ | ○ | ○ |
| 18. I feel I must repeat certain acts or rituals | ○ | ○ | ○ | ○ | ○ |
| 19. I feel the need to check and recheck things | ○ | ○ | ○ | ○ | ○ |

At any time in your life have there been phases or periods when you have:

| | | | | | |
|---|---|---|---|---|---|
| 20. Had more energy than usual | ○ | ○ | ○ | ○ | ○ |
| 21. Felt unusually irritable or angry | ○ | ○ | ○ | ○ | ○ |
| 22. Felt unusually excited, revved up or high | ○ | ○ | ○ | ○ | ○ |
| 23. Needed less sleep than usual | ○ | ○ | ○ | ○ | ○ |

Indicate whether any of the above symptoms:

| | | | | | |
|---|---|---|---|---|---|
| 24. Interferes with work or school | ○ | ○ | ○ | ○ | ○ |
| 25. Affects my relationships with friends or family | ○ | ○ | ○ | ○ | ○ |
| 26. Has led to my using alcohol to get by | ○ | ○ | ○ | ○ | ○ |
| 27. Has led to my using drugs | ○ | ○ | ○ | ○ | ○ |



M3 Clinician Solutions for the Patient-Centered Medical Home

**Test 14: Clinician-Rated Dimensions of Psychosis Severity**

## Clinician-Rated Dimensions of Psychosis Symptom Severity

Name:_____ Age: _____ Sex: [ ] Male [ ] Female Date:_____

**Instructions:** Based on all the information you have on the individual and using your clinical judgment, please rate (with checkmark) the presence and severity of the following symptoms as experienced by the individual in the past seven (7) days.

| Domain | 0 | 1 | 2 | 3 | 4 | Score |
|---|---|---|---|---|---|---|
| I. Hallucinations | ❑ Not present | ❑ Equivocal (severity or duration not sufficient to be considered psychosis) | ❑ Present, but mild (little pressure to act upon voices, not very bothered by voices) | ❑ Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices) | ❑ Present and severe (severe pressure to respond to voices, or is very bothered by voices) | |
| II. Delusions | ❑ Not present | ❑ Equivocal (severity or duration not sufficient to be considered psychosis) | ❑ Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs) | ❑ Present and moderate (some pressure to act upon beliefs, or is somewhat bothered by beliefs) | ❑ Present and severe (severe pressure to act upon beliefs, or is very bothered by beliefs) | |
| III. Disorganized speech | ❑ Not present | ❑ Equivocal (severity or duration not sufficient to be considered disorganization) | ❑ Present, but mild (some difficulty following speech) | ❑ Present and moderate (speech often difficult to follow) | ❑ Present and severe (speech almost impossible to follow) | |
| IV. Abnormal psychomotor behavior | ❑ Not present | ❑ Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior) | ❑ Present, but mild (occasional abnormal or bizarre motor behavior or catatonia) | ❑ Present and moderate (frequent abnormal or bizarre motor behavior or catatonia) | ❑ Present and severe (abnormal or bizarre motor behavior or catatonia almost constant) | |
| V. Negative symptoms (restricted emotional expression or avolition) | ❑ Not present | ❑ Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behavior | ❑ Present, but mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior | ❑ Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior | ❑ Present and severe decrease in facial expressivity, prosody, gestures, or self-initiated behavior | |
| VI. Impaired cognition | ❑ Not present | ❑ Equivocal (cognitive function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean) | ❑ Present, but mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean) | ❑ Present and moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean) | ❑ Present and severe (severe reduction in cognitive function; below expected for age and SES, > 2 SD from mean) | |
| VII. Depression | ❑ Not present | ❑ Equivocal (occasionally feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied) | ❑ Present, but mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation) | ❑ Present and moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong) | ❑ Present and severe (deeply depressed or hopeless daily; delusional guilt or unreasonable self-reproach grossly out of proportion to circumstances) | |
| VIII. Mania | ❑ Not present | ❑ Equivocal (occasional elevated, expansive, or irritable mood or some restlessness) | ❑ Present, but mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness) | ❑ Present and moderate (frequent periods of extensively elevated, expansive, or irritable mood or restlessness) | ❑ Present and severe (daily and extensively elevated, expansive, or irritable mood or restlessness) | |

*Note.* SD = standard deviation; SES = socioeconomic status.

**Test 15: Brief Psychiatric Rating Scale (BPRS)**

# BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Patient Name _____ Today's Date _____

Please enter the score for the term that best describes the patient's condition.

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe

| Score | | |
|---|---|---|
| ☐ | 1. | SOMATIC CONCERN<br>Preoccupation with physical health, fear of physical illness, hypochondriasis. |
| ☐ | 2. | ANXIETY<br>Worry, fear, over-concern for present or future, uneasiness. |
| ☐ | 3. | EMOTIONAL WITHDRAWAL<br>Lack of spontaneous interaction, isolation deficiency in relating to others. |
| ☐ | 4. | CONCEPTUAL DISORGANIZATION<br>Thought processes confused, disconnected, disorganized, disrupted. |
| ☐ | 5. | GUILT FEELINGS<br>Self-blame, shame, remorse for past behavior. |
| ☐ | 6. | TENSION<br>Physical and motor manifestations of nervousness, over-activation. |
| ☐ | 7. | MANNERISMS AND POSTURING<br>Peculiar, bizarre, unnatural motor behavior (not including tic). |
| ☐ | 8. | GRANDIOSITY<br>Exaggerated self-opinion, arrogance, conviction of unusual power or abilities. |
| ☐ | 9. | DEPRESSIVE MOOD<br>Sorrow, sadness, despondency, pessimism. |
| ☐ | 10. | HOSTILITY<br>Animosity, contempt, belligerence, disdain for others. |
| ☐ | 11. | SUSPICIOUSNESS<br>Mistrust, belief others harbor malicious or discriminatory intent. |
| ☐ | 12. | HALLUCINATORY BEHAVIOR<br>Perceptions without normal external stimulus correspondence. |
| ☐ | 13. | MOTOR RETARDATION<br>Slowed, weakened movements or speech, reduced body tone. |
| ☐ | 14. | UNCOOPERATIVENESS<br>Resistance, guardedness, rejection of authority. |
| ☐ | 15. | UNUSUAL THOUGHT CONTENT<br>Unusual, odd, strange, bizarre thought content. |
| ☐ | 16. | BLUNTED AFFECT<br>Reduced emotional tone, reduction in formal intensity of feelings, flatness. |
| ☐ | 17. | EXCITEMENT<br>Heightened emotional tone, agitation, increased reactivity. |
| ☐ | 18. | DISORIENTATION<br>Confusion or lack of proper association for person, place or time. |

**Test 16: CAGE and CAGE-AID**

# The CAGE and CAGE-AID Questionnaires

| Item | Text |
|---|---|
| 1. | Have you ever felt you ought to cut down on your drinking *or drug use*? |
| 2. | Have people annoyed you by criticizing your drinking *or drug use*? |
| 3. | Have you ever felt bad or guilty about your drinking *or drug use*? |
| 4. | Have you ever had a drink *or used drugs* first thing in the morning to steady your nerves or to get rid of a hangover? |

*Note*. The plain text shows the CAGE questions. The italicized text was added to produce the CAGE-AID. For this study, the CAGE-AID was preceded by the following instruction: "When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed."



# The CAGE and CAGE-AID Questions

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs (CAGE-AID) are the original CAGE questions modified by the *italicized text.*

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.

## *CAGE and CAGE-AID Questions*

1. In the last three months, have you felt you should cut down or stop drinking or *using drugs?*
   Yes No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?*
   Yes No
3. In the last three months, have you felt guilty or bad about how much you drink *or use drugs*?
   Yes No
4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*?
   Yes No

**Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.**

Reference: The Society of Teachers of Family Medicine. Project SAEFP Workshop Materials, Screening and Assessment Module, page 18. Funded by the Division of Health Professionals, HRSA, DHHS, Contract No. 240-89-0038. Used with permission.

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**Test 17: Alcohol Use Disorder Identification Test-C (AUDIT-C)**



## AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

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

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

**2. How many standard drinks containing alcohol do you have on a typical day?**

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

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

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

*AUDIT-C is available for use in the public domain.*

**Test 18: Alcohol Use Disorder Identification Test (AUDIT)**

# AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

**12 oz. of beer** (about 5% alcohol) = **8-9 oz. of malt liquor** (about 7% alcohol) = **5 oz. of wine** (about 12% alcohol) = **1.5 oz. of hard liquor** (about 40% alcohol)

| Questions | 0 | 1 | 2 | 3 | 4 | |
|---|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times a month | 2 to 3 times a week | 4 or more times a week | |
| 2. 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 | |
| 3. How often do you have 5 or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | 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? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |
| | | | | | **Total** | |

***Note:*** This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at ***www.who.org***.

Excerpted from NIH Publication No. 07-3769 **National Institute on Alcohol and Alcoholism** ***www.niaaa.nih.gov/guide***

**Test 19: NIDA Quick Screen v1.0**

## NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

**Introduction (Please read to patient)**

*Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.*

**Instructions:** For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

| **NIDA *Quick Screen* Question:**<br><br>**In the past year, how often have you used the following?** | **Never** | **Once or Twice** | **Monthly** | **Weekly** | **Daily or Almost Daily** |
|---|---|---|---|---|---|
| **Alcohol**<br>• **For men, 5 or more drinks a day**<br>• **For women, 4 or more drinks a day** | | | | | |
| **Tobacco Products** | | | | | |
| **Prescription Drugs for Non-Medical Reasons** | | | | | |
| **Illegal Drugs** | | | | | |

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1] *This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/activities/assist_v3_english.pdf).*

**Test 20: NIDA - Modified ASSIST v2.0**

## Questions 1-8 of the NIDA-Modified ASSIST V2.0

**Instructions:** Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

| Question 1 of 8, NIDA-Modified ASSIST | Yes | No |
|---|---|---|
| **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.*** | | |
| a. **Cannabis** (marijuana, pot, grass, hash, etc.) | | |
| b. **Cocaine** (coke, crack, etc.) | | |
| c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | | |
| d. **Methamphetamine** (speed, crystal meth, ice, etc.) | | |
| e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, etc.) | | |
| f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.) | | |
| g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | | |
| h. **Street opioids** (heroin, opium, etc.) | | |
| i. **Prescription opioids** (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | | |
| j. **Other – specify:** | | |

- Given the patient's response to the Quick Screen, the patient *should not indicate* **"NO"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1.** If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST.
- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

2

| Question 2 of 8, NIDA-Modified ASSIST<br>2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| • Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Cocaine (coke, crack, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Street opioids (heroin, opium, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 2 | 3 | 4 | 6 |
| • Other – Specify: | 0 | 2 | 3 | 4 | 6 |

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8.**
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

| 3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 4 | 5 | 6 |
| b. Cocaine (coke, crack, etc.) | 0 | 3 | 4 | 5 | 6 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 3 | 4 | 5 | 6 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 3 | 4 | 5 | 6 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 3 | 4 | 5 | 6 |
| f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 3 | 4 | 5 | 6 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 3 | 4 | 5 | 6 |
| h. Street Opioids (heroin, opium, etc.) | 0 | 3 | 4 | 5 | 6 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 3 | 4 | 5 | 6 |
| j. Other – Specify: | 0 | 3 | 4 | 5 | 6 |

| 4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 4 | 5 | 6 | 7 |
| b. Cocaine (coke, crack, etc.) | 0 | 4 | 5 | 6 | 7 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 4 | 5 | 6 | 7 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 4 | 5 | 6 | 7 |
| e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.) | 0 | 4 | 5 | 6 | 7 |
| f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 4 | 5 | 6 | 7 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 4 | 5 | 6 | 7 |
| h. Street opioids (heroin, opium, etc.) | 0 | 4 | 5 | 6 | 7 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 4 | 5 | 6 | 7 |
| j. Other – Specify: | 0 | 4 | 5 | 6 | 7 |

| 5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)? | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 5 | 6 | 7 | 8 |
| b. Cocaine (coke, crack, etc.) | 0 | 5 | 6 | 7 | 8 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 5 | 6 | 7 | 8 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 5 | 6 | 7 | 8 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 5 | 6 | 7 | 8 |
| f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.) | 0 | 5 | 6 | 7 | 8 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 5 | 6 | 7 | 8 |
| h. Street Opioids (heroin, opium, etc.) | 0 | 5 | 6 | 7 | 8 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 5 | 6 | 7 | 8 |
| j. Other – Specify: | 0 | 5 | 6 | 7 | 8 |

**Instructions:** Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

| 6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)? | No, never | Yes, but not in the past 3 months | Yes, in the past 3 months |
|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 6 |
| b. Cocaine (coke, crack, etc.) | 0 | 3 | 6 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 3 | 6 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 3 | 6 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 3 | 6 |
| f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.) | 0 | 3 | 6 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 3 | 6 |
| h. Street opioids (heroin, opium, etc.) | 0 | 3 | 6 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 3 | 6 |
| j. Other – Specify: | 0 | 3 | 6 |

| 7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)? | No, never | Yes, but not in the past 3 months | Yes, in the past 3 months |
|---|---|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 3 | 6 |
| b. Cocaine (coke, crack, etc.) | 0 | 3 | 6 |
| c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | 0 | 3 | 6 |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | 0 | 3 | 6 |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | 0 | 3 | 6 |
| f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.) | 0 | 3 | 6 |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | 0 | 3 | 6 |
| h. Street opioids (heroin, opium, etc.) | 0 | 3 | 6 |
| i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 0 | 3 | 6 |
| j. Other – Specify: | 0 | 3 | 6 |

**Instructions:** Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

| 8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)? | No, never | Yes, but not in the past 3 months | Yes, in the past 3 months |
|---|---|---|---|

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

**Note:** Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

**Tally Sheet for scoring the full NIDA-Modified ASSIST:**

**Instructions:** For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

| Substance Involvement Score | Total (SI SCORE) |
|---|---|
| a. Cannabis (marijuana, pot, grass, hash, etc.) | |
| b. Cocaine (coke, crack, etc.) | |
| c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.) | |
| d. Methamphetamine (speed, crystal meth, ice, etc.) | |
| e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.) | |
| f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.) | |
| g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.) | |
| h. Street Opioids (heroin, opium, etc.) | |
| i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | |
| j. Other – Specify: | |

**Use the resultant Substance Involvement (SI) Score to identify patient's risk level.**

To determine patient's risk level based on his or her SI score, see the table below:

| Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use | |
|---|---|
| 0-3 | Lower Risk |
| 4-26 | Moderate Risk |
| 27+ | High Risk |

**Test 21: DAST-10**

# DRUG USE QUESTIONNAIRE (DAST -10)

NAME: _____ Date: _____

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each countyment and decide if your answer is "YES" or "NO". Then, check the appropriate box beside the question.

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

Please answer every question. If you have difficulty with a countyment, then choose the response that is mostly right.

| **These questions refer to the past 12 months only.** | **YES** | **NO** |
|---|---|---|
| 1. Have you used drugs other than those required for medical reasons?..... | | |
| 2. Do you abuse more than one drug at a time?..... | | |
| 3. Are you always able to stop using drugs when you want to?..... | | |
| 4. Have you had "blackouts" or "flashbacks" as a result of drug use?..... | | |
| 5. Do you ever feel bad or guilty about your drug use?..... | | |
| 6. Does your spouse (or parent) ever complain about your involvement with drugs?..... | | |
| 7. Have you neglected your family because of your use of drugs?..... | | |
| 8. Have you engaged in illegal activities in order to obtain drugs?..... | | |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?..... | | |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding etc…)?..... | | |
| *** DAST Score**..... | | |
| ** See scoring instructions for correct scoring procedu* | | |

# DRUG USE QUESTIONNAIRE (DAST -10)

## Administration & Interpretation

## Instructions

The DAST-10 is a 10-item, yes/no, self-report instrument that has been shortened from the 28-item DAST and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. It is **strongly recommended** that the SMAST be used along with the DAST-10 unless there is a clear indication that the client uses NO ALCOHOL at all. The answer options for each item are "YES" or "NO". The DAST-10 is a self-administered screening instrument.

Scoring and Interpretation – For the DAST-10, score 1 point for each question answered, "YES", except for question (3) for which a "NO" answer receives 1 point and (0) for a "YES". Add up the points and interpretations are as followed:

| DAST-10 Score | Degree of Problem Related to Drug Abuse | Suggested Action |
|---|---|---|
| 0 | No problems reported | None at this time. |
| 1 – 2 | Low Level | Monitor, reassess at a later date. |
| 3 – 5 | Moderate Level | Further investigation is required. |
| 6 – 8 | Substantial Level | Assessment required. |
| 9 – 10 | Severe Level | Assessment required. |

**Test 22: Mini-Cog**

## Instructions for the Mini-Cog Test

### Administration

the Mini-Cog test is a 3-minute instrument to screen for cognitive impairment in older adults in the primary care setting. The Mini-Cog uses a three-item recall test for memory and a simply scored clock-drawing test (CDT). The latter serves as an "informative distractor," helping to clarify scores when the memory recall score is intermediate. The Mini-Cog was as effective as or better than established screening tests in both an epidemiologic survey in a mainstream sample and a multi-ethnic, multilingual population comprising many individuals of low socioeconomic status and education level. In comparative tests, the Mini-Cog was at least twice as fast as the Mini-Mental State Examination. The Mini-Cog is less affected by subject ethnicity, language, and education, and can detect a variety of different dementias. Moreover, the Mini-Cog detects many people with mild cognitive impairment (cognitive impairment too mild to meet diagnostic criteria for dementia).

### Scoring (see figure 1)

1 point for each recalled word

Score clock drawing as **Normal** (the patient places the correct time and the clock appears grossly normal) or **Abnormal**

Score

| | |
|---|---|
| 0 | Positive for cognitive impairment |
| 1-2 | **Abnormal** CDT then positive for cognitive impairment |
| 1-2 | **Normal** CDT then negative for cognitive impairment |
| 3 | Negative screen for dementia (no need to score CDT) |

UT MEDICINE

# THE MINI-COG

1. Instruct the patient to listen carefully and repeat the following

APPLE WATCH PENNY

MANZANA RELOJ PESETA

2. Administer the Clock Drawing Test

3. Ask the patient to repeat the three words given previously

_____ _____ _____

**Scoring**

Number of correct items recalled _____ [if 3 then negative screen. STOP]

If answer is 1-2
Is CDT Abnormal? No Yes

If No, then negative screen
If Yes, then screen positive for cognitive impairment

UT MEDICINE

Pt. Name:_____ DOB:_____
Date:_____

**Instructions**
Inside the circle draw the hours of a clock as if a child would draw them
Place the hands of the clock to represent the time "forty five minutes past ten o'clock"

**Instrucciones**
Dentro del circulo dibuje las horas del reloj como si lo haria un niño.
Ponga las manos del reloj para representar el tiempo "cuarenta y cinco minutos despues de las diez"