SMH Screening for Mental Health®

Screening Tools Available for Community*Response* Clients

ADOLESCENT DEPRESSION SCREENING (BSAD)
The Brief Screen for Adolescent Depression is intended for use by parent(s) or guardian(s) on behalf of their child.
Shaffer, D., Fisher, P., Lucas, C.P., Dulcan, M.K., Schwab-Stone, M.E. (2000). NIMH Diagnostic Interview Schedule for Children version IV (NIMH DISC-IV): description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 28-38.

ALCOHOL USE SCREENING (AUDIT)
Developed in 1982 by the World Health Organization the questionnaire, the Alcohol Use Disorder Identification Test consists of 10 questions. The AUDIT alcohol screening was developed as a simple and efficient method for assessment of alcohol use.
Allen, J. P., Litten, R. Z., Fertig, J. B. and Babor, T. (1997), A Review of Research on the Alcohol Use Disorders Identification Test (AUDIT). Alcoholism: Clinical and Experimental Research, *21*: 613–619.

BIPOLAR DISORDER SCREENING (MDQ)
The mood disorder questionnaire was developed by Robert Hirschfeld, MD and is the only validated screening for bipolar disorder.
Hirschfeld, R. M., Holzer, C., Calabrese, J. R., Weissman, M., Reed, M., Davies, M., Frye, M. A., Keck, P., McElroy, S., Lewis, L., Tierce, J., Wagner, K. D., & Hazard, E. (2003). Validity of the mood disorder questionnaire: a general population study. *American Journal of Psychiatry, 160,* 178-180.

DEPRESSION: CLINICAL SCREENING (PHQ-9)
The Patient Health Questionnaire is a multipurpose tool for screening, monitoring, and measuring the severity of depression.
Kroenke K, Spitzer R L, Williams J B (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine,* 16(9): 606-613.

DEPRESSION: COMMUNITY SCREENING (HANDS®)
Developed by Harvard Medical School's Department of Psychiatry and Screening for Mental Health's Founder Dr. Douglas Jacobs, the questionnaire consists of 10 questions followed by three additional items targeting bipolar disorder.
Baer, L., Jacobs, D. G., Meszleer-Reizes, J., Blais, M., Fava, M., Kessler, R., Magruder, K., Murphy, J., Kopans, B., Cukor, P., Leahy, L., & O'Laughlen, J. (2000). Development of a Brief Screening Instrument: The HANDS. *Psychother Psychosom, 69,* 35-41.

EATING DISORDERS SCREENING (EAT-11)
Created by David Gamer, PhD, the questionnaire is a modified version of the EAT26.
Garner, D. M., Olmsted, M. P., Bohr, Y. and Garfinkel, P.E. (1982). The eating attitudes test: Psychometric features and clinical correlates. *Psychological Medicine*, *12*, 871-878.

GENERALIZED ANXIETY DISORDER SCREENING (CD-GAD)
The Carroll-Davidson GAD scale (CD-GAD) is a 12-item screening tool for Generalized Anxiety Disorder. The CD-GAD has a yes/no format and measures GAD symptoms occurring over the past six months.
Carroll, B., & Davidson, J.R.T. (2000).

POST-TRAUMATIC STRESS DISORDER SCREENING (SPRINT-4)
Developed by Jonathon Davidson, MD at Duke University Medical Center.
Connor, K. M., & Davidson, J. R. T. (2001). SPRINT: a brief global assessment of posttraumatic stress disorder. *International Clinical Psychopharmacology, 16,* 279-284.

PSYCHOSIS SCREENING FOR INDIVIDUALS (PQ-16)
The psychosis screening is a modified version of the PQ-16 (Prodromal Questionnaire 16) and was developed to bring about the implementation of routine screening for psychosis risk.
Ising, H.K., Veling, W., Loewy, R.L., Rietveld, M.W., Rietdijk, J., Dragt, S., Klaassen, R.M.C., Neiman, D. H., Wunderink, L., Linszen, D.H., & van der Gaag, M. (2012). The validity of the 16-item version of the Prodromal Questionnaire (PQ-16) to screen for ultra high risk of developing psychosis in the general help-seeking population. *Schizophrenia Bulletin*, 38(6), 1288–1296.

PSYCHOSIS SCREENING FOR LOVED ONES/FRIENDS (PQ-16)

The psychosis screening is a modified version of the PQ-16 (Prodromal Questionnaire 16) and was developed to bring about the implementation of routine screening for psychosis risk. The questionnaire has been further modified so that it can be taken on behalf of friends/loved ones.

Ising, H.K., Veling, W., Loewy, R.L., Rietveld, M.W., Rietdijk, J., Dragt, S., Klaassen, R.M.C., Neiman, D. H., Wunderink, L., Linszen, D.H., & van der Gaag, M. (2012). The validity of the 16-item version of the Prodromal Questionnaire (PQ-16) to screen for ultra high risk of developing psychosis in the general help-seeking population. *Schizophrenia Bulletin,* 38(6), 1288–1296.

SUBSTANCE USE SCREENING (ASSIST)

Developed by the World Health Organization, the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a brief screen that was developed to detect substance use and includes questions on alcohol use.

Humeniuk, RE, Ali RA, Babor TF, Farrell M, Formigoni ML, Jittiwutikarn J, Boerngen de Larcerda R, Ling W, Marsden J, Monteiro M, Nhiwhatiwa S, Pal H, Poznyak V & Simon S (2008). Validation of the Alcohol Smoking and Substance Involvement Screening Test (ASSIST). Addiction 103(6): 1039-1047.

The Brief Screening for Adolescent Depression (BSAD)[1]

The BSAD is intended for use by parent(s) or guardian(s) to assess for possible depression and suicide factors apparent in their child. The screening consists of six questions related to symptoms of depression that have been noticeable in the child in the past four weeks, and one question asks whether the child has attempted suicide in the past year.

Sample Screening Questions:

- Does he/she seem to have less energy than he/she usually does?
- In the last four weeks, has there been a time when it seemed like nothing is fun for him/her?
- In the last four weeks, has he/she talked seriously about killing him/herself?

Questions are answered Yes or No.

Scoring assigns each answer a numerical value and adds the total value of responses to the seven questions.

- Yes = 1
- No = 0

Interpretation:

- 0-2: It is unlikely that your child has depression.
- 3: It is possible that your child has depression
- 4-7: It is likely that your child has depression.

Two questions ask about suicidal thoughts and behaviors. If either of these questions are answered "Yes" indicating suicidality, help from a mental health professional should be sought, regardless of the total BSAD score.

[1] Shaffer, D., Fisher, P., Lucas, C.P., Dulcan, M.K., Schwab-Stone, M.E. (2000). NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): description, differences from previous versions, and reliability of some common diagnoses. Journal of the American Academy of Child and Adolescent Psychiatry, 39, 28-38.

Alcohol Use Disorders Identification Test (AUDIT)[1]

The AUDIT screens individuals for problematic alcohol consumption and abuse/dependence. The screening consists of ten questions related to drinking habits, attitudes towards drinking, and consequences of drinking behaviors over the past twelve months.

Screening Questions:

The first two questions ask how often individuals consume alcohol and how much alcohol they consume when they drink.

The third question determines how frequently individuals meet the criteria for a binge drinking episode (note that criteria is dependent on gender due to differing rates of the metabolism of alcohol).

The next five questions ask about the frequency of negative consequences related to drinking behaviors. These questions can be answered:

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

The final two questions ask if the individuals or others have been injured as a result of their drinking and whether someone else has expressed concern about their drinking.
These questions can be answered:

- No
- Yes, but not in the past year
- Yes, during the past year

Scoring assigns a numerical value to each answer. Absence of drinking behaviors and negative consequences correspond to a lower score on the question (min = 0). Greater alcohol consumption and more frequent negative consequences correspond to a higher score on the question (max = 4). Scores to each question are tallied for interpretation.

Interpretation:

0-7: Low risk
8-18: Individual may already be experiencing) health consequences as a result of drinking
19-40: Score indicates possible alcohol dependence or abuse

[1] *The Alcohol Use Disorder Identification Test was developed in 1982 by the World Health Organization.*
Allen, J. P., Litten, R. Z., Fertig, J. B. and Babor, T. (1997), A Review of Research on the Alcohol Use Disorders Identification Test (AUDIT). Alcoholism: Clinical and Experimental Research, *21*: 613–619.

The Mood Disorder Questionnaire Bipolar Screening (MDQ)[1]

The MDQ is the only validated screening for bipolar disorder. The screening asks if individuals have experienced any of thirteen symptoms over a period of time.

Symptoms include:

- 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 did things that were unusual for you or that other people might have through were excessive, foolish, or risky?

Individuals respond by indicating Yes or No.

The next question asks if individuals experienced several of the symptoms during the same period of time.

The final question asks the severity of problems the symptoms caused, in terms of being unable to work, having family, money or legal troubles, or getting into arguments or fights, etc.

- No problem
- Minor problem
- Moderate problem
- Serious problem

Scoring assigns a numerical value to each answer of a symptom question and adds the total value of responses:

- Yes = 1
- No = 0

Interpretation:

Individuals are considered positive for bipolar disorder if they scored between 7 and 13 AND answered Yes to experiencing multiple symptoms during the same period of time AND that symptoms were a Moderate problem or Serious problem.

These respondents should be evaluated for bipolar disorder.

[1] Hirschfeld, R. M., Holzer, C., Calabrese, J. R., Weissman, M., Reed, M., Davies, M., Frye, M. A., Keck, P., McElroy, S., Lewis, L., Tierce, J., Wagner, K. D., & Hazard, E. (2003). Validity of the mood disorder questionnaire: a general population study. American Journal of Psychiatry, 160, 178-180.

The Patient Health Questionnaire (PHQ-9)[1]

The Patient Health Questionnaire (PHQ-9) consists of nine questions related to the emotional, physical, and behavioral symptoms of depression and a tenth question about the level of impairment caused by symptoms. The screening asks individuals how frequently they have experienced these symptoms over the past two weeks.

Sample symptoms include:

- Little interest or pleasure in doing things
- Trouble falling asleep, staying asleep, or sleeping too much
- Feeling bad about yourself – or that you're a failure or have let your family down
- Thoughts that you would be better off dead or of hurting yourself in some way

Individuals indicate:
- Not at All
- Several Days
- More Than Half the Days
- Nearly Every Day

The tenth question asks: "If you checked off any problems, how difficult have those problems made it for you to: Do your work, take care of things at home, or get along with other people?"

Individuals indicate:
- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

Scoring assigns answers to the first nine questions the following values:
- Not at All = 0
- Several Days = 1
- More Than Half the Days = 2
- Nearly Every Day = 3

Interpretation:

Scores from the first nine questions are added together and interpreted as follows.
- 0 to 4 - not consistent with depression
- 5 to 9 - consistent with depression
- 15 to 27 - highly consistent with depression

1. *Kroenke K, Spitzer R L, Williams J B (2001). The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine, 16(9): 606-613.*

Harvard Department of Psychiatry/NDSD Scale (HANDS)[1]

The HANDS depression screening tool consists of ten questions covering a variety of emotional, behavioral, and physical symptoms. The screening asks how often individuals have experienced symptoms in the past two-week period.

Sample questions include:

- Been feeling low in energy, slowed down?
- Been feeling hopeless about the future?
- Thought about or wanted to commit suicide?

Individuals respond by indicating one of the following:

- None or little of the time
- Some of the time
- Most of the time
- All of the time

Scoring assigns each answer a numerical value and adds the total value of responses to the ten questions:

- None or little of the time = 0
- Some of the time = 1
- Most of the time = 2
- All of the time = 3

Interpretation:

0-8: symptoms are not consistent with a major depressive episode and presence of major depressive disorder is unlikely.

9-16: symptoms are consistent with a major depressive episode, presence of major depressive disorder is likely, and severity level is typically mild or moderate. The individual could alternatively or additionally be experiencing an anxiety disorder.

17-30: symptoms are strongly consistent with a major depressive episode and presence of major depressive disorder is very likely.

[1]Baer, L., Jacobs, D. G., Meszleer-Reizes, J., Blais, M., Fava, M., Kessler, R., Magruder, K., Murphy, J., Kopans, B., Cukor, P., Leahy, L., & O'Laughlen, J. (2000). Development of a Brief Screening Instrument: The HANDS. *Psychother Psychosom, 69,* 35-41.

Eating Attitudes Test (EAT-11)[1]

The EAT-11 is a shortened validated version of the EAT-26. The EAT-11 asks 11 questions related to thoughts, beliefs, and fears regarding food choices and behavioral questions related to diet and exercise. The online screening also includes six behavioral questions relating to bingeing and purging.

Sample Screening Questions:

- I am terrified about being overweight.
- I feel extremely guilty after eating.
- I have the impulse to vomit after meals.

These questions can be answered as follows; the score related to each answer is included in parentheses:

- Always (3)
- Usually (2)
- Often (1)
- Sometimes (0)
- Rarely (0)
- Never (0)

The remaining six behavioral questions relate to the frequency of bingeing and purging behaviors in the last three months, and weight loss of 20 pounds of more in the previous six months.

These questions can be answered as follows:

- Never
- Once a month or less
- 2-3 times a month
- Once a week
- 2-6 times a week
- Once a day or more
  - The weight loss question is answered Yes or No.

Interpretation:

Individuals will score *at risk* for an eating disorder if they score above the threshold for the EAT-11, the behavioral questions, or both. Individuals will only score *not at risk* for an eating disorder if they are below the threshold for both the EAT-11 and the behavioral questions.

[1] Garner, D. M., Olmsted, M. P., Bohr, Y. and Garfinkel, P.E. (1982). The eating attitudes test: Psychometric features and clinical correlates. Psychological Medicine, 12, 871-878.

The Carroll-Davidson Generalized Anxiety Disorder Scale (CD-GAD)[1]

The CD-GAD consists of twelve questions covering emotional and physical symptoms, symptom impact on daily life, and symptom severity. The screening asks about things individuals may have felt most days in the past six months.

Sample symptoms include:

- Most days I worry about lots of things.
- I have trouble concentrating.
- Were the things you noted above bad enough that you thought about getting help for them?

Individuals indicate Yes or No.

Scoring assigns each answer a numerical value and adds the total value of responses to the twelve questions:

- Yes = 1
- No = 0

Interpretation:

- 0-5: symptoms are not suggestive of GAD. A complete evaluation is not recommended
- 6-12: symptoms are suggestive of Generalized Anxiety Disorder. A complete evaluation is recommended.

Notes:

- Studies have shown that patients with a score of 6 or above who did not have a final diagnosis of Generalized Anxiety Disorder often had other important psychiatric problems, such as major depression or another anxiety diagnosis.
- A score of 0-2 during treatment of a patient with GAD is consistent with remission of the disorder.

[1] 2000 by B.J. Carroll, MD, PhD, and Jonathan R.T. Davidson, MD

Short Post-Traumatic Stress Disorder Rating Interview (SPRINT-4)[1]

The SPRINT-4 asks four questions regarding individuals who have experienced or witnessed a traumatic event that involved loss of life, serious injury, or threat of either. These questions address emotional, behavioral, and physical symptoms experienced most days in the past week.

Questions include:

- Have you been bothered by unwanted memories, nightmares, or reminders of this event?
- Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?
- Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?
- Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?

Individuals respond by indicating Yes or No.

Scoring assigns each answer a numerical value and adds the total value of responses to the four questions:

- Yes = 1
- No = 0

Interpretation:

0-1: symptoms are not consistent with PTSD. A complete evaluation is not recommended.

2-3: symptoms may be consistent with PTSD. Further evaluation is recommended.

4: symptoms correspond to PTSD. A complete evaluation is strongly recommended.

[1] Connor, K. M., & Davidson, J. R. T. (2001). SPRINT: a brief global assessment of posttraumatic stress disorder. International Clinical Psychopharmacology, 16, 279-284.

National Psychosis Awareness Program for Individuals

The National Psychosis Awareness Program is a modified version of the Prodromal Questionnaire 16[1] (PQ-16) and screens individuals for psychosis risk. The screening consists of 16 questions, including 9 items related to perceptual abnormalities and hallucinations, 5 items related to unusual thought content/delusional ideas/paranoia, and 2 items related to negative symptoms. The screening asks if these symptoms have been experienced in the past year.

All symptom-related questions are first answered "True/False"

<u>Sample Questions:</u>

I feel uninterested in things I used to enjoy.

- True
- False

I have heard things other people can't hear like voices of people whispering or talking.

- True
- False

If an individual answers "True" to a question, the following is asked: "How much discomfort has this experience caused?" The follow-up questions are answered:

- None
- Mild
- Moderate
- Severe

Scoring assigns a numerical value to the discomfort level associated with each "True" answer. A discomfort level of "None" receives a score of 0. "Mild" is scored 1, "Moderate" is 2, and "Severe" is 3. "False" answers do not receive a score. Scores for the discomfort level associated with each "True" answer are tallied for interpretation.

<u>Interpretation:</u>

0 – 5 (with no discomfort level rating above 1): Not experiencing distress due to unusual experiences or behaviors

0 – 5 (with at least one discomfort rating of 2): Experiencing mild to moderate distress due to unusual experiences or behaviors; follow-up with a professional is suggested

6 + (or a discomfort level of 3 on any item): Experiencing moderate or severe distress due to unusual experiences or behaviors; follow-up with a professional is encouraged

[1] Ising, H.K., Veling, W., Loewy, R.L., Rietveld, M.W., Rietdijk, J., Dragt, S., Klaassen, R.M.C., Neiman, D. H., Wunderink, L., Linszen, D.H., & van der Gaag, M. (2012). The validity of the 16-item version of the Prodromal Questionnaire (PQ-16) to screen for ultra high risk of developing psychosis in the general help-seeking population. Schizophrenia Bulletin, 38(6), 1288–1296

National Psychosis Awareness Program for Loved Ones

The National Psychosis Awareness Program is a modified version of the Prodromal Questionnaire 16[1] (PQ-16) and allows individuals to take a screening for psychosis risk on behalf of a loved one. The screening consists of 16 questions, including 9 items related to perceptual abnormalities and hallucinations, 5 items related to unusual thought content/delusional ideas/paranoia, and 2 items related to negative symptoms. The screening asks if the loved one has experienced these symptoms in the past year.

All symptom-related questions are first answered "True/False"

Sample Questions:

They feel uninterested in things they used to enjoy.

- True
- False

They have reported hearing things other people can't hear like voices of people whispering or talking.

- True
- False

If an individual answers "True" to a question, the following is asked: "How much discomfort has this experience caused?" The follow-up questions are answered:

- None
- Mild
- Moderate
- Severe

Scoring assigns a numerical value to the discomfort level associated with each "True" answer. A discomfort level of "None" receives a score of 0. "Mild" is scored 1, "Moderate" is 2, and "Severe" is 3. "False" answers do not receive a score. Scores for the discomfort level associated with each "True" answer are tallied for interpretation.

Interpretation:

0 – 3 (with no discomfort level rating above 1): Friend/loved one is not experiencing distress due to unusual experiences or behaviors

0 – 4 (with at least one discomfort rating of 2): Friend/loved one is experiencing mild to moderate distress due to unusual experiences or behaviors; follow-up with a professional is suggested

5 + (or a discomfort level of 3 on any item): Friend/loved one is experiencing moderate or severe distress due to unusual experiences or behaviors; follow-up with a professional is encouraged

[1] Ising, H.K., Veling, W., Loewy, R.L., Rietveld, M.W., Rietdijk, J., Dragt, S., Klaassen, R.M.C., Neiman, D. H., Wunderink, L., Linszen, D.H., & van der Gaag, M. (2012). The validity of the 16-item version of the Prodromal Questionnaire (PQ-16) to screen for ultra high risk of developing psychosis in the general help-seeking population. Schizophrenia Bulletin, 38(6), 1288–1296

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)[1]

The ASSIST consists of eight questions related to substance use, frequency of use, and negative consequences related to substance use. The first two questions ask which substances individuals have used in their lifetime and in the past three months. The next five questions prepopulate to ask only about substances individuals indicated using in the relevant time frame (past three months or lifetime).

Sample Screening Questions:

- During the past three months, how often have you had a strong desire or urge to use the substances you checked?
- During the past three months, how often have you failed to do what was normally expected of you because of your use of the [substances listed below]?

Individuals respond to the first two questions by indicating Yes or No. The remaining questions are generally answered:

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

The final question asks whether individuals have ever used a drug by injection (answered Yes or No).

Scoring follows this pattern: Indication of drug use, frequent drug use, and frequent negative consequences will result in a higher score. Questions related to negative consequences of drug use are more heavily weighted. Drug use in the past three months is more highly weighted than lifetime drug use.

Interpretation:

Interpretation of this screening differs based on substance.

For alcohol use:

0-10: Low risk for substance use problems
11-26: Moderate risk for substance abuse
27+: High risk for substance use problems

For tobacco and other substances:

0-3: Low risk for substance use problems
4-26: Moderate risk for substance problems
27+: High risk for substance use problems

[1] Humeniuk, RE, Ali RA, Babor TF, Farrell M, Formigoni ML, Jittiwutikarn J, Boerngen de Larcerda R, Ling W, Marsden J, Monteiro M, Nhiwhatiwa S, Pal H, Poznyak V & Simon S (2008). Validation of the Alcohol Smoking and Substance Involvement Screening Test (ASSIST). Addiction 103(6): 1039-1047.