Patient-Centered Medical Home Behavioral Health Screening Toolkit
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DISCLAIMER

This toolkit comprises publicly available resources that the Oklahoma Health Care Authority (OHCA) has compiled for the convenience of our providers. It is intended to serve as a starting point for providers in the development of their own protocols for use in treating patients.

The resources provided herein are not exhaustive. Providers are strongly encouraged to review additional resources and to contact behavioral health professionals for further assistance in developing their own practices. Providers must determine for themselves the accuracy, completeness, utility, and fitness for purpose of any information or other resources identified herein. Neither the OHCA, nor any of its agents, officers, employees, or representatives will be held liable to any party for any damages arising from the use of this toolkit or the information contained herein, or any website accessible through links or other information contained in this toolkit.

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This toolkit is also not a guarantee of payment by the OHCA. This means that if a provider follows a protocol recommended by an included resource, it is not guaranteed that the services will be paid for by OHCA.
The PROBLEM
People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions.

70% of adults with a mental illness have a co-occurring substance use disorder.

The SOLUTION
The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services. Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

INTEGRATION WORKS
Community-based addiction treatment can lead to...

- 35% reduce risk of cardiovascular disease
- 39% maintain ideal body weight
- 26% decrease in risk of relapse
- 17% fewer nights in detox
- 17% fewer ER visits
- 17 fewer nights homeless
- $2,500,000 in savings over the year.

Integration works. It improves lives. It saves lives. And it reduces healthcare costs.
OHCA 2016-31

December 15, 2016

RE: Important Coding and Reporting Changes to the SoonerCare Choice Behavioral Health Screening – Effective January 1, 2017

Dear SoonerCare Provider,

This letter is to notify you of important coding and billing changes in our SoonerCare Choice Patient-Centered Medical Home program.

Effective January 1, 2017 Current Procedural Terminology (CPT) 96160 (Administration and interpretation of patient-focused health risk assessment) will replace 99420 (Administration and interpretation of health risk assessment). This change is necessary due to the American Medical Association (AMA) new codes and guideline revisions being implemented for 2017.

Providers shall bill 96160 for providing the annual behavioral health screening to SoonerCare Choice members assigned to your panel that are ages 5 and older. This code is in addition to any other code you bill for the visit. This code is non-compensable so we have designed the SoonerExcel initiative called “Annual Behavioral Health Screening.” The incentive will continue to follow our current quarterly payment process, which compensates at $5 per screen, depending on available funds.

If you have any questions regarding the information provided in this letter, please call the OHCA Provider Helpline at (800) 522-0114.

Thank you for the services you provide to our SoonerCare members.

Sincerely,

Rebecca Pasternik-Ikard
Chief Executive Officer
The letter is to notify you of changes in our SoonerCare Choice Patient-Centered Medical Home program. When we transitioned our payment methodology in 2009, we knew there would be changes to the program as we advanced our delivery system to support the SoonerCare Choice membership.

One of the emerging changes in primary care is the national and local trend to integrate behavioral health into the physical health delivery system. The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) know this is important to our members, and therefore, OHCA is implementing the following changes.

Effective January 1, 2014 you will be required to have your staff perform an annual Behavioral Health screening for SoonerCare Choice members assigned to your panel that are ages 5 and older. During your time with the member if the screening tool denotes a positive finding, we know you will take the next step to assist these members by providing an appropriate intervention and/or referral for behavioral health services.

To help your practice integrate this new requirement OHCA has the following guidance.

1. Although this screening will be part of your tier requirements effective January 1, 2014, we will utilize 2014 as an educational/implementation year and the screening requirement will not be part of your compliance review by our Quality Assurance department. Your office will receive on-site training during 2014 to assist you in the integration of these new screening tools.

2. You may bill code 99420 (administration and interpretation of health risk assessment) for providing the screening. This code is in addition to any other code you bill for the visit. This code is non-compensable so we have designed a new SoonerExcel initiative called "Annual Behavioral Health Screening." This new incentive will follow our current quarterly payment process and will replace the current incentive payment for Generic Drug Prescribing.

3. For members who screen positive for alcohol or drug use, providers who have completed special training provided by ODMHSAS may bill 99408, (Alcohol and/or substance abuse structured screening and brief intervention), in addition to your E&M and be paid for all compensable services provided during the visit. ODMHSAS will hold training sessions, which you can complete at your convenience. These sessions will begin in early 2014 and continue throughout the year. Training information can be found at http://ok.gov/odmhsas/Prevention in Practice.html.

4. For members who screen positive for depression, please bill the appropriate E&M code for the time you spent with this member.
If you have a current Group or Individual Provider Agreement as a Medical Home Primary Care Provider, this letter serves as the required contractual notification under Section 6.2 of Addendum 1 that OHCA is amending Attachment B and the SoonerCare Excel Methodology. The revised Attachment B is attached to this document; the new methodology will be available on the OHCA website before January 1, 2014.

Improved outcomes for our SoonerCare members are very important to us and we know it is also important to you. Thank you for your continued support and commitment to our SoonerCare program.

Sincerely,

Garth L. Splinter, MD
State Medicaid Director
ATTACHMENT B
REQUIRED AND OPTIONAL SERVICES FOR MEDICAL HOMES

Tier One - Entry Level Medical Home

Provider shall:

1.1 Supply all medically necessary primary and preventive services for panel members;

1.2 Be a VFC participant *(if Provider sees members less than 18 of age for primary care)*;

1.3 Organize clinical data in a paper or electronic format as a patient specific charting system for individual panel members; a patient-specific charting system is defined as charting tools that organize and document clinical information, such as the medical record, problem lists, medication list, structured template for appropriate risk factors, structured templates for narrative progress notes, etc.;

1.4 Maintain medication list within the medical record and should be updated during each office visit. This medication list includes chronic, acute, over-the-counter medications, and herbal supplements; to include all prescribing instructions, i.e. dosage, method of administration, frequency, etc;

1.5 Maintain a step-by-step system to track the entire process for lab/diagnostic tests; this should include the process of follow-up on test results as well as patient reminders and notifications as needed; this tracking method can be via written logs/paper-based documents or electronic reports; Provider must have written policies and procedures for this measure; the written policy and procedures should include the designated staff *(by position, i.e. nurse, medical assistant, clerk, etc.)* assigned to maintain and oversee this process;

1.6 Maintain a step-by-step system to track referrals including self-referrals communicated to provider by member; this should include the process of follow-up on consult notes and findings as well as to remind and notify patients to follow-up as needed; this tracking method can be via written logs/paper based documents or electronic reports; Provider notifies panel members when a specialty appointment is made by the PCP; Provider documents attempts to obtain a copy of the specialist provider’s consult notes and findings; Provider must have written policies and procedures for this measure; the written policy and procedures should include the designated staff *(by position, i.e. nurse, medical assistant, clerk, etc.)* assigned to maintain and oversee this process;

1.7 Supply Care Coordination for all SoonerCare members; this includes continuity of care through proactive contact with panel members and incorporates the family/support system with coordination of care; Provider will coordinate the delivery of primary care services with any specialist, case manager, and community-based entity involved with the patient *(WIC, and Children’s First program, home health, hospice, DME, etc.)*; this includes but is not limited to: referrals, lab/diagnostic testing, preventive services and behavioral health screening;

1.8 Supply patient/family education and support utilizing varying forms of educational materials appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided and plan of treatment; an example would include patient education handouts; this education must be documented within the patient medical record;
1.9 Explains the expectations of a patient-centered medical home with the patient and obtain a patient and provider signature on the “Medical Home Agreement” form; the defined roles should be explained within the context of all of the joint principles which reflect a patient-centered medical home; this agreement is to be maintained within the patient’s medical record;

1.10 Use scheduling processes to promote continuity of care, through maintaining open appointment slots daily; open scheduling is defined as the practice of having open appointments slots available in the morning and afternoon for same day/urgent care appointments; this does not include double-booking appointment times; Provider implements training and written triage procedures for the scheduling staff;

1.11 Accept electronic communication from OHCA; Provider maintains access and is responsible for updating contact information utilizing the OHCA provider portal;

1.12 Supply voice-to-voice telephone coverage to panel members 24 hours a day, seven days a week; this must provide an opportunity for the patient to speak directly with a licensed health care professional; the number to call should connect to a person or message which can be returned within thirty minutes; all calls are triaged and forwarded to the PCP or on-call provider when necessary; this coverage includes after office hours and weekend/vacation coverage; Provider maintains a formal professional agreement with the on-call PCP or provider and notification is shared relating to panel members’ needs and issues; and

1.13 Use behavioral screening, brief intervention, and referral to treatment for members five years of age and above; behavioral screening is an annual requirement; through the use of screening tools the provider will coordinate treatment for members with positive screens with the goal of improving outcomes for members with mental health and/or alcohol or substance use disorders.

Tier Two – Advanced Medical Home

Provider shall meet all Tier One requirements shown above as 1.1 through 1.13 and shall also:

2.1 Maintain a full-time practice which is as defined as having established appointment times available to patients during a minimum of thirty (30) hours each week;

2.2 Use data received from OHCA (i.e. rosters, patient utilization profiles, immunization reports, etc.) and/or information obtained from secure website (eligibility, last dates of EPSDT/mammogram/pap, etc.) to identify and track panel members both inside and outside of the PCP practice;

2.3 Provide transitional care coordination for all panel members; this is the coordination and follow-up for any care/services received by member in any outpatient and inpatient facilities; information can be obtained from the member, OHCA or the facility; this information should be documented within the medical record and added to the problem list; upon notification of member activity, the provider attempts to contact member and schedule a follow up appointment as appropriate;

2.4 Implement processes to promote access to care and provider-member communication. PCP or office staff communicates directly with panel members through a variety of methods (email, scheduled and unscheduled postal mailings, etc.);

Optional Measures (Provider must choose three additional components):

2.5 Implement a PCP led practice by developing a healthcare team that provides ongoing support, oversight, and guidance of all medical care received by the member; Provider
leads and oversees the healthcare team to meet the specific needs and plan of care for each panel member; this requirement also includes documentation of contact with specialist and other health care disciplines that provide care for the member outside of the PCP office; the team may include doctors, nurses, and other office staff;

2.6 Implement post-visit outreach; the outreach effort should be done after an (acute or chronic) visit and is documented within the member’s medical record. *(Examples of outreach include phone calls to monitor medications changes, weight checks, blood glucose, blood pressure monitoring, etc.)*; outreach is overseen and directed by the provider but may be performed by the appropriate designated staff;

2.7 Implement specific evidence-based clinical practice guidelines for preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc;

2.8 Implement a medication management procedure to avoid interactions or contraindications; examples may include using e-Pocrates, e-Prescribing, SoonerScribe, Pro-DUR software, screening for drug interactions, etc. and/or;

2.9 Offer at least 4 hours of after-hours care to SoonerCare members in addition to the required 30 hours per week for the full time provider requirement; *(After hours care is defined as appointments, scheduled or work-ins, readily available to SoonerCare members outside the hours of 8 a.m. - 5 p.m. Monday – Friday)*; this requirement is per location regardless of number of providers; solo practitioners can arrange after hours coverage through another approved choice provider location; multiple locations can submit for a single location to provide after-hours coverage; these requests will be reviewed and decided on a case by case basis; Provider maintains vacation coverage in the same manner.

Tier Three – Optimal Medical Home

Provider shall meet all Tier One and Tier Two requirements shown as 1.1 through 2.9 and shall also:

3.1 Use health assessment tools *(other than Behavioral Health)* to identify potential patient needs and risks; e.g. developmental or symptom specific; tool may address potential health risks such as demographics, lifestyle, medical history, illness, etc. (examples include AAP approved standardized developmental screening tool, disease-specific screening tool, etc.). Use a secure electronic interactive web site to maximize communications with panel members/families to allow patients to request appointments, referrals, test results and prescription refills, as well as allow Provider to contact patients to schedule follow-up appointments, relay test results, inform patients of preventive care needs, instruct on medication.

Tier Three Optional. These are not required but are recommended if applicable:

3.2 Use a secure electronic interactive web site to maximize communication with panel members/families this will allow patients to request appointments, referrals, test results, and prescription refills; as well as allow the practice to contact patients to schedule follow-up appointments, relay test results, inform patients of preventive care needs, instruct on medication, etc. and/or;

3.3 Utilize integrated care plans for panel members who are co-managed with specialist(s)/other healthcare disciplines, and maintains a central record or database that contains all pertinent information and/or;
3.4 Regularly measure their performance for quality improvement, using national benchmarks for comparison; Provider takes necessary actions to continuously improve services/processes; all quality improvement projects measured by the provider must be reported to OHCA on a quarterly basis.
Billing for Screening
Implemented January 1, 2017

CPT 96160*
Administration and interpretation of patient-focused health risk assessment

*This code is in addition to any other code you bill for the visit.

This code is non-compensable, so we have designed a new SoonerExcel initiative called Annual Behavioral Health Screening. This new incentive follows our quarterly payment process and pays $5 per screen. This replaces the incentive payment for generic drug prescribing.
Screening

**Purpose:**
To quickly identify members who have psychosocial needs

**Method:**
Member completes Annual Screen once every 12 months

**Pediatric Screen 5 - 16 years**
(PSC - Pediatric Symptom Checklist, Functional Impairment)
Screens for:
- Internalizing/Externalizing symptoms
- Attention problems
- Impact on functioning

**Adult Screen 17+**
( PHQ-9, Audit and DAST; ASSIST may also be used)
Screens for:
- Depression
- Substance use

*Recommendation: Give screening to patient while patient is in examination room to ensure more accurate and confidential results.*

If the screening is positive, it may warrant additional screening, brief intervention, monitoring and/or referral to specialized treatment.
INFORMATION FOR YOUR DOCTOR

Physical and emotional health go together. You can help us provide you with the best health care possible by answering these questions. Please circle the box that best describes you. If you do not wish to answer a question, you can leave it blank.

Your Name: __________________________________________________    Date: ________________

<table>
<thead>
<tr>
<th>PHQ-2+1</th>
<th>Not At All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>3. Thinking that you would be better off dead or that you want to hurt yourself in some way</td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AUDIT, NM-ASSIST</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you drink alcohol?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How many drinks of alcohol do you have on a typical day (leave blank if you don’t drink alcohol)</td>
<td>1 or 2 drinks a day</td>
<td>3 or 4 drinks a day</td>
<td>5 or 6 drinks a day</td>
<td>7 to 9 drinks a day</td>
<td>10 or more drinks a day</td>
</tr>
<tr>
<td>3. In the past year, did you have 6 or more drinks* of alcohol in one day if you are male; 5 or more if you are female?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*one drink means 12 oz. of beer, 1.5 oz. of liquor or 5 oz. of wine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. In the past 3 months, how often have you used marijuana, other drugs, or nonmedical use of prescription drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. In the past 3 months, how often have you had a strong desire or urge to use alcohol or drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. In the past 3 months, has your use of alcohol or drugs led to health, social, legal, or financial problems?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. In the past 3 months, how often have you failed to do what was normally expected of you because of your use of alcohol or drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you currently receiving services from a psychologist, a substance abuse program or counselor, and/or a mental health program or counselor? (Circle your answer)    YES    NO
INFORMACIÓN PARA SU MÉDICO
La salud física y emocional van juntas. Usted puede ayudarnos a proporcionarle el mejor cuidado de salud posible respondiendo a estas preguntas. Por favor circule la casilla que mejor lo describa. Si no desea responder a una pregunta, puede dejarla en blanco.

Su nombre: ____________________________________________ Fecha: __________________

PHQ-2+1
Por favor circule la casilla que mejor lo describa durante las últimas dos semanas.

<table>
<thead>
<tr>
<th></th>
<th>Ningún día</th>
<th>Varios días</th>
<th>Más de la mitad de los días</th>
<th>Casi todos los días</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Poco interés o placer en hacer cosas</td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas</td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>3. ¿Ha tenido pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera?</td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
</tbody>
</table>

AUDIT, NM-ASSIST
Por favor circule la respuesta que mejor describa su uso de alcohol o drogas. Las drogas incluyen todo tipo de drogas callejeras, marihuana, metanfetamina, cocaína o medicamentos recetados como tranquilizantes o analgésicos que no se toman según las indicaciones de su médico.

<table>
<thead>
<tr>
<th></th>
<th>Nunca</th>
<th>Menos de una vez al mes</th>
<th>Una vez al mes o menos de una vez al mes</th>
<th>Más de una vez al mes</th>
<th>Menos de la mitad de los días</th>
<th>Más de la mitad de los días</th>
<th>Casi todos los días</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ¿Con qué frecuencia bebe alcohol?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ¿Cuántas bebidas de alcohol consume en un día típico (deje en blanco si no bebe alcohol)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. En el último año, ¿usted consumió 6 o más bebidas * de alcohol en un día si usted es varón; 5 o más si es mujer? * Una bebida significa 12 oz. De cerveza, 1.5 oz. De licor o 5 oz. de vino</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. En los últimos 3 meses, ¿con qué frecuencia ha usado marihuana, otras drogas o uso de medicamentos recetados que no fueron para uso médicos?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. En los últimos 3 meses, ¿con qué frecuencia ha tenido un fuerte deseo o ansias de consumir alcohol o drogas?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. En los últimos 3 meses, ¿su consumo de alcohol o drogas ha provocado problemas de salud, sociales, legales o financieros?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. En los últimos 3 meses, ¿con qué frecuencia ha fallado en hacer lo que normalmente se esperaba de usted por su uso de alcohol o drogas?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¿Está actualmente recibiendo servicios de un psicólogo, un programa de abuso de sustancias o consejero, y / o un programa de salud mental o consejero? (Circule su respuesta)  

<table>
<thead>
<tr>
<th>SI</th>
<th>NO</th>
</tr>
</thead>
</table>

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The comprehensive screening tools were developed as a way to provide a quick measure of mental health and substance abuse issues in the primary care setting. Areas covered: substance abuse, depression, anxiety and familial relations. The backside of the forms allow for fast documentation for the medical record. The scoring instructions below correspond with the appropriate sections on each of the tools.

**Adult Behavioral Health Screener**

**PHQ – Patient Health Questionnaire 2+1 (initial Depression and Anxiety Screen)**

1. Sum items 1 & 2. If total is ≥3 then result is a positive screen. Recommend completing PHQ-9, which is provided in the toolkit to further assess depressive symptoms.*
2. If item 3 is endorsed ≥ 1 then result is a positive screen and warrants further assessment.

**AUDIT – Alcohol Use Disorder Identification Test (Alcohol Screen)**

3. Sum items 1, 2 & 3. If total ≥5 then result is a positive screen and warrants further assessment.

**NM-ASSIST – National Institute Drug Abuse Modified Alcohol, Smoking and Substance Involvement Screening Test**

4. Drug Use – If Item 4 is endorsed as “Daily or Almost Daily” then result is a positive screen and warrants further assessment.
5. Alcohol and Drug Functional Impairment – Sum items 5, 6 & 7. If total is ≥ 15 then result is a positive screen and warrants further assessment.

**Conversation Starter Questions**

6. The last question was included to assist with making appropriate referrals for further behavioral health and/or substance use assessment.

**Screening Instructions**

1. Client (or guardian for children) completes the screening tool as part of their regular visit paperwork.
2. PCP and/or office staff calculates the score.
3. If screen is positive, PCP will discuss results with member and refer for a full assessment if needed.
4. PCP completes documentation side of the tool to place in the medical record.
5. PCP’s office bills procedure code – 96160 – in addition to their E & M code.

*Optional: PHQ-9 (follow-up depression screen located in toolkit provided)

*Optional: PHQ-9 (follow-up depression screen located in toolkit provided)

**Sum items 1-9 to determine severity of depressive symptoms**

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal symptoms</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild symptoms</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate symptoms</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe symptoms</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe symptoms</td>
</tr>
</tbody>
</table>

If item 9 is endorsed ≥ 1 then result is a positive screen and warrants further assessment. Item 10 provides estimate of functional impairment.
Patient’s Name: ________________________________

Screening Date: __________________

**Screening Results**

**PHQ-2 for depression** was

- [ ] Negative
- [ ] Positive
- [ ] Positive for suicidal ideation

**AUDIT for alcohol use** was

- [ ] Negative
- [ ] Positive

**Drug use screen** was

- [ ] Negative
- [ ] Positive

Symptoms endorsed on patient’s drug and alcohol screen _____ in functional impairment.

- [ ] Do not result
- [ ] Result

Patient currently followed by a mental health provider

- [ ] No
- [ ] Yes – Provider is ________________________________

**Screening Summary**

Patient’s overall screen was:

- [ ] Negative.
- [ ] Positive, but patient is already followed by a mental health provider.
- [ ] Positive and warrants further monitoring.
- [ ] Positive and warrants further assessment.

**Intervention**

- [ ] Reviewed screening results with patient/family.
- [ ] Discussed with patient/family impact of screening results on patient’s health & need for:
  - [ ] Continued monitoring of patient’s symptoms.
  - [ ] Further assessment by a behavioral health provider.
  - [ ] Patient to follow up with patient’s current mental health provider.
- [ ] Patient/family given copy of screening results.

**Referral**

- [ ] No referral made at this time.
- [ ] Referred patient to in-house Behavioral Health/Pediatric Psychology service for further assessment and treatment recommendations.
- [ ] Referred patient to ________________________________

- [ ] Patient/family has appointment ________________________________

- [ ] Patient/family given contact number 1-800-652-2010 to call for assistance with locating a behavioral health provider to conduct further assessment.

**Comments**

__________________________________________

__________________________________________

__________________________________________

__________________________________________
INFORMATION FOR YOUR CHILD’S DOCTOR

Emotional and physical health go together in children. Parents are often the first to notice a problem with their child’s behavior and/or emotions. You can help your child get the best care possible by answering these questions.

Please circle the box that best describes your child. If you do not wish to answer a question, you can leave it blank.

Please circle the answer that best describes your child:

<table>
<thead>
<tr>
<th>PSC</th>
<th>NEVER</th>
<th>SOME TIMES</th>
<th>OFTEN</th>
<th>Office Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fidgety, unable to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2. Feels sad, unhappy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. Daydreams too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. Refuses to share</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. Does not understand other people’s feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>6. Feels hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7. Has trouble paying attention</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>8. Fights with other children</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>9. Is down on himself or herself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10. Blames others for his or her troubles</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>11. Seems to be having less fun</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12. Doesn’t listen to rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>13. Acts as if driven by a motor</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>14. Teases others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>15. Worries a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>16. Takes things that don’t belong to him or her</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>17. Distracted easily.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

How much do the problems or difficulties you circled above interfere with your child’s everyday life?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Only a little</th>
<th>A lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Do the difficulties you checked above upset or distress your child?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Do the difficulties you checked above place a burden on you and your family?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Do the difficulties you checked above interfere with your child’s home life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Do the difficulties you checked above interfere with your child’s friendships?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Do the difficulties you checked above interfere with your child’s activities?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Do the difficulties you checked above interfere with school or learning?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Do you think your child might have a problem with alcohol or drugs?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Is your child in in counseling or seeing a mental health professional?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Does your child have an IEP (Individualized Educational Plan) at school?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Are there problems or concerns about your child, yourself or your family that you would like to talk about privately with your doctor?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Persona que llena el formulario: ____________________________ | Relación con el/la niño(a): ____________________________

INFORMACIÓN PARA EL MÉDICO DE SU NIÑO(A)

La salud emocional y física van juntas en los niños. Los padres suelen ser los primeros en notar un problema con el comportamiento y/o las emociones de sus hijos. Usted puede ayudar a su hijo(a) a obtener el mejor cuidado posible respondiendo estas preguntas.

Por favor circule la casilla que mejor describa a su hijo(a). Si no desea responder a una pregunta, puede dejarla en blanco.

Por favor circule la respuesta que mejor describa a su hijo(a):

<table>
<thead>
<tr>
<th>PSC</th>
<th>NUNCA</th>
<th>ALGUNAS VECES</th>
<th>A MENUDO</th>
<th>Uso de oficina</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A</td>
<td>E</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Inquieto, incapaz de quedarse quieto
2. Se siente triste, infeliz
3. Sueña despertado(a) demasiado
4. Se niega a compartir
5. No entiende los sentimientos de otras personas
6. Se siente sin esperanzas
7. Tiene problemas para prestar atención
8. Pelea con otros niños
9. Está en contra de sí mismo (a)
10. Culpa a otros de sus propios errores
11. Parece divertirse menos
12. No escucha las reglas
13. Actúa como si tuviera un motor por dentro
14. Se burla de los demás
15. Se preocupa mucho
16. Toma cosas que no le pertenecen
17. Se distrae fácilmente

¿CUÁNTO INTERFIERE LOS PROBLEMAS O LAS DIFICULTADES QUE USTED HA CIRCULADO ANTERIORMENTE EN LA VIDA DE SU NIÑO(A)?

18. ¿Las dificultades que marcó anteriormente alteran o afectan a su niño(a)?
19. ¿Las dificultades que marcó anteriormente causan una carga a usted y su familia?
20. ¿Las dificultades que marcó anteriormente interfieren con la vida en el hogar de su niño(a)?
21. ¿Las dificultades que marcó anteriormente interfieren con la vida con las amistades de su niño(a)?
22. ¿Las dificultades que marcó anteriormente interfieren con las actividades de su niño(a)?
23. ¿Las dificultades que marcó anteriormente interfieren con la escuela o el aprendizaje?
24. ¿Cree que su niño(a) podría tener problemas con el alcohol o drogas?
25. ¿Su niño(a) está en consejería o está viendo a un profesional de salud mental?
26. ¿Su niño(a) tiene un Plan Educativo Individualizado (IEP por sus siglas en inglés) en la escuela?
27. ¿Hay problemas o preocupaciones acerca de su niño(a), usted o su familia que le gustaría hablar de forma privada con su médico?
The comprehensive screening tools were developed as a way to provide a quick measure of mental health and substance abuse issues in the primary care setting. Areas covered: substance abuse, depression, anxiety and familial relations. The backside of the forms allow for fast documentation for the medical record. The scoring instructions below correspond with the appropriate sections on each of the tools.

**Pediatric Behavioral Health Screener**

**PSC – Pediatric Symptom Checklist**

Transfer parents responses to the white boxes in scoring grid on right side of the page. Sum the columns to create scores for scale scores. Sum these scores to create total score.

- I (Internalizing symptoms – anxiety and depression) ≥ 5 positive
- A (Attention – ADHD) ≥ 7 positive
- E (Externalizing symptoms – disruptive behavior) ≥ 7 positive
- Total Score ≥ 15 positive

**Functional Impairment**

For items 18-23, any item ≥ 2 represents functional impairment and warrants further assessment.

**Conversation Starter Questions**

Items 24-26 are open-ended questions, included as conversation starters between the physician and the patient regarding any mental health and/or substance abuse concerns.

Item 27 is included in the event that there are issues the patient may be concerned with, which have not been covered by other questions.

**Screening Instructions**

1. Client (or guardian for children) completes the screening tool as part of their regular visit paperwork.
2. PCP and/or office staff calculates the score.
3. If screen is positive, PCP will discuss results with member and refer for a full assessment if needed.
4. PCP completes documentation side of the tool to place in the medical record.
5. PCP’s office bills procedure code – 96160 – in addition to their E & M code.
Child’s Name: _______________________________
Screening Date: ________________________

Screening Results
Patient’s Pediatric Symptom Checklist was

☑️ Negative
☐ Positive for
  ☐ Internalizing symptoms
  ☐ Externalizing symptoms
  ☐ Attention symptoms
  ☐ Overall symptoms

Symptoms endorsed on patient’s Pediatric Symptom Checklist

☐ Do not result in functional impairment
☐ Result in functional impairment for:
  ☐ Child
  ☐ Family
  ☐ Child activities
  ☐ Child’s home life
  ☐ Child’s friendships
  ☐ Child’s school or learning

☐ Caregiver has concern for patient’s use of alcohol or drugs:
  ☐ No
  ☐ Yes

☐ Caregiver had other concerns:
  ☐ No
  ☐ Yes – Concern was ______________________________

Patient currently followed by a mental health provider:

☐ No
☐ Yes – Provider is ______________________________

Patient currently on an Individualized Education Plan at school

☐ No
☐ Yes – Reason for IEP: ______________________________

Screening Summary
Patient’s overall screen was:

☐ Negative
☐ Positive, but patient is already followed by a mental health provider
☐ Positive and warrants further monitoring
☐ Positive and warrants further assessment

Intervention

☐ Reviewed screening results with patient/family
☐ Discussed with patient/family impact of screening results on patient’s health & need for:
  ☐ Continued monitoring of patient’s symptoms
  ☐ Further assessment by a behavioral health provider
  ☐ Family to follow up with patient’s current mental health provider
  ☐ Family to follow up with patient’s school personnel

☐ If ADHD is considered, then will further assess for ADHD with Vanderbilt Assessment Protocol
☐ Patient/family given copy of screening results

Referral

☐ No referral made at this time
☐ Referred patient to in-house Behavioral Health/Pediatric Psychology service for further assessment and treatment recommendations
☐ Referred patients to ______________________________

☐ Patient/family has appointment ______________________________

☐ Patient/family given contact number 1-800-652-2010 to call for assistance with locating a behavioral health provider to conduct further assessment.

Comments: ______________________________
Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT IS OPTIONAL FOR PROVIDERS

CPT 99408*

Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., EG, AUDIT, DAST) and brief intervention (SBI) services -- 15 to 30 minutes

*For members who screen positive for alcohol or drug use and receive the brief intervention (BI).

Training is offered by the Department of Mental Health and Substance Abuse Services (ODMHSAS)

http://ok.gov/odmhsas/Prevention_in_Practice.html

2.5 hour CME is offered to providers who successfully complete the online training
Brief Intervention Defined:

**Brief intervention (BI)** is a time-limited, patient-centered strategy that focuses on changing a patient’s behavior by increasing insight and awareness regarding substance use.

A five to 20 minute discussion provides the patient with personalized feedback that shows concern for their use. Frequently addressed topics include how substances can interact with medications, cause/exacerbate health problems or interfere with personal responsibilities.

Typically BIs are given to patients who are at low-to-moderate risk and do not need specialized treatment.

The essential elements of brief intervention include:
1. Providing information and feedback about screening results.
2. Understanding patients’ views of their use, and then coaching them to change their perceptions about their use.
3. Encouraging patients to discuss their views, likes and dislikes about use and how they may consider changing.
4. Advising patients in clear but respectful terms to decrease or abstain from substances.
5. Teaching behavior change skills that may reduce substance use as well as the chances of negative consequences.
6. Establishing a method for follow-up with the patient. (Follow up may be done in another visit or by phone.)

Patients are also encouraged to examine how ready they are to reduce or abstain from substance use. If a patient is ready to change, a plan and reasonable goals are set.
The format of multiple BI sessions can be very flexible. As an individual moves through stages of change, extra help may be given to the participant that is tailored to his or her specific goals. Encouragement is provided when goals are met or for whatever attempts are made.

**Basic Steps to Brief Intervention:**

**Raise the subject:** “If it’s okay with you, let’s take a minute to talk about the annual screening form you’ve completed today.”

**Provide feedback:** “As your doctor, I can tell you that drinking (drug use) at this level can be harmful to your health and possibly contributing to the health problem you have today.”

**Enhance motivation:** “On a scale of 0 - 10, how ready are you to cut back?
“Why that number and not ___ (lower one)?”
“Have you ever done anything while drinking (using drugs) that you later regretted?”

**Negotiate plan:** “What steps can you take to cut back your use?”
“How would your drinking (drug use) have to impact your life in order for you to start thinking about cutting back?”
What is SBIRT?

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs (illicit or misuse of prescription). SBIRT can be used to effectively encourage individuals to reduce or eliminate problematic drug or alcohol use. There are three components of SBIRT.

- Screening quickly assesses the severity of substance use and mental health issues to identify the appropriate level of response.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Why SBIRT?

SBIRT places risky substance use where it belongs—in the realm of healthcare. It focuses on identifying risky substance use to help prevent the onset of the more costly disease of addiction. Similar to preventive screenings for chronic diseases such as cancer, diabetes, and hypertension, SBIRT is an effective tool for identifying risk levels related to substance use and for providing the appropriate intervention.

SBIRTOK is an initiative of the Oklahoma State Department of Mental Health and Substance Abuse Services (ODMHSAS). For Information about establishing the evidence based SBIRT protocol in your primary care practice, emergency department or trauma center call 1-877- SBIRTOK (1-877-724-7865) or email SBIRT@ODMHSAS.org
Is SBIRT Effective? YES.

Research has shown that large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through primary care screening. Interventions such as SBIRT have been found to:

- Reduce health care costs
- Decrease the frequency and severity of drug and alcohol use
- Reduce the risk of trauma
- Increase the percentage of patients who enter specialized substance abuse treatment

Researchers analyzed controlled trials on treating alcohol use disorders and found that alcohol screening and brief intervention was the single most effective treatment method of more than 40 methods studied. Additional studies and reports have produced similar results, showing that substance use screening and intervention is effective at helping people recognize unhealthy patterns and change their behaviors.

People who received screening and brief intervention from their physicians experienced:

- 20 percent fewer emergency department visits,
- 33 percent fewer nonfatal injuries,
- 37 percent fewer hospitalizations,
- 46 percent fewer arrests, and
- 50 percent fewer motor vehicle crashes.

Additionally, economic analyses showed that screening and brief counseling of nondependent, risky alcohol users allowed for a cost savings of $4.30 in future health care costs for every dollar invested in intervention.

Due to such studies, many health care organizations, government agencies and provider associations have chosen to implement guidelines and accreditation standards that mandate, endorse or recommend substance abuse screening and brief intervention.

The American Medical Association (AMA) is one of nearly 20 health care associations that recommends training in screening and brief intervention as well as demonstration of clinical competency. Likewise, major medical associations that disseminate evidence-based clinical practice guidelines for their members recommend routine use of substance use assessment and intervention.

Federal agencies, such as the Veterans Administration (VA), Department of Defense (DoD), White House Office of National Drug Control Policy (ONDCP), U.S. Preventive Services Task Force, and the Institute of Medicine also have made significant recommendations for the adoption of screening and brief intervention.


Training for Brief Intervention

For training information, please visit the website of the Oklahoma Department of Mental Health and Substance Abuse Services: [http://ok.gov/odmhsas/Prevention_in_Practice.html](http://ok.gov/odmhsas/Prevention_in_Practice.html)

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Senior Prevention Program Manager
SBIRT Project Director
Oklahoma Department of Mental Health and Substance Abuse Services
Phone 405-248-9331
[Angela.Dickson@odmhsas.org](mailto:Angela.Dickson@odmhsas.org)
A Game-Based Simulation Utilizing Virtual Humans to Train Physicians to Screen and Manage the Care of Patients with Mental Health Disorders

Glenn Albright, PhD,1,2 Cyrille Adam, EdM,1,3 Ron Goldman, BBA,1 and Deborah Serri, MS1

Abstract

Every year, one in four American adults suffers from a diagnosable mental disorder, yet most of them go untreated, creating a significant public health challenge. This challenge is compounded by large-scale disasters, which can cause an influx of primary care patients presenting with physical symptoms that mask mental health disorders. Primary care providers (PCPs) are usually the first point of contact for those patients; thus there exist crucial opportunities to detect and address nonphysical disorders in primary care settings that would improve patient outcomes and quality of care. Unfortunately, many PCPs view mental health as separate from the services that they provide, and the majority of them have received little training during or after medical or nursing school about risk factors, symptoms, and treatment options. To help integrate behavioral health into primary care, Kognito Interactive developed “At-Risk in Primary Care,” an online game-based simulation that integrates role-play conversations with virtual humans to train PCPs to screen patients for mental health disorders, perform brief behavioral interventions using motivational interviewing (MI), refer patients, and integrate behavioral health into their treatment while building patients’ intrinsic motivation to adhere to it. Preliminary findings on the implementation of this game in New York City show significant increases in skill and motivation to screen patients, conduct behavioral interventions, and refer patients to specialized care. These results show the promise of innovative technology-based solutions to integrate mental health training in primary care.

Missed Opportunities in Primary Care

Every year, more than 57 million American adults suffer from a diagnosable mental disorder,1 yet 62.1% of them go untreated, creating a significant public health challenge.2 The problem also extends to young people: Half of all mental health problems manifest themselves before 14 years of age, and three-quarters are evident by 24 years of age.3 The National Institute of Mental Health estimates the total costs associated with serious mental illness, which includes disorders that are severely debilitating and affect about 6% of the adult population, to be in excess of $300 billion per year.4

Primary care providers (PCPs) are the first point of contact for most patients: In 2006, there were 568 million visits to primary care physicians, accounting for 57% of all medical visits that year.5 Although patients may present with a physical health complaint, data have shown that underlying mental health issues are often the trigger for primary care visits.6,7 In fact, as many as 70% of primary care visits are prompted by psychosocial issues, yet mental health conditions are often overlooked or mistaken for physical illness in primary care.8

Thus there exist crucial opportunities to detect and address nonphysical disorders in primary care, for they are all too often missed. Of the patients who die by suicide, 90% had contact with their PCP in the year prior to death, and 76% did so in the month before their death.9 PCPs are therefore in a key position to recognize symptoms and integrate behavioral health into their patient’s treatment plan.

However, integrating behavioral health into primary care requires training and changes in workflow that include concerns surrounding time and costs. Many primary care physicians and nurses view mental health as separate from the services that they provide, and the majority of them have received little training during or after medical or nursing school about risk factors, symptoms, and treatment options. Furthermore, although administering a depression screening tool such as the Patient Health Questionnaire (PHQ)-9

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3Department of Mathematics, Science and Technology, Teachers College, Columbia University, New York, New York.
requires little training, discussing the result of the screening, conducting a brief intervention, collaboratively developing a treatment plan that integrates behavioral health, and building the intrinsic motivation in the patient to follow that plan require training that includes how to effectively manage these challenging conversations with patients. There is growing momentum and need to expand mental health services and to provide FCPS with the training and monetary incentives to conduct screening, brief interventions, and referral to treatment. The Affordable Care Act is expected to bring mental health coverage to 62 million new patients. In recent years, the U.S. Preventive Services Task Force and other government agencies have issued recommendations for screening in all primary care settings, and the Centers for Medicare and Medicaid Services have issued new Health Care Procedure Coding System codes to reimburse screening and behavioral assessments for alcohol misuse, depression, and obesity. The White House also calls for the expansion of Screening, Brief Intervention and Referral to Treatment (SBIRT), an evidence-based approach to screening and early intervention that seeks not only to address the problem use of alcohol and drugs, but also to detect those who are at risk of such behaviors.

The Game

“At-Risk in Primary Care” is an online game-based simulation designed to help address these challenges by training FCPS, including doctors, nurse practitioners, nurses, and physician assistants, to screen patients for mental health disorders, perform brief behavioral interventions using motivational interviewing (MI), refer patients, and integrate behavioral health into their treatment while building patients’ intrinsic motivation to adhere to it. The 1-hour online training is approved for 1.50 CME AMA PRA Category 1 Credits™ (American Medical Association, Chicago, IL) and 1.50 American Nurses Credentialing Center (Silver Spring, MD) CNE contract hours.

“At-Risk in Primary Care” is built around a series of mini-conversation games where users assume the role of a primary care doctor and face a variety of increasingly difficult conversational challenges where they need to effectively apply MI skills to screen patients, conduct brief interventions, discuss treatment plans, and make referrals to a behavioral health specialist.

The role-play conversations with virtual humans were built using Kognito Interactive’s proprietary Human Interaction Game Engine™, which supports the creation and delivery of simulated conversations with intelligent, fully animated, and emotionally responsive virtual humans. These virtual humans are coded to possess their own personality and memory and adapt their behaviors to the player’s decisions throughout the conversation to provide a player with a highly realistic yet risk-free experience interacting with patients and experimenting with different communication approaches to achieve his or her goals and “win” the game. A free demonstration of the game can be viewed at www.kognito.com/pcp

MI conversation tactics

Conversations were developed iteratively by Kognito in collaboration with subject matter experts and end-users who provided guidance and feedback on the situations presented in each conversation scenario. Subject matter experts are nationally recognized scholars and professionals in mental health, public health, social work, and health education. Conversations were designed to comply with the SBIRT training protocol. SBIRT itself relies on the use of MI, a counseling method developed by Miller and Rollnick that fosters a collaborative relationship between doctor and patient to resolve patients’ ambivalence about changing their behavior. This is achieved through several conversational tactics that can help patients make positive changes for their own health by highlighting cognitive dissonance between patients’ unhealthy behaviors and their healthy goals. Because it is quick and conversational in nature, MI can be integrated in most routine health practices, and controlled trials have shown it to be effective in bringing positive change to asthma management, oral care, weight management, and alcohol and substance abuse.

Role-play conversation scenarios

The game is structured around three mini-conversation games. In the first conversation game, the player guides Dr. Rodgers, a primary care physician, through a conversation with Antoine, a new 38-year-old patient who suffers from back pain and requests prescription painkillers to remedy the pain (Fig. 1). Players refer to Antoine’s medical record before engaging in conversation with him. The first player goal is to gather enough information about Antoine to determine whether he is at risk for a mental health disorder. The player must use MI conversation skills such as open-ended questions and reflective listening in order to gain Antoine’s trust so that he will open up and provide more information. Players communicate with this virtual human patient by selecting from a dynamic menu of dialogue options. The dialogue options represent a variety of effective, neutral, and ineffective conversation tactics. In some cases, a tactic that is ineffective at one point in the conversation may be effective elsewhere. Once players choose a dialogue option, they see their virtual patient “perform” the dialogue and then observe the verbal and nonverbal response of the virtual patient. A new set of dialogue options then appears, based on which tactic was selected. Antoine’s level of trust in Dr. Rodgers is displayed on a Trust Meter, which provides continual feedback based on the choices made by the player as he or she progresses through the game. If players select choices that include being critical, judgmental, labeling, or complying with Antoine’s request for drugs before gathering enough information, the Trust Meter will show a decrease, and players will find it harder to win the game within the allotted time frame. Throughout the game players are able to occasionally view Antoine’s private thoughts, which enables players to gain greater insight and understanding of the patient, thus increasing their empathic communication skills, which ultimately helps them “win” the game. The game is won once players gather enough details to determine that Antoine is a veteran who may be at risk for posttraumatic stress disorder (PTSD) and substance use and that further screening is necessary.

Players are then tasked with engaging in a second conversation with Antoine to collaboratively develop a treatment plan with him. Players are encouraged to build on the MI strategies they used previously by addressing the patient’s motivation to change, guiding the patient to recognize the connection between his physical pain and emotional stress.
outlining treatment options, including a mental health referral, discussing potential barriers to treatment, and helping patients to think about solutions to those barriers. Players’ choices are again reflected in the Trust Meter, and inner thoughts continue to build upon emotional intelligence. The game is won when the player successfully helps Antoine recognize his mental health symptomatology and he agrees to talk to a mental health professional, thus overcoming his initial resistance to the behavioral treatment.

In the third conversation, players guide Dr. Rodgers through a conversation with Judith, a patient who has seen Dr. Rodgers for the past few years. Her chief complaint is osteoarthritis for which she has been prescribed ibuprofen and physical therapy in the past. Judith filled out the CAGE-AID, PHQ-2, and PHQ-9 questionnaires in the waiting room, and her results correlate with moderately severe depression; she also indicated the possibility of suicidal thoughts. Throughout this game, players must gather enough information about Judith’s complaint, discuss her depression and suicidal thoughts, and collaboratively decide on a treatment plan with her. By using the same MI tactics, Trust Meter, and inner thoughts, players learn that Judith was strongly affected by the loss of her daughter on September 11, 2001. Players discuss Judith’s motivation for changing her unhealthy behaviors and collaboratively break down barriers for her to speak with a mental health professional. The game is won when players successfully reach an agreement with Judith that she will go to physical therapy and speak with a mental health professional by phone about her depression.

Training New York City PCPs

As part of its extensive emergency response strategy, the New York City Department of Health and Mental Hygiene (DOHMH) decided to utilize a tailored version of Kognito’s “At-Risk in Primary Care” to further train the city’s 7,000 PCPs to manage acute and long-term mental health conditions most commonly associated with trauma exposure. The City recognizes that large-scale traumatic events, both natural and man-made, often lead to a surge in the number of patients seeking help for physical ailments, which may be masking underlying mental health disorders. Increasing New York City’s capability to efficiently respond to the mental health consequences of trauma, including those affected by the devastating consequences that arise after traumatic events like 9/11 and Hurricane Sandy, can benefit a significant number of New Yorkers. The need for such training is well-illustrated by Neria et al.,15 who found that of the 929 adult primary care patients they followed, over 25% knew someone who had died in the September 11th attacks and that these patients were twice as likely to meet the clinical criteria for at least one of the four most common trauma-related mental health disorders.

During June–December 2012, Kognito worked closely with the DOHMH and conducted focus groups with New York City–based PCPs to narrow the program’s scope from general mental health disorders to the four most common disaster mental health disorders: PTSD, substance use disorder, generalized anxiety disorder, and depression. The training
program was delivered within weeks after Hurricane Sandy and utilized in the City’s recovery efforts.

**Preliminary Results**

As part of the training, learners are asked to fill out an optional pretraining Likert-scale survey measuring (1) their knowledge and skills in approaching patients demonstrating mental health symptomatology, (2) their likeliness to screen and manage the treatment of these patients, (3) the frequency with which they screen patients for such problems, and (4) whether they currently manage patients’ mental health. An optional post-training survey measures their skill, motivation, self-efficacy and general satisfaction with the training.

As of September 2013, 66 primary care physicians, nurses, and care managers completed the presurvey and then the training, after which 27 finished the post-training survey. Data showed significant increases in all dependent variables ($P<0.01$), including PCPs’ knowledge, skill, likelihood, and behavioral intent (1) to identify risk factors and warning signs for trauma-related mental health disorders, (2) to screen patients for trauma-related mental health disorders, (3) to discuss treatment options, (4) to engage in collaborative decision-making about treatment plans, and (5) to build intrinsic motivation in patients to adhere to a suggested treatment plan.

The post-training survey also shows high satisfaction rates with the training as a learning tool: 80% found it well-constructed to a very great or great extent, 100% found it overall excellent (50%), very good (20%), or good (30%), and 95% said they would recommend it to a colleague. In addition, participants indicated in the post-training survey that they particularly appreciated the interactions with realistic virtual patients and the ability to take the training on their own time.

Collecting follow-up data is ongoing, with only eight matched pairs having finished the 3-month survey. Nonetheless, preliminary data is encouraging: 50% of participants agreed that as a result of the training there had been an increase in the number of patients they (1) identified and screened to be at risk for trauma-related mental health disorders, and (2) engaged in collaborative decision-making about treatment plans.

These preliminary findings suggest that “At-Risk in Primary Care” can be effectively used to train and motivate PCPs to screen, conduct brief intervention, and integrate behavioral health into their treatment.

**Conclusions**

Integrating behavioral health into primary care is an important initiative that will result in better health outcomes for patients and increased efficiency and cost savings for the nation’s healthcare system. Successful integration will require innovative approaches not only to address gaps in knowledge, skill, and motivation, but also to address concerns about training costs and time constraints. Additionally, to result in real changes in behavior, these trainings should include effective communication tactics such as motivational interviewing to ensure that providers can engage patients in screening, brief intervention, and referral to treatment. Training games such as Kognito’s that integrate role-play conversations with virtual patients offer an effective and engaging way for PCPs to develop and practice these critical skills while saving valuable time and cost for the national healthcare infrastructure.

**Author Disclosure Statement**

G.A. is Co-Founder and Director of Applied Research at Kognito Interactive. C.A. is a research and development consultant for Kognito Interactive. R.G. is Co-Founder and CEO of Kognito Interactive. D.S. is Vice-President of Production at Kognito Interactive.

**References**


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Brief Biosketches

Glenn Albright, PhD, is a clinical psychologist and is Co-Founder and Director of Applied Research at Kognito Interactive, where he leads a research team in evaluating the efficacy of Kognito’s training simulations. Dr. Albright received his PhD from the City University of New York in the area of experimental cognition with concentrations in neuropsychology and applied psychophysiology and is a former chair of the Department of Psychology at Baruch College. He is particularly interested in the application of recent findings in neuroscience that impact our understanding of what drives learning and changes in behavior in game-based training environments.

Cyrille Adam, EdM, is a Research and Development Consultant at Kognito Interactive and an EdD candidate in Communication, Computing and Technology in Education at Columbia University’s Teachers College. Mr. Adam’s research focuses on the design and effectiveness of games and simulations for behavioral change in the prevention and treatment of mental health disorders. Prior to joining Kognito, Mr. Adam helped design educational platforms for behavioral health at the Columbia Center for New Media Teaching and Learning.

Ron Goldman, BBA, is Co-Founder and CEO of Kognito Interactive, a New York City–based developer of training simulations that utilize virtual humans to help address the nation’s health and behavioral health problems. Mr. Goldman has over 15 years of experience in business development, strategic planning, gaming technology, and learning design. Mr. Goldman also founded and manages the New York City Health Games Meetup events.

Deborah Serri has a Masters’ degree in Digital Media & Design for Learning from New York University and over 10 years of experience in managing large-scale consulting projects and teams through the development of complex and multifaceted training software and programs for Fortune 500 companies, government agencies, and nonprofits. Ms. Serri joined Kognito in March 2010 as an instructional designer. Prior to Kognito she worked at leading companies including MTV, VH1, and Sudden Industries.
Quick Guide for Primary Care

BEHAVIORAL HEALTH SCREENING & INTERVENTION

Your patient’s complaint may relate to a psychiatric issue rather than a physical one.

Start Screening

What You Need to Know

- Alcohol & Drugs
- Depression
- Anxiety
- Suicide

Next Steps

- Alcohol & Drugs
- Depression
- Anxiety
- Suicide

Resources & Referral

This document serves as a resource guide. This material is not intended to function as a standard of care, nor does it include every acceptable approach. Evidence-based protocols/interventions for validated screening instruments should be utilized.
Visit [ok.gov/odmhsas/Prevention_in_Practice.html](ok.gov/odmhsas/Prevention_in_Practice.html) for essential resources related to behavioral health screening and intervention.

- Screening tools and protocols
- Local behavioral health referral
- Billing guides
- Patient materials
- Research and news
- Industry recommendations
- Primary care widgets for preventive screening

**Receive free screening consultation:**

- Go to [ok.gov/odmhsas/Prevention_in_Practice.html](ok.gov/odmhsas/Prevention_in_Practice.html)
- Email [sbirt@odmhsas.org](mailto:sbirt@odmhsas.org)
- Call 1-877-SBIRTOK (1-877-724-7865)

**Billing & Coding**

A long list of preventative services including alcohol counseling and depression screening for patients is covered by private insurance and, in most cases, without co-pays or coinsurance. In addition, Medicare reimburses for preventative screening and counseling, and SoonerCare covers tobacco cessation and screening for behavioral health symptoms, substance misuse and abuse. Please visit [ok.gov/odmhsas/Prevention_in_Practice.html](ok.gov/odmhsas/Prevention_in_Practice.html) for more information.
Substance use disorders are associated with significant morbidity and mortality worldwide. Patients with alcohol/drug problems frequently present in primary care.\(^1\) Alcohol problems are overrepresented in many populations seeking medical care, affecting up to 44\(^2\) of primary care patients.

In addition to alcohol and illicit drug use, nonmedical use of prescription drugs is also common in the primary care setting.\(^3\) “In 2007, 16.3 million Americans age 12 and older had taken a prescription pain reliever, tranquilizer, stimulant, or sedative for nonmedical purposes at least once in the past year—behaviors that can lead to serious health problems, including addiction,” according to Dr. Galson, a rear admiral in the U.S. Public Health Service.

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1. Treating substance abuse in primary care: a demonstration project Denise Ernst, MA, MS, William R. Miller, PhD, and Stephen Rollnick, PhD
3. A Single-Question Screening Test for Drug Use in Primary Care Peter C. Smith, MD, MSc, Susan M. Schmidt, Donald Allensworth-Davies, MSc, and Richard Saitz, MD, MPH.
Primary care doctors carrying heavier mental health load, more than a third of patients rely solely on them to treat psychiatric conditions as the number of psychiatrists fails to keep pace with demand. Nearly one in 10 Americans 18 and older is depressed, according to a Centers for Disease Control and Prevention study in the Oct. 1 Morbidity and Mortality Weekly Report. One in four adults has a diagnosable mental disorder in any given year, according to the National Institute of Mental Health. Depressive disorders affect approximately 18.8 million adults or 9.5% of the U.S. population age 18 and older in a given year. This includes major depressive disorder, dysthymic disorder, and bipolar disorder.

**Signs/Symptoms**
- Feelings of sadness or unhappiness
- Irritability or frustration, even over small matters
- Loss of interest or pleasure in normal activities
- Reduced sex drive
- Insomnia or excessive sleeping
- Changes in appetite
- Agitation or restlessness
- Slowed thinking, speaking or body movements
- Indecisiveness, distractibility and decreased concentration
- Fatigue, tiredness and loss of energy
- Feelings of worthlessness or guilt, fixating on past failures
- Frequent thoughts of death, dying or suicide
- Unexplained physical problems, such as back pain or headaches.

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5 NIMH. “The Numbers Count: Mental Illness in America,” Science on Our Minds Fact Sheet Series
In any given year, 18% of people will suffer from an anxiety disorder. The majority of these individuals receive treatment in general medical rather than specialty mental health settings.

**Signs/Symptoms**

- Bothered by nerves, feeling anxious, or on edge
- Anxious or uncomfortable around people
- Spells or attacks where all of a sudden feels frightened, anxious, or uneasy
- Recurrent dreams or nightmares of trauma, or avoidance of trauma reminders

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Since physical illness itself is a risk factor for suicide primary care physicians and other health care providers are highly likely to see patients who are depressed and may be at risk of suicide.\(^8\)

Most people who complete suicide signal their intention to do so before ending their lives, and they often display these distress signals to their doctors. A substantial number of elderly people who die by suicide contact their primary care physicians within a month before their death.\(^9\)

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\(^9\) Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence, Jason B. Luoma, M.A.; Catherine E. Martin, M.A.; Jane L. Pearson, Ph.D., Am J Psychiatry 2012; 159: 909-916. 10.1176/appi.ajp.159.6.369

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**Signs/Symptoms**

- Talking about suicide or death
- Giving direct verbal cues, such as “I wish I were dead”
- Giving less direct verbal cues, such as “What’s the point of living?”
- Isolating him- or herself from friends and family
- Expressing the belief that life is meaningless or hopeless
- Giving away cherished possessions
- Exhibiting a sudden and unexplained improvement in mood
- Neglecting his or her appearance and hygiene

These signs are especially critical if the patient has a history or current diagnosis of a psychiatric disorder, such as depression, alcohol or drug abuse, bipolar disorder, or schizophrenia.
## Commonly Used Screening Tools:

**Adolescent:** CRAFFT

**Adult:** Alcohol Use Disorders Identification Test (AUDIT)  
Drug Abuse Screening Test (DAST)

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss results with patient</td>
<td>Discuss results with patient</td>
<td>Discuss results with patient</td>
</tr>
<tr>
<td>Reinforce and educate healthy limits</td>
<td>Educate and motivate change (Discuss laws – i.e. minimum drinking age)</td>
<td>Educate and motivate change (Discuss laws – i.e. minimum drinking age)</td>
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<tr>
<td></td>
<td>Negotiate plan</td>
<td>Negotiate plan</td>
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<td></td>
<td>Refer to Behavioral Health (See Referral and Resource Section of Guide)</td>
</tr>
</tbody>
</table>
## Commonly Used Screening Tools:

**Pediatric:** Center for Epidemiological Studies Depression Scale for Children (CES-DC)

**Adolescent:** 11-Item Kutcher Adolescent Depression Scale (KADS-11)  
Patient Health Questionnaire Modified for Teens (PHQ-9)  
Pediatric Symptom Checklist – Youth (PSC-Y)

**Adult:** Patient Health Questionnaire (PHQ-9)

**Older Adult:** Geriatric Depression Scale (GDS)

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<th></th>
<th>Low Risk</th>
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<th>High Risk</th>
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<tbody>
<tr>
<td><strong>Discuss</strong></td>
<td>Discuss results with patient</td>
<td>Discuss results with patient</td>
<td>Discuss results with patient</td>
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<tr>
<td><strong>Support</strong></td>
<td>Discuss patient support and healthy behaviors</td>
<td>Discuss patient support and healthy behaviors</td>
<td>Discuss patient support and healthy behaviors</td>
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<tr>
<td></td>
<td>Call if symptoms worsen</td>
<td>Call if symptoms worsen</td>
<td>Call if symptoms worsen</td>
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Call if symptoms worsen  
**Refer to Behavioral Health**  
(See Referral and Resource Section of Guide)
Commonly Used Screening Tools:

**Adolescent**: Pediatric Symptom Checklist – Youth (PSC-Y)

**Adult**: Hamilton Anxiety Rating Scale (HAM-A)
- Generalized Anxiety Disorder 7-item (GAD-7)
- Post Traumatic Stress Disorder (PTSD) Checklist – civilian version
- Zung Self-Rating Anxiety Scale (SAS)

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
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<tbody>
<tr>
<td>Discuss results with patient</td>
<td>Discuss results with patient</td>
<td>Discuss results with patient</td>
</tr>
<tr>
<td>Discuss patient support and healthy behaviors</td>
<td>Discuss patient support and healthy behaviors</td>
<td>Discuss patient support and healthy behaviors</td>
</tr>
<tr>
<td>Call if symptoms worsen</td>
<td>Refer to Behavioral Health (See Referral and Resource Section of Guide)</td>
<td>Assess for psychiatric medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer to Behavioral Health (See Referral and Resource Section of Guide)</td>
</tr>
</tbody>
</table>
**Commonly Used Screening Tools:**

**Adolescent:** Pediatric Symptom Checklist – Youth (PSC-Y)

**Adult:** Columbia Suicide Severity Rating Scale (C-SSRS)

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
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<tbody>
<tr>
<td>Refer to High Risk</td>
<td>Refer to High Risk</td>
<td>Discuss results with patient</td>
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<tr>
<td></td>
<td></td>
<td>Keep patient safe (supervised)</td>
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<tr>
<td></td>
<td></td>
<td>Discuss hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If involuntary, call 911 or local police</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If voluntary, secure safe transportation</td>
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</tbody>
</table>
Patient Supports and Behavioral Health Referral:

- **211 Oklahoma:**
  
  [www.211oklahoma.org](http://www.211oklahoma.org)
  
  Information and referrals to human services for every day needs and in times of crisis.

- **Substance Abuse Treatment Facility Locator:**
  
  [findtreatment.samhsa.gov/TreatmentLocator/](http://findtreatment.samhsa.gov/TreatmentLocator/)
  
  Find the Closest Services & Treatment Locations.
  
  Find alcohol and drug abuse treatment or mental health treatment facilities and programs around the country.

- **SAMHSA’s National Helpline:**
  
  [www.samhsa.gov/treatment/natHelpFAQs.aspx](http://www.samhsa.gov/treatment/natHelpFAQs.aspx)
  
  1-800-662-HELP (4357)
  
  TTY: 1-800-487-4889
  
  Also known as, the Treatment Referral Routing Service, this Helpline provides 24-hour free and confidential treatment referral and information about mental and/or substance use disorders, prevention, and recovery in English and Spanish.

- **National Suicide Prevention Lifeline:**
  
  [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)
  
  1-800-273-TALK
  
  24-hour Assistance for Individuals in Emotional Distress

- **Oklahoma Health Care Authority:**
  
  [www.okhca.org](http://www.okhca.org)
  
  (800) 987-7767
  
  (800) 757-5979 (TDD)
  
  For SoonerCare eligible customers contact Member Services

Screening in Primary Care for substance abuse and mental health is critical as more than a third of patients rely solely on primary care for treatment.
Clinical Screening Tools

Health benefit carriers and epidemiologists increasingly recommend the use of screening instruments to identify individuals with undiagnosed disorders, to monitor ongoing symptom severity, and to assess outcomes in clinical practice.

Adolescent

- CES Depression Scale for Children

- 11 Item Kutcher Adolescent Depression Scale (KADS-11)
  http://psychology-tools.com/kutcher-adolescent-depression-scale/

Alcohol and Substance Use
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- Screening - Quickly assesses the severity of substance use and identifies the appropriate level of treatment.
  http://www.integration.samhsa.gov/clinical-practice/sbirt

- Brief intervention - Focuses on increasing the patient’s insight and awareness regarding substance use and motivation toward behavioral change.

- Referral to treatment – Provides those identified as needing more extensive intervention with access to specialty care.
  http://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment

Alcohol and Substance Use Screening Instruments

- AUDIT – Alcohol Use Disorders Identification Test
  http://libdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

  ASSIST – Alcohol, Smoking, and Substance Involvement Screening Test
  http://www.who.int/substance_abuse/activities/assist_v3_english.pdf

  CRAFFT – Substance Abuse Screen (for use with adolescents)
  http://ceasar-boston.org/clinicians/crafft.php


CIWA-Ar – Clinical Institute Withdrawal Assessment of Alcohol Scale Assessment for alcohol withdrawal. [https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf]


Additional SBIRT Resources

- The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) - Available to provide the physician’s office with one-on-one SBIRT assistance. To learn more, please contact Angela Dickson, MSW, LCSW, ACSW, at 405-248-9331 or Angela.Dickson@odmhsas.org.


- National Institute on Drug use – On-line screening
http://www.drugabuse.gov/nidamed/

- **ONDCP** – Office of National Drug Control Policy SBIRT webpage  
  www.whitehousedrugpolicy.gov/treat/screen_brief_intv.htm

- **SAMHSA** – Substance Abuse & Mental Health Services Administration SBIRT  
  http://www.integration.samhsa.gov/clinical-practice/SBIRT

- **SAMHSA** – Treatment locator  
  http://findtreatment.samhsa.gov/

### Anxiety

- **Zung Anxiety Scale**  
  http://en.wikipedia.org/wiki/Zung_Self-Rating_Anxiety_Scale

### Bipolar Depression

- **MDQ** – Mood Disorder Questionnaire  
  Thirteen questions derived from clinical experience and from the DSM-IV criteria  
  that screen for a lifetime history manic or hypo-manic symptoms  
  http://www.dbsalliance.org/pdfs/MDQ.pdf

### Children

- **Ages and Stages Questionnaire (ASQ-3)**  
  http://agesandstages.com/

- **Ages and Stages Questionnaire SE (ASQ:SE)**  
  http://agesandstages.com/

- **Modified Checklist of Autism in Toddlers (M-CHAT)**  
  Twenty-three-item checklist for identifying autism in primary care  
  http://www.firstsigns.org/downloads/m-chat.PDF

- **Pediatric Symptom Checklist 17**  
  The PSC 17 can be used as a youth self report.  
  http://www.massgeneral.org/psychiatry/services/psc_forms.aspx

- **Pediatric Symptom Checklist 35**  
  Standard parent-completed PSC form consisting of 35 items.  
  http://www.massgeneral.org/psychiatry/services/psc_forms.aspx

- **Survey of Well-being of Young Children (SWYC)**  
  Forms are available for children 1 month-old to 60 months.  
Vanderbilt Assessment Scale-Parent Informant
http://www.myadhd.com/vanderbiltparent6175.html

Depression

- Zung Depression Scale

- Hamilton Depression Scale
  http://healthnet.umassmed.edu/mhealth/HAMD.pdf

- PHQ-9
  The PHQ-9 is a tool specific to depression. It simply scores each of the nine
  DSM-IV criteria, based on the mood module from the original PRIME-MD.
  http://www.phqscreeners.com/overview.aspx#

Depression /Panic Disorder

- PHQ Brief
  A shorter, alternative version of the PHQ that assesses depression, anxiety,
  psychological stressors and women’s reproductive health.
  http://www.phqscreeners.com/select-screener/111

Anxiety

- Spence Children’s Anxiety Scale
  http://www.scaswebsite.com/1_1_.html

Postnatal Depression

- Edinburgh Postnatal Depression Scale
  Screening for postpartum women in outpatient, home visiting settings or at the 6 - 8
  week postpartum examination.
  http://www2.aap.org/sections/scan/practicingsafety/toolkit_resources/module2/
  epds.pdf

Domestic Violence

- HITS: A Domestic Violence Screening Tool
  http://www.baylorhealth.com/PhysiciansLocations/Dallas/SpecialtiesServices/EmergencyCare/Documents/
  BUMCD-262_2010_HITS%20survey.pdf

Eating Disorder

- Scoff Eating Disorders Questionnaire –
  http://www.fpnotebook.com/legacy/Psych/Exam/ScfQstnr.htm
Elderly

- Geriatric Depression Scale - Short
  http://www.stanford.edu/~yesavage/GDS.english.short.score.html

- Cornell Scale for Depression in Dementia
  http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf

Gambling

- Centre for Addiction and Mental Health (CAMH) Gambling Screen
  http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/CAMHGaminblingScreen.aspx

Suicide

- Primary Care Pocket Guide

- The Risk of Suicide Questionnaire-Revised (RSQ-R)

Trauma

- Primary Care PTSD Screen

- Impact of Event Scale
  http://academic.regis.edu/clinicaleducation/pdf's/IES_scoring.pdf

Other Screening Tools

PHQ-15 – A self-administered version of the PRIME-MD that contains only the mood, anxiety and some of the sleep disorder modules. This tool assesses the 15 most common physical symptoms in primary care. http://www.phqscreeners.com/terms.aspx
The Patient Health Questionnaire (PHQ-9) - Overview

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression:
- The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation.
- A follow up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient’s level of function.

Clinical Utility
The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which can reflect improvement or worsening of depression in response to treatment.

Scoring
See PHQ-9 Scoring on next page.

Psychometric Properties
- The diagnostic validity of the PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics.
- PHQ scores ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression.
- PHQ-9 scores of 5, 10, 15, and 20 represents mild, moderate, moderately severe and severe depression.¹

¹ Kroenke K, Spitzer R, Williams W. The PHO-9: Validity of a brief depression severity measure. JGIM, 2001, 16.606-616
### The Patient Health Questionnaire (PHQ-9)

**Patient Name _______________________________ Date of Visit __________________**

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

<table>
<thead>
<tr>
<th></th>
<th>Not At all</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Column Totals**  
Add Totals Together  

---

10. 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?  
☐ Not difficult at all  ☐ Somewhat difficult  ☐ Very difficult  ☐ Extremely difficult

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The Patient Health Questionnaire (PHQ-9) Scoring

Use of the PHQ-9 to Make a Tentative Depression Diagnosis:
The clinician should rule out physical causes of depression, normal bereavement and a history of a manic/hypomanic episode

Step 1: Questions 1 and 2
Need one or both of the first two questions endorsed as a "2" or a "3" (2 = "More than half the days" or 3 = "Nearly every day")

Step 2: Questions 1 through 9
Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count. (Questions 1-8 must be endorsed as a "2" or a "3"; Question 9 must be endorsed as "1" a "2" or a "3")

Step 3: Question 10
This question must be endorsed as "Somewhat difficult" or "Very difficult" or "Extremely difficult"

Use of the PHQ-9 for Treatment Selection and Monitoring

Step 1
A depression diagnosis that warrants treatment or a treatment change, needs at least one of the first two questions endorsed as positive ("more than half the days" or "nearly every day") in the past two weeks. In addition, the tenth question, about difficulty at work or home or getting along with others should be answered at least "somewhat difficult"

Step 2
Add the total points for each of the columns 2-4 separately (Column 1 = Several days; Column 2 = More than half the days; Column 3 = Nearly every day. Add the totals for each of the three columns together. This is the Total Score
The Total Score = the Severity Score

Step 3
Review the Severity Score using the following TABLE.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Preferences should be considered</td>
<td></td>
</tr>
<tr>
<td>5-9</td>
<td>Minimal Symptoms*</td>
<td>Support, educate to call if worse, return in one month</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ++</td>
<td>Support, watchful waiting</td>
</tr>
<tr>
<td></td>
<td>Dysthymia*</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Major Depression, mild</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>&gt;20</td>
<td>Major Depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")
++ If symptoms present ≥ one month or severe functional impairment, consider active treatment
**CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)**

**Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?** *(Marque con un “* para indicar su respuesta)*

<table>
<thead>
<tr>
<th></th>
<th>Ningún día</th>
<th>Varios días</th>
<th>Más de la mitad de los días</th>
<th>Casi todos los días</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Poco interés o placer en hacer cosas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Se ha sentido cansado(a) o con poca energía</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Sin apetito o ha comido en exceso</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**FOR OFFICE CODING**

\[
\text{Total Score: } \sum \text{ responses} = \sum (0 + 1 + 2 + 3) = \text{Total Score: } \sum \text{ responses}
\]

Si marcó *cualquiera* de los problemas, ¿qué tanta dificultad le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

<table>
<thead>
<tr>
<th></th>
<th>No ha sido dificil</th>
<th>Un poco dificil</th>
<th>Muy dificil</th>
<th>Extremadamente dificil</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Elaborado por los doctores Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke y colegas, mediante una subvención educativa otorgada por Pfizer Inc. No se requiere permiso para reproducir, traducir, presentar o distribuir.
NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today’s Date: ___________  Child’s Name: _____________________________________________  Date of Birth: ________________

Parent’s Name: _____________________________________________  Parent’s Phone Number: _____________________________

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

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

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does not pay attention to details or makes careless mistakes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>with, for example, homework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through when given directions and fails to finish</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>activities (not due to refusal or failure to understand)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or does not want to start tasks that requireongoing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>mental effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (toys, assignments,</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>pencils, or books)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or beginning quiet play activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting his or her turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes in on others’ conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Argues with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Actively defies or refuses to go along with adults’ requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Deliberately annoys people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Blames others for his or her mistakes or misbehaviors</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Is touchy or easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Is spiteful and wants to get even</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Bullies, threatens, or intimidates others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Starts physical fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Lies to get out of trouble or to avoid obligations (ie, “cons” others)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Is truant from school (skips school) without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Is physically cruel to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Has stolen things that have value</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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

Revised – 1102
### Symptoms (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Deliberately destroys others’ property</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Is physically cruel to animals</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36. Has deliberately set fires to cause damage</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37. Has broken into someone else’s home, business, or car</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Has stayed out at night without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. Has run away from home overnight</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. Has forced someone into sexual activity</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. Is fearful, anxious, or worried</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. Is afraid to try new things for fear of making mistakes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Feels worthless or inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. Blames self for problems, feels guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Is sad, unhappy, or depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>Performance</th>
<th>Excellent</th>
<th>Average</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. Overall school performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>49. Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>50. Writing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>51. Mathematics</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>52. Relationship with parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>53. Relationship with siblings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>54. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>55. Participation in organized activities (eg, teams)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

### Comments:

---

**For Office Use Only**

- Total number of questions scored 2 or 3 in questions 1–9: _______________________
- Total number of questions scored 2 or 3 in questions 10–18: _____________________
- Total Symptom Score for questions 1–18: _______________________________________
- Total number of questions scored 2 or 3 in questions 19–26: ____________________
- Total number of questions scored 2 or 3 in questions 27–40: ____________________
- Total number of questions scored 2 or 3 in questions 41–47: ____________________
- Total number of questions scored 4 or 5 in questions 48–55: ____________________
- Average Performance Score: ___________________
Instrucciones: Conteste basándose en lo que considera apropiado para un niño de esa edad. Al completar este cuestionario, piense por favor en la conducta de su niño durante los últimos seis meses.

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

Esta evaluación se refiere a un período en que su hijo(a)

Is this evaluation based on a time when the child

☐ tomaba medicamentos

☐ no tomaba medicamentos

☐ no lo recuerda

<table>
<thead>
<tr>
<th>Síntomas/ Symptoms</th>
<th>Nunca/ Never</th>
<th>A veces/ Occasionally</th>
<th>Seguido/ Often</th>
<th>Muy seguido/ Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No pone atención a los detalles o comete errores por descuido, como por ejemplo, cuando hace la tarea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Se le dificulta mantenerse atento al llevar a cabo sus actividades</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Parece no estar escuchando cuando se le habla directamente</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. No sigue las instrucciones hasta el final y no concluye sus actividades (no porque se rühse a seguirlas o porque no las comprenda)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Tiene dificultad al organizar sus tareas diarias y actividades</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Evita, le disgusta o no quiere comenzar actividades que requieren un mayor esfuerzo mental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Pierde cosas que son indispensables para cumplir con sus tareas o actividades (juguete, tareas de la escuela, lápices o libros)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Se distrae fácilmente con ruidos u otros estímulos externos</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Es olvidadizo(a) en sus actividades cotidianas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Mueve constantemente las manos o los pies, o no se está quieto(a) en su asiento</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Se pone de pie cuando debiera permanecer sentado(a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

La información contenida en esta publicación no debe usarse a manera de substitución del cuidado médico y consejo de su pediatra. Éste podría recomendar variaciones en el tratamiento, según hechos y circunstancias individuales.
### Sistema NICHQ Vanderbilt de Evaluación. Continuación cuestionario para PADRES

**NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued**

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

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

**Fecha de nacimiento / Date of Birth:**

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

**Teléfono / Parent's Phone Number:**

<table>
<thead>
<tr>
<th>Síntomas (continuación) / Symptoms (continued)</th>
<th>Nunca / Never</th>
<th>A veces / Occasionally</th>
<th>Seguido / Often</th>
<th>Muy seguido / Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Corre o camina por todos lados cuando debiera permanecer sentado</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Runs about or climbs too much when remaining seated is expected</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Se le dificulta jugar o empezar actividades recreativas más tranquilas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Has difficulty playing or beginning quiet play activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Está en constante movimiento o actúa como si “tuviera un motor por dentro”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Is &quot;on the go&quot; or often acts as if &quot;driven by a motor&quot;</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Habla demasiado</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Talks too much</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Responde precipitadamente, incluso antes de escuchar la pregunta completa</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Blurs out answers before questions have been completed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Tiene dificultad al esperar su turno</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Has difficulty waiting his or her turn</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Interrumpe o se entromete en conversaciones o actividades ajenas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Interrupts or intrudes in on others' conversations and/or activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Discute con adultos</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Argues with adults</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Se enfurece con facilidad</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Loses temper</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Desafía abiertamente o se niega a cumplir las órdenes o las reglas de los adultos</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Active ly defies or refuses to go along with adults' requests or rules</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Molesta a los demás</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Deliberately annoys people</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Culpa a otros de sus propios errores o su mal comportamiento</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Blames others for his or her mistakes or misbehaviors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Se ofende o se molesta fácilmente con otros</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Is touchy or easily annoyed by others</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Está enojado(a) o resentido(a)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Is angry or resentful</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Es rancoroso y vengativo</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Is spiteful and wants to get even</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Reta, amenaza o intimidá a otros</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Bullies, threatens, or intimidates others</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Comienza peleas de contacto físico</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Starts physical fights</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Miente con el fin de salir de apuros o para eludir sus obligaciones</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Lies to get out of trouble or to avoid obligations (ie, &quot;cons&quot; others)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Falta a la escuela sin permiso</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Is truant from school (skips school) without permission</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Fecha de hoy/Today’s Date: ____________________

Nombre del niño(a)/Child’s Name: ____________________

Fecha de nacimiento/Date of Birth: ____________________

Nombre del padre y/o de la madre/Parent’s Name: ____________________

Teléfono/Parent’s Phone Number: ____________________

<table>
<thead>
<tr>
<th>Síntomas (continuación)/Symptoms (continued)</th>
<th>Nunca/Never</th>
<th>A veces/Occasionally</th>
<th>Seguido/Often</th>
<th>Muy seguido/Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. Es físicamente cruel con los demás</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Is physically cruel to people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Ha robado cosas de valor</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has stolen things that have value</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Destruye deliberadamente la propiedad ajena</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Deliberately destroys others’ property</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Ha usado un objeto que puede herir a alguien</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has used a weapon that can cause serious harm (bat, knife, brick, gun)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Tortura animales</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Is physically cruel to animals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Ha provocado fuegos para causar daños</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has deliberately set fires to cause damage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Ha entrado a una casa, un negocio o un carro ajeno</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has broken into someone else’s home, business, or car</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Ha permanecido fuera de la casa sin permiso durante la noche</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has stayed out at night without permission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Se ha escapado de la casa durante la noche</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has run away from home overnight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Ha obligado a alguien a sostener algún tipo de actividad sexual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has forced someone into sexual activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Siente miedo, ansiedad o está preocupado</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Is fearful, anxious, or worried</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Teme hacer nuevas cosas por temor a cometer errores</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Is afraid to try new things for fear of making mistakes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. Se desprecia a sí mismo se siente inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feels worthless or inferior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. Siente que los problemas son responsabilidad suya y se siente culpable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Blames self for problems, feels guilty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. Se siente solo(a), rechazado(a) o sin amor; se queja de que nadie lo quiere</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feels lonely, unwanted, or unloved; complains that “no one loves him or her”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Se siente triste, infeliz o deprimido(a)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Is sad, unhappy, or depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Está al pendiente de sus actos o se avergüenza fácilmente</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Is self-conscious or easily embarrassed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Fecha de hoy/Today’s Date: 
Nombre del niño(a)/Child’s Name: 
Fecha de nacimiento/Date of Birth: 
Nombre del padre y/o de la madre/Parent’s Name: 
Teléfono/Parent’s Phone Number: 

<table>
<thead>
<tr>
<th>Comportamiento Performance</th>
<th>Excelente/ Excellent</th>
<th>Sobre lo normal/ Above Average</th>
<th>Normal/ Average</th>
<th>Cierta dificultad/ Somewhat of a Problem</th>
<th>Con dificultad/ Problematic</th>
</tr>
</thead>
</table>
| 48. Comportamiento general en la escuela
   Overall school performance | 1 | 2 | 3 | 4 | 5 |
| 49. Lectura
   Reading | 1 | 2 | 3 | 4 | 5 |
| 50. Escritura
   Writing | 1 | 2 | 3 | 4 | 5 |
| 51. Matemáticas
   Mathematics | 1 | 2 | 3 | 4 | 5 |
| 52. Relación con sus padres
   Relationship with parents | 1 | 2 | 3 | 4 | 5 |
| 53. Relación con sus hermanos
   Relationship with siblings | 1 | 2 | 3 | 4 | 5 |
| 54. Relación con sus compañeros
   Relationship with peers | 1 | 2 | 3 | 4 | 5 |
| 55. Participación en actividades organizadas
   (ejemplo: equipos deportivos)
   Participation in organized activities (eg, teams) | 1 | 2 | 3 | 4 | 5 |

**Comentarios/Comments:**

---

**For Office Use Only**

- Total number of questions scored 2 or 3 in questions 1–9: 
- Total number of questions scored 2 or 3 in questions 10–18: 
- Total Symptom Score for questions 1–18: 
- Total number of questions scored 2 or 3 in questions 19–26: 
- Total number of questions scored 2 or 3 in questions 27–40: 
- Total number of questions scored 2 or 3 in questions 41–47: 
- Total number of questions scored 4 or 5 in questions 48–55: 
- Average Performance Score: 

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

North Carolina Children’s Healthcare Improvement Program
National Initiative for Children’s Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals
The CRAFFT Questionnaire (version 2.0)

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Drink more than a few sips of beer, wine, or any drink containing <strong>alcohol</strong>? Put “0” if none.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td># of days</td>
</tr>
<tr>
<td>2. Use any <strong>marijuana</strong> (pot, weed, hash, or in foods) or “<strong>synthetic marijuana</strong>” (like “K2” or “Spice”)? Put “0” if none.</td>
<td></td>
<td></td>
<td># of days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or “huff”)? Put “0” if none.</td>
<td></td>
<td></td>
<td># of days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- If you put “0” in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.
- If you put “1” or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have you ever ridden in a <strong>CAR</strong> driven by someone (including yourself) who was “high” or had been using alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you ever use alcohol or drugs to <strong>RELAX</strong>, feel better about yourself, or fit in?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Do you ever use alcohol or drugs while you are by yourself, or <strong>ALONE</strong>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you ever <strong>FORGET</strong> things you did while using alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do your <strong>FAMILY</strong> or <strong>FRIENDS</strong> ever tell you that you should cut down on your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Have you ever gotten into <strong>TROUBLE</strong> while you were using alcohol or drugs?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:**
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

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For more information and versions in other languages, see [www.ceasar.org](http://www.ceasar.org)
Cuestionario CRAFFT 2.0
Para que lo conteste el paciente

Por favor, conteste todas las preguntas honestamente; sus respuestas se tratarán de forma confidencial.

Durante los ÚLTIMOS 12 MESES, ¿cuántos días usted:

1. bebió más de unos sorbos de cerveza, vino u otra bebida que contenía alcohol? Escriba “0” si la respuesta es ninguno.

2. consumió marihuana (hierba, mota, hachís o comidas de cannabis) o “marihuana sintética” (como “K2” o “Spice”)? Escriba “0” si la respuesta es ninguno.

3. consumió alguna otra sustancia para drogarse (p.ej.: otras drogas ilícitas, medicamentos recetados o de venta libre, y cosas que se aspiran o inhalan)? Escriba “0” si la respuesta es ninguno.

LEA ESTAS INSTRUCCIONES ANTES DE CONTINUAR:
- Si usted escribió “0” en TODOS los casilleros de arriba, RESPONDA LA PREGUNTA 4, LUEGO DETÉNGASE.
- Si usted escribió “1” o números más altos en CUALQUIERA de los casilleros anteriores, RESPONDA LAS PREGUNTAS 4 a 9.

4. ¿Ha viajado alguna vez en un CARRO o vehículo conducido por una persona (o usted mismo/a) que estaba “drogada” o había consumido alcohol o drogas?

5. ¿consume alguna vez alcohol o drogas para RELAJARSE, sentirse mejor consigo mismo/a o integrarse en un grupo?

6. ¿consume alguna vez alcohol o drogas mientras está SOLO/A, o sin compañía?

7. ¿Alguna vez se le OLVIDAN cosas que hizo mientras consumía alcohol o drogas?

8. ¿le han sugerido alguna vez sus FAMILIARES o AMIGOS que disminuya el consumo de alcohol o drogas?

9. ¿Se ha metido alguna vez en LÍOS o problemas al tomar alcohol o drogas?

AVISO PARA EL PERSONAL DE LA CLÍNICA Y EXPEDIENTES MÉDICOS:
La información incluida en esta página está protegida por normas federales sobre confidencialidad (42 CFR Parte 2) que prohíben su divulgación, salvo que mediera una autorización escrita para el caso específico. NO basta con que se cuente con una autorización generalizada en materia de divulgación de la información médica.

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Para obtener más información y versiones en otros idiomas, ingrese en www.ceasar.org
1. Show your patient his/her score on the graph

![Bar Graph: Probability of a Substance Use Disorder](image)

2. Talking Points for Clinician Counseling

   **No Use**
   - Not using drugs and alcohol is a smart decision for your health. You should be proud of yourself. If that ever changes, I hope you trust me enough that we can talk about it.

   **Any Use**
   - My recommendation as your doctor is not to use drugs or alcohol *at all.*

   **CRAFFT score ≥ 2**
   - I am quite concerned about you. Let’s plan a follow-up meeting in about a month.

3. Counseling Points for All
   - Alcohol and drugs can affect brain development, which continues into your mid-20s.
   - Early alcohol and drug use greatly increases your risk for developing addiction, major depression, anxiety disorders, and psychotic thinking.
   - Alcohol can hurt and scar your liver; marijuana can hurt your lungs
   - Alcohol and drugs can cause car crashes. Marijuana impairs driving just as much as alcohol does, and its effects last longer.

4. Give each patient the Contract for Life

   [www.crafft.org/contract](http://www.crafft.org/contract)

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The Center for Adolescent Substance Abuse Research, (CeASAR) at Boston Children’s Hospital
(617) 355-5433 www.ceasar.org
For more information, contact ceasar@childrens.harvard.edu

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Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals: 

<table>
<thead>
<tr>
<th>12 oz.</th>
<th>5 oz.</th>
<th>1.5 oz. liquor (one shot)</th>
</tr>
</thead>
<tbody>
<tr>
<td>beer</td>
<td>wine</td>
<td>(one shot)</td>
</tr>
</tbody>
</table>

1. How often do you have a drink containing alcohol?
   - Never
   - Monthly or less
   - 2 - 4 times a month
   - 2 - 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?
   - 0 - 2
   - 3 or 4
   - 5 or 6
   - 7 - 9
   - 10 or more

3. How often do you have four 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, in 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, in the last year

Have you ever been in treatment for an alcohol problem?

☐ Never  ☐ Currently  ☐ In the past

<table>
<thead>
<tr>
<th>M: 0-4</th>
<th>5-14</th>
<th>15-19</th>
<th>20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>W: 0-3</td>
<td>4-12</td>
<td>13-19</td>
<td>20+</td>
</tr>
</tbody>
</table>
Cuestionario de detección de alcohol (AUDIT – Spanish)
El consumo de alcohol puede afectar su salud y a algunos medicamentos que podría estar consumiendo. Ayúdenos a darle la mejor atención médica contestando a las siguientes preguntas.

<table>
<thead>
<tr>
<th>Un trago equivale a:</th>
<th>12 oz de cerveza</th>
<th>5 oz de vino</th>
<th>1.5 oz de licor (una copita)</th>
</tr>
</thead>
</table>

1. ¿Con qué frecuencia bebe un trago con contenido de alcohol?  
   Nunca | Una vez al mes o menos | 2 - 4 veces al mes | 2 - 3 veces por semana | 4 o más veces por semana |

2. ¿Cuántos tragos que contengan alcohol consume en un día típico cuando está bebiendo?  
   0 - 2 | 3 o 4 | 5 o 6 | 7 - 9 | 10 o más |

3. ¿Con qué frecuencia bebe cuatro o más tragos en una ocasión?  
   Nunca | Menos de una vez al mes | Mensualmente | Semanalmente | Diario o casi a diario |

4. ¿Con qué frecuencia durante el último año se dio cuenta de que no pudo dejar de beber una vez que había empezado?  
   Nunca | Menos de una vez al mes | Mensualmente | Semanalmente | Diario o casi a diario |

5. ¿Con qué frecuencia durante el último año ha dejado de hacer lo que normalmente se esperaba de usted debido a la bebida?  
   Nunca | Menos de una vez al mes | Mensualmente | Semanalmente | Diario o casi a diario |

6. ¿Con qué frecuencia durante el último año ha necesitado un primer trago en la mañana para ponerse en acción después de una sesión de beber abundantemente?  
   Nunca | Menos de una vez al mes | Mensualmente | Semanalmente | Diario o casi a diario |

7. ¿Con qué frecuencia durante el último año ha tenido una sensación de culpa o remordimiento después de beber?  
   Nunca | Menos de una vez al mes | Mensualmente | Semanalmente | Diario o casi a diario |

8. ¿Con qué frecuencia durante el último año ha sido incapaz de recordar lo que pasó la noche anterior debido a su forma de beber?  
   Nunca | Menos de una vez al mes | Mensualmente | Semanalmente | Diario o casi a diario |

9. ¿Usted o alguien más han resultado heridos debido a su forma de beber?  
   No | Sí, pero no en el último año | Sí, en el último año |

10. ¿Ha estado preocupado por su forma de beber o le ha sugerido que beba menos algún pariente, amigo, médico u otro trabajador de la atención a la salud?  
    No | Sí, pero no en el último año | Sí, en el último año |

¿Ha estado alguna vez en tratamiento por un problema de alcohol?  ☐ Nunca  ☐ Actualmente  ☐ En el pasado

<table>
<thead>
<tr>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>M: 0-4</td>
<td>5-14</td>
<td>15-19</td>
<td>20+</td>
</tr>
<tr>
<td>W: 0-3</td>
<td>4-12</td>
<td>13-19</td>
<td>20+</td>
</tr>
</tbody>
</table>
Scoring and interpreting the AUDIT:

Each answer receives a point ranging from 0 to 4. Points are added for a total score that correlates with a zone of use that can be circled on the bottom left corner of the page.

<table>
<thead>
<tr>
<th>Score*</th>
<th>Suggested zone</th>
<th>Indicated action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3: Women 0-4: Men</td>
<td><strong>I – Low risk</strong> (low risk of health problems related to alcohol use)</td>
<td>Brief education</td>
</tr>
<tr>
<td>4-12: Women 5-14: Men</td>
<td><strong>II - Risky</strong> (increased risk of health problems related to alcohol use)</td>
<td>Brief intervention</td>
</tr>
<tr>
<td>13-19: Women 15-19: Men</td>
<td><strong>III - Harmful</strong> (increased risk of health problems related to alcohol use and a possible mild or moderate alcohol use disorder)</td>
<td>Brief intervention or referral to specialized treatment</td>
</tr>
<tr>
<td>20+: Men 20+: Women</td>
<td><strong>IV - Severe</strong> (increased risk of health problems related to alcohol use and a possible moderate or severe alcohol use disorder)</td>
<td>Referral to specialized treatment</td>
</tr>
</tbody>
</table>

**Brief education:** An opportunity to educate patients about low-risk consumption levels and the risks of excessive alcohol use.

**Brief intervention:** Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual’s awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention.

The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Patients with numerous or serious negative consequences from their drinking, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up. The recommended behavior change in this case is to either cut back to low-risk drinking levels or abstain from use.

**Referral to specialized treatment:** A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to alcohol and drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral. Referrals to treatment are delivered to the patient using the brief intervention model.

More resources: [www.sbirtoregon.org](http://www.sbirtoregon.org)

Drug Screening Questionnaire (DAST)
Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

- methamphetamines (speed, crystal)
- cannabis (marijuana, pot)
- inhalants (paint thinner, aerosol, glue)
- tranquilizers (valium)
- cocaine
- narcotics (heroin, oxycodone, methadone, etc.)
- hallucinogens (LSD, mushrooms)
- other ______________________________

How often have you used these drugs?  □ Monthly or less  □ Weekly  □ Daily or almost daily

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you used drugs other than those required for medical reasons?</td>
<td></td>
<td>☐</td>
</tr>
<tr>
<td>2. Do you abuse more than one drug at a time?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Are you unable to stop using drugs when you want to?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Have you ever had blackouts or flashbacks as a result of drug use?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Do you ever feel bad or guilty about your drug use?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Does your spouse (or parents) ever complain about your involvement with drugs?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Have you neglected your family because of your use of drugs?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>8. Have you engaged in illegal activities in order to obtain drugs?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever injected drugs?</td>
<td>□ Never</td>
<td>□ Yes, in the past 90 days</td>
</tr>
<tr>
<td>Have you ever been in treatment for substance abuse?</td>
<td>□ Never</td>
<td>□ Currently</td>
</tr>
</tbody>
</table>
Cuestionario de detección de drogas (DAST – Spanish)

El uso de drogas puede afectar su salud y a algunos medicamentos que podría estar consumiendo. Ayúdenos a darle la mejor atención médica contestando a las siguientes preguntas.

¿Cuál de las siguientes drogas utilizó el año pasado?

- [ ] metanfetaminas (speed, cristal)
- [ ] cannabis (marijuana, maría)
- [ ] inhalantes (tíner o adelgazante de pintura, aerosol, pegamento)
- [ ] tranquilizantes (valium)
- [ ] cocaína
- [ ] narcóticos (heroina, oxicodona, metadona, etc.)
- [ ] alucinógenos (LSD, hongos)
- [ ] otros _______________________________

¿Con qué frecuencia ha usado estas drogas?

- [ ] Mensualmente o menos
- [ ] Semanal
- [ ] A diario o casi a diario

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ¿Ha utilizado medicamentos distintos de los necesarios por motivos médicos?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>2. ¿Abusa de más de una droga a la vez?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>3. ¿No puede dejar de usar drogas cuando quiere?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>4. ¿Ha experimentado pérdida temporal de la memoria o escenas retrospectivas como resultado del uso de drogas?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>5. ¿En ocasiones se siente mal o culpable por su uso de drogas?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>6. ¿Se quejan alguna vez su cónyuge (o padres) por su implicación con las drogas?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>7. ¿Ha descuidado a su familia debido a su uso de drogas?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>8. ¿Ha participado en actividades ilegales a fin de obtener drogas?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>9. ¿Ha experimentado alguna vez síntomas de abstinencia (sentirse enfermo) cuando ha dejado de consumir drogas?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
<tr>
<td>10. ¿Ha tenido problemas médicos como resultado de su uso de drogas (por ejemplo, pérdida de memoria, hepatitis, convulsiones, hemorragias)?</td>
<td>No</td>
<td>Sí</td>
<td></td>
</tr>
</tbody>
</table>

¿Alguna vez se ha inyectado drogas?

- [ ] Nunca
- [ ] Sí, en los últimos 90 días
- [ ] Sí, hace más de 90 días

¿Ha estado alguna vez en tratamiento por abuso de sustancias?

- [ ] Nunca
- [ ] Actualmente
- [ ] En el pasado

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
</tr>
<tr>
<td>0</td>
<td>1-2</td>
<td>3-5</td>
<td>6+</td>
</tr>
</tbody>
</table>
(For the health professional)

Scoring and interpreting the DAST:

“Yes” responses receive one point each and are added for a total score. The score correlates with a zone of use that can be circled on the bottom right corner of the page.

<table>
<thead>
<tr>
<th>Score</th>
<th>Zone of use</th>
<th>Indicated action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I – Healthy (no risk of related health problems)</td>
<td>None</td>
</tr>
<tr>
<td>1 - 2, plus the following criteria: No daily use of any substance; no weekly use of drugs other than cannabis; no injection drug use in the past 3 months; not currently in treatment.</td>
<td>II – Risky (risk of health problems related to drug use)</td>
<td>Offer advice on the benefits of abstaining from drug use. Monitor and reassess at next visit. Provide educational materials.</td>
</tr>
<tr>
<td>1 - 2 (without meeting criteria)</td>
<td>III – Harmful (risk of health problems related to drug use and a possible mild or moderate substance use disorder)</td>
<td>Brief intervention</td>
</tr>
<tr>
<td>3 - 5</td>
<td>IV – Severe (risk of health problems related to drug use and a possible moderate or severe substance use disorder)</td>
<td>Brief intervention or Referral to specialized treatment</td>
</tr>
<tr>
<td>6+</td>
<td></td>
<td>Referral to specialized treatment</td>
</tr>
</tbody>
</table>

**Brief intervention:** Patient-centered discussion that employs Motivational Interviewing concepts to raise an individual’s awareness of his/her substance use and enhancing his/her motivation towards behavioral change. Brief interventions are typically performed in 3-15 minutes, and should occur in the same session as screening. The recommended behavior change is to abstain from illicit drug use.

Patients with numerous or serious negative consequences from their substance use, or patients with likely dependence who cannot or will not obtain conventional specialized treatment, should receive more numerous and intensive interventions with follow up.

**Referral to specialized treatment:** A proactive process that facilitates access to specialized care for individuals who have been assessed to have substance use dependence. These patients are referred to drug treatment experts for more definitive, in-depth assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

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