MENTAL WELLNESS SCREENING TOOL

COMPLETE DOCUMENTATION

Prepared by Southwest Regional Mental Health Board

April 2017

1. Purpose and Background

The Mental Wellness Screen was developed by the Behavioral Health Promotion Subcommittee of the Primary Care Action Group (PCAG), which serves the Greater Bridgeport, Connecticut area. The committee's goal was to normalize the concept of assessing mental health and to increase detection in order to provide earlier access to treatment.

The committee chose to develop this tool after reviewing many others but not finding a simple tool that met the committee's major criteria:

- Tool should assess for all of the following: anxiety, depression, suicidality, trauma, alcohol, and other drugs. (Many tools focus on depression, missing the opportunity to capture anxiety, which is even more prevalent. Similarly, some tools assess only for alcohol but not other drugs, or for substance use but not mental illness.)
- To minimize the burden to the provider, tool should be quick and easy for the client to fill out and for the provider to score. This tool can be filled out in as little as 2 minutes and can be scored in less than a minute.

This screening tool was first used in Fall 2016 in college- and community-based screening programs organized by the Southwest Regional Mental Health Board (SWRMHB) and its partners as part of SWRMHB's October "Wellness Month" screening initiative. Based on those experiences, the tool is being incorporated by Greenwich Department of Human Services into their client assessment and tracking tools as of the spring of 2017 and is anticipated to be used by Bridgeport Department of Social Services. In municipal social services departments that use the tool as part of an intake process, there should be clear protocols for referring clients identified at risk.

The Primary Care Action Group subcommittee plans to implement the tool in urgent care settings where a linkage to behavioral health services is available, due to data indicating that the majority of people under age 30 visit Urgent Care centers more than primary care providers. A pilot originally scheduled for Fall/Winter 2016 has been postponed pending organizational changes in the St. Vincent's Medical Center system.

Please contact the PCAG Subcommittee Chairs with any questions about this project:

- Margaret Watt, Executive Director, Southwest Regional Mental Health Board: 203-840-1187 or mwatt@healthymindsct.org
- Tammy Trojanowski, Administrator, Stratford Community Services: 203-385-4095 or ttrojanowski@townofstratford.com

2. Content of Screening Tool

The Mental Wellness Screen assembled by the committee is composed of 4 evidence-based screening tools recommended by SAMHSA. These are the PHQ-9 and GAD-7, the PC-PTSD, and the CAGE-AID. All tools are in the public domain and are easy to administer and user-friendly.

The tool is reproduced on the next pages in English and Spanish. The scoring guidelines follow.

Mental Wellness Screen

First Name (optional): _____

Date: _____

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

	Not at all	Several days	More than half the days	Nearly every day	
1. Little interest or pleasure in doing things	0	1	2	3	
2. Feeling down, depressed, or hopeless	0	1	2	3	
3. □ Trouble falling or staying asleep, or □ Sleeping too much	0	1	2	3	
4. Feeling tired or having little energy	0	1	2	3	
5. □ Poor appetite or □ overeating	0	1	2	3	
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3	
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8. □ Moving or speaking so slowly that other people could have noticed, or □ the opposite – being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3	
9. □ Thoughts that you would be better off dead, or □ Hurting yourself in some way	0	1	2	3	Total
(10)	*Add columns:*				

1. Feeling nervous, anxious or on edge	0	1	2	3	
2. Not being able to stop or control worrying	0	1	2	3	
3. Worrying too much about different things	0	1	2	3	
4. Trouble relaxing	0	1	2	3	
5. Being so restless that it is hard to sit still	0	1	2	3	
6. Becoming easily annoyed or irritable	0	1	2	3	
7. Feeling afraid as if something awful might happen	0	1	2	3	Total
(10)	*Add columns:*				

Please also complete the back side →

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

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

Do you use alcohol or drugs? **No** *(stop here)* **Yes** *(continue below)*

When answering about drug use, consider both illegal drugs and prescription drugs used other than as prescribed.

1. Have you ever felt you should cut down on your drinking or drug use?	Drinking:	No	Yes
	Drug use:	No	Yes
2. Have people annoyed you by criticizing your drinking or drug use?	Drinking:	No	Yes
	Drug use:	No	Yes
3. Have you ever felt bad or guilty about your drinking or drug use?	Drinking:	No	Yes
	Drug use:	No	Yes
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?	Drinking:	No	Yes
	Drug use:	No	Yes
(1)		*# of Yes responses:*	

Thank you for filling out this form. Please return it to a clinician who will discuss your answers with you and give you recommendations.

Developed by Southwest Regional Mental Health Board & the Primary Care Action Group as part of an integrated behavioral health screening initiative. All materials public domain and available at samhsa.gov. Based on PHQ9, GAD7, PC-PTSD and CAGE-AID.

Southwest Regional Mental Health Board

PRIMARY CARE ACTION GROUP

St. Vincent's MEDICAL CENTER

YaleNewHavenHealth Bridgeport Hospital

Cuestionario sobre el bienestar emocional

Nombre (opcional): _____ Fecha: _____

Durante las *<u>últimas 2 semanas</u>*, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?

	Ningún día	Varios días	Más de la mitad de días	Casi todos los días	
10. Poco interés o placer en hacer cosas	0	1	2	3	
11. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3	
12. □ Ha tenido dificultad para quedarse o permanecer dormido(a), o □ ha dormido demasiado	0	1	2	3	
13. Se ha sentido cansado(a) o con poca energía	0	1	2	3	
14. □ Sin apetito, o □ ha comido en exceso	0	1	2	3	
15. 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	0	1	2	3	
16. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	0	1	2	3	
17. □ 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	0	1	2	3	
18. □ Pensamientos de que estaría mejor muerto(a) o □ de lastimarse de alguna manera	0	1	2	3	Total
(10)	*Sumar:*				

8. Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	0	1	2	3	
9. No ha sido capaz de parar o controlar su preocupación	0	1	2	3	
10. Se ha preocupado demasiado por motivos diferentes	0	1	2	3	
11. Ha tenido dificultad para relajarse	0	1	2	3	
12. Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	0	1	2	3	
13. Se ha molestado o irritado fácilmente	0	1	2	3	
14. Ha tenido miedo de que algo terrible fuera a pasar	0	1	2	3	Total
(10)	*Sumar:*				

Continúa al reverso →

En su vida, ha tenido una experiencia que fue tan terrible o que le trastornó tanto que, ***en el mes pasado*, usted:

5. ¿Ha tenido pesadillas o ha pensado en lo que le pasó, sin querer hacerlo?	No	Sí
6. ¿Trató de evitar esos pensamientos o evitó situaciones que para usted le podrían recorder la terrible experiencia que tuvo?	No	Sí
7. ¿Estaba constantemente en guardia, atento, o asustado fácilmente?	No	Sí
8. ¿Se ha sentido entumecido(a) o separado(a) de otros, de actividades o sus alrededores?	No	Sí
(3)	*Sumar los Sí:*	

¿Utiliza Ud. alcohol o drogas? **No** *(fin del cuestionario)* **Sí** *(siga abajo)*

Al contestar sobre las drogas, por favor tome en cuenta tanto las drogas ilegales como las drogas recetadas que usted ha usado de manera diferente a la manera prescrita.

5. ¿Alguna vez ha sentido que debería disminuir o reducir su uso de alcohol y/o drogas?	Alcohol:	No	Sí
	Uso de drogas:	No	Sí
6. ¿Se ha sentido alguna vez molesto(a) por las críticas de la gente acerca de su uso de alcohol y/o drogas?	Alcohol:	No	Sí
	Uso de drogas:	No	Sí
7. ¿Alguna vez se ha sentido culpable debido al uso de alcohol y/o drogas?	Alcohol:	No	Sí
	Uso de drogas:	No	Sí
8. ¿Alguna vez ha necesitado alcohol y/or drogas temprano en la mañana para estabilizar sus nervios o ayudalo con la resaca?	Alcohol:	No	Sí
	Uso de drogas:	No	Sí
(1)		*Sumar los Sí:*	

Gracias por contestar a estas preguntas. Favor de devolver el cuestionario para conocer los resultados y hablar de las recomendaciones.

Desarrollado por la Southwest Regional Mental Health Board y el Primary Care Action Group como parte de una iniciativa sobre la integración de evaluaciones de salud mental en los servicios de salud. Los materiales son de dominio público – visite a www.samhsa.gov. Basado en los cuestionarios PHQ9, GAD7, PC-PTSD y CAGE-AID.

3. Scoring of Screening Tool

The purpose of the Mental Wellness Screen is to identify adults (ages 18+) at risk in order to provide referrals. In discussing findings, it should be made clear that **a higher score indicates risk but is *not* a diagnosis**. Clients at risk should be referred for further evaluation and treatment.

Below we provide information about the screening, scoring and interpretation process for each tool. **As a helpful reminder for interpreting results, we have included a small number in parentheses under each of the four sections of the tool. This number is the cutoff score meaning the person has scored at moderate risk and should be referred.**

Depression screener: PHQ-9

The first tool (top of page 1) is the PHQ-9 by Pfizer, which can be used clinically both as a diagnostic tool for depression and as a depression severity tool. Here it is used non-clinically as a screening tool for adults. Pfizer also has an adapted version for adolescents, the PHQ-A.

1. Patient assigns scores of 0, 1, 2, and 3, to the response categories of Not at All, Several Days, More than Half the Days, and Nearly Every Day, respectively.
2. Provider adds the column totals in the gray cells, and then adds the grand total in the gray cell in the right margin. Total score ranges from 0 to 27.
3. Scores of 5, 10, 15, and 20 represent cut-points for mild, moderate, moderately severe and severe depression, respectively (see table below). Sensitivity to change has been confirmed.
4. **Always look at the answer to Q9, which relates to suicide, in addition to the total score.** Any answer other than 0 (Not At All) requires a discussion with patient. You may wish to use the Columbia Suicide Severity Rating Scales (CSSRS) to investigate further.

PHQ-9 Score	Depression Severity	Proposed Clinical Treatment
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14 (yellow flag)	Moderate	Brief intervention & referral for evaluation. Treatment plan should consider counseling, follow-up and/or pharmacotherapy
15 – 19 (red flag)	Moderately Severe	Brief intervention & warm handoff for evaluation. Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Brief intervention & immediate handoff for evaluation. Treatment may include immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Anxiety screener: GAD-7

The second tool (bottom of page 1) is the GAD-7 by Pfizer, which screens for Generalized Anxiety Disorder. It is also proven to have good sensitivity and specificity as a screener for panic, social anxiety & post-traumatic stress disorder.

1. Patient assigns scores of 0, 1, 2, and 3, to the response categories of Not at All, Several Days, More than Half the Days, and Nearly Every Day, respectively.
2. Provider adds the column totals in the gray cells, and then adds the grand total in the gray cell in the right margin. Total score ranges from 0 to 21.
3. Scores of 5, 10 (yellow flag), and 15 (red flag) represent cut-points for mild, moderate, and severe anxiety, respectively.
4. The recommended cut-point to refer for further evaluation is a score of 10 or greater.

Trauma screener: PC-PTSD

The third tool (top of page 2) is the Primary Care-PTSD screen (PC-PTSD) by Prins, Ouimette, & Kimerling.

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events.

1. Patient assigns scores of No or Yes to each question.
2. Provider adds the number of Yes answers.
3. Results should be considered "positive" if a patient answers "yes" to any 3 items.
4. Those screening positive (3 Yes answers) should be referred for further assessment with a structured interview for PTSD.

Substance use screener: CAGE-AID

The last tool (bottom of page 2) is the CAGE-AID by Robert Brown, MD. CAGE-AID is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. The target population is both adults and adolescents and can be administered by patient interview or self-report in a primary care setting.

1. Patient assigns scores of No or Yes to each question.
2. Of the 4 items, a "yes" answer to even one item indicates a possible substance use disorder. Refer for further assessment.

Further Information about Tools

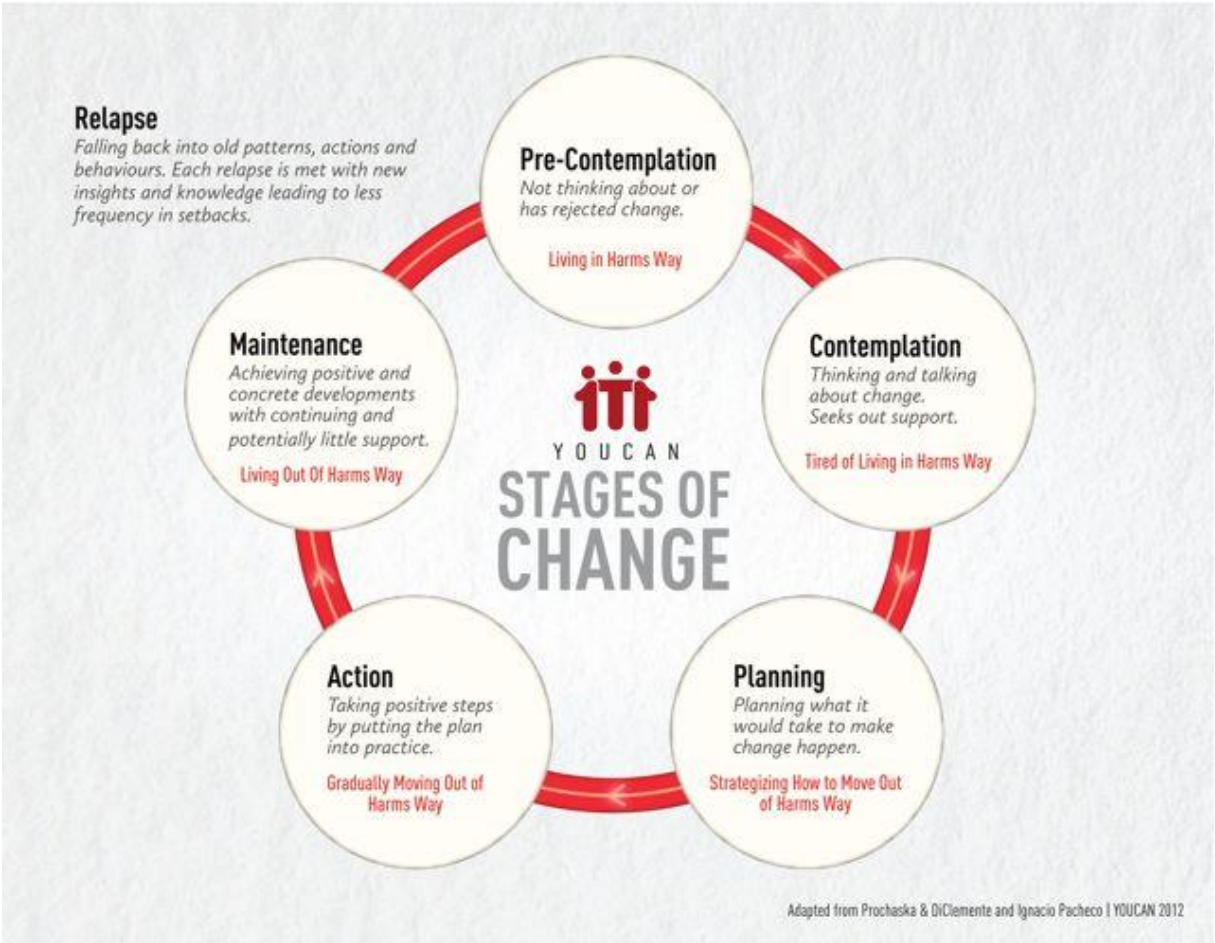
For more information about the PHQ9 and GAD7 tools, research evidence, and scoring, of for translated tools, please visit www.phqscreeners.com. The PHQ family of measures was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. All of the measures are in the public domain; no permission is required to reproduce, translate, display or distribute. For more information about the PC-PTSD or CAGE-AID, visit SAMHSA.gov.

4. Connecting with the Client

Because of the simplicity of the tool, many clients add up the totals on the screener before handing it in. When you receive it, you can very quickly determine whether the client is at risk. Be sure to thank the client for filling it out and to review it with them. You can explain to the client what the various sections of the tool screened for and congratulate them on the parts where they did not score at risk. For the areas where they scored at risk, you can ask them if that finding seems right to them. **Provide an opening for them to speak,** using non-judgmental and open-ended questions, and validate their response. For those who are at risk, discuss counseling and/or other options.

Score	Actions to Take
Low risk (not above cutoff scores)	• Thank client. • Congratulate client on their mental wellbeing. • Ask if they have any questions or concerns.
At risk (at or above cutoff scores)	• Thank client. • Tell them their scores indicate some risk & ask them if that seems right. • Recommend talking with a counselor. • Provide resource guide: circle a couple of numbers including town social services
High risk (suicidal ideation)	• Thank client. • Review findings & ask follow-up suicide question. • Follow agency protocol.

A client may not be ready to seek help, but having a conversation will be a positive step forward. (See "Stages of Change" graphic below.) It may help to provide a handout (see sample next page).



Could Counseling Help?

(courtesy of Stratford Community Services)

Every person is unique. Reactions to stress and circumstances in life can vary from individual to individual and family to family. Safe, stable supports are the best resources individuals and families have in overcoming any type of challenging time.

The following is a list of **possible symptoms** that you may notice in yourself or someone you care for:

- Sadness
- Irritable mood; grouchy or crabby
- Defiant/uncooperative
- Low energy, low motivation, fatigue
- Swinging emotions
- Persistent worry
- Anxiety; panic attacks
- Highly sensitive
- Excessive crying
- Withdrawal from activities typically enjoyed; isolation
- Aggression
- Aggressive or consistent negative play, recreating scary events in play (children)
- Changes in eating and sleeping
- Poor coping skills, or unhealthy coping skills such as substance use, self-injury, compulsive or obsessive behaviors and thoughts
- Not being able to concentrate; lack of focus
- Unexplained physical aches and pains (headaches, stomachaches)
- Nightmares
- Avoidance of places or people that may remind the person of fearful experiences
- Startle responses to stimulus, e.g. loud noises, scenes on television shows

➲ While we all show some of these signs at times, what is important is **how long** they last and **how intense** these symptoms are. How much are they **interfering** with daily life?

➲ Should any of these symptoms—or any other behaviors or reactions that are not typical for this person—persist for several weeks, consider a few visits with a counselor.

➲ **Therapy can help you identify and change your patterns of thinking or behaviors, improve your sleep, and develop coping strategies.** Therapy is covered under public and private insurance plans. If you don't have insurance, you can still get help! For assistance in locating services in CT, call 211. In southwestern CT, you can also call 203-840-1187 or visit www.HealthyMindsCT.org, the website of the Southwest Regional Mental Health Board.

5. Making Referrals

When a referral is needed, the **best referral is a warm handoff**, where you make a direct connection or help the client make the call to set up an appointment.

If a warm handoff is not possible, be sure to:

1. Provide a list of **local providers**, such as the Regional Mental Health Board's resource guide. Circle just a few (2 or 3) phone numbers that you recommend for this client based on the areas of need and geographical area.
2. Explain about **crisis and warmline numbers** and circle them on the resource guide. For young people, point out the state's Young Adult Warmline, staffed by young adults who are trained Recovery Support Specialists. This warmline operates from 12-9pm every day: 855-6-HOPENOW. Also inform teens and young adults about TurningPointCT.org, the online peer support / wellness resource by and for young people in Connecticut.
3. Provide a list of **free peer support groups** in the area, such as the list provided by the Regional Mental Health Board, again circling recommendations.
4. Provide information about **wellness practices** such as breathing exercises, and if possible demonstrate them. You may wish to provide a **list of apps** or websites with more information.

Note: The Southwest Regional Mental Health Board updates its resource guides and peer support group list throughout each year. These can be downloaded from the website, HealthyMindsCT.org, or copies can be mailed upon request. SWRMHB also has a list of wellness apps that you may wish to distribute to clients.