"Check Up from the Neck Up":

INTEGRATED BEHAVIORAL HEALTH SCREENER

COMPLETE DOCUMENTATION

Version 3, August 2019

The Hub: Behavioral Health Action Organization for Southwestern CT

CONTENTS

1. PURPOSE AND HISTORY

This screening tool integrates several evidence-based screeners in order to efficiently assess an individual's risk of a variety of behavioral health issues: **anxiety, depression, suicidality, PTSD, alcohol, other drugs, vaping and nicotine use, problem gambling, other problem behaviors, and domestic violence.** It is designed to be quick and easy for the individual to fill out and for the provider to score. It can be filled out in as little as 3 minutes and scored in under a minute.

The tool was first developed by the Behavioral Health Promotion Subcommittee of what is now known as the Health Improvement Alliance (HIA)—a consortium of hospital and community partners that serves the Greater Bridgeport, Connecticut area. The subcommittee was chaired by the Southwest Regional Mental Health Board (SWRMHB), now known as The Hub, and the Town of Stratford Community Services.

The committee's goals were to **normalize the concept of checking in on one's mental health** and to **increase detection** in order to provide earlier access to treatment. The committee chose to develop an ***integrated* screening tool** after reviewing local practices and existing tools available through SAMHSA, DMHAS and other agencies, and finding that many screening practices focus solely on depression (although anxiety is even more prevalent), or assess for alcohol but not other drugs, or for substance use but not mental illness, even though these are frequently co-occurring.

The first version of the tool was tested during the Fall of 2016 at college- and community-based screening events during SWRMHB's October "Wellness Month" screening initiative, where community members are encouraged to "get your check-up from the neck up." That version screened for mental illness, alcohol, and other drugs. In October 2018, SWRMHB revised the tool to add questions on vaping and nicotine use, problem gambling, and one general question to elicit other possible problem behaviors (e.g., hoarding, internet addiction, etc.). In August 2019, The Hub added one additional question to screen for risk of domestic violence.

The tool has been positively received by clients and providers. It has been incorporated by the Greenwich Department of Human Services into their client assessment and tracking tools, is used by other area town human and social services departments, provider agencies, and colleges, and was shared by St. Vincent's Medical Center with other hospitals in the Ascension Hospital System. It continues to be used annually in the regional Wellness Month initiative.

Who Should Use This Tool?

Use by a wide variety of healthcare providers is encouraged, since patients are unlikely to open up about these issues without prompting, but are usually quite willing to talk after filling out the tool. The United States Preventive Services Task Force (USPSTF) recommends screening everyone over age 12 for depression, everyone over age 18 for unhealthy alcohol use, and all women of reproductive age for Intimate Partner Violence (IPV).

We encourage **urgent care practices** to use this screener whenever a linkage to behavioral health services is available, as data indicate that close to half people under age 30 are more likely to visit Urgent Care centers than primary care providers[1]. **Primary care providers** should be aware that 44% of those who die by suicide visited their PCP during the

[1] https://www.washingtonpost.com/national/health-science/for-millennials-a-regular-visit-to-the-doctors-office-is-not-a-primary-concern/2018/10/05/6b17c71a-aef3-11e8-9a6a-565d92a3585d_story.html?noredirect=on

month prior to their death[2], suggesting a possible opportunity to identify those at risk and provide help. In any agency adopting the tool, there should be clear protocols for referring clients identified at high risk.

2. CONTENT AND SCREENING TOOLS

The Integrated Behavioral Health Screener is composed of 5 evidence-based screening tools recommended by SAMHSA. These are the PHQ-9 and GAD-7, the PC-PTSD, the CAGE-AID, and the BBGS. All tools are in the public domain and are easy to administer and user-friendly. The additional questions regarding nicotine/vaping and domestic violence are simple questions already used by providers to identify a need for further discussion.

The tool is reproduced on the next pages in English and Spanish. Each tool is 2 pages and can be copied back-to-back on a single sheet of paper.

The scoring guidelines follow in Section 3.

[2] https://www.ncbi.nlm.nih.gov/pubmed/29207932

Check Up from the Neck Up 2019

First Name (optional): _____

Date: _____

A. 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 →

B. 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:*	

C. Do you use alcohol or other drugs? **No** *(skip to D)* **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:*	

D. Do you use vapes or nicotine products (cigarettes, chew, e-cigs/JUULs, etc.)? **No** **Yes**

E. During the past 12 months:

Have you become restless, irritable or anxious when trying to stop or cut down on gambling? **No** **Yes**

Have you tried to keep your family or friends from knowing you much you gambled? **No** **Yes**

Did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare? **No** **Yes**

(1)

F. Are you concerned about any behaviors that you find hard to control? **No** **Yes**

G. Is there anyone in your life who is hurting or threatening you in any way? **No** **Yes**

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

All materials public domain and available at samhsa.gov. Based on PHQ9, GAD7, PC-PTSD, CAGE-AID, & BBGS.

Evalúe su estado de ánimo 2019

Nombre (opcional): _____ Fecha: _____

A. Durante las *últimas 2 semanas*, ¿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	
1. Poco interés o placer en hacer cosas	0	1	2	3	
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3	
3. □ Ha tenido dificultad para quedarse o permanecer dormido(a), o □ ha dormido demasiado	0	1	2	3	
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3	
5. □ Sin apetito, o □ ha comido en exceso	0	1	2	3	
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	0	1	2	3	
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	0	1	2	3	
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	0	1	2	3	
9. □ Pensamientos de que estaría mejor muerto(a) o □ de lastimarse de alguna manera	0	1	2	3	Total
(10)	*Sumar:*				

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

Continúa al reverso →

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

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

C. ¿Utiliza Ud. alcohol u otras drogas? **No** *(siga con la parte **D**)* **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:

1.	¿Alguna vez ha sentido que debería disminuir o reducir su uso de alcohol y/o drogas?	Alcohol:	No	Sí
		Uso de drogas:	No	Sí
2.	¿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
3.	¿Alguna vez se ha sentido culpable debido al uso de alcohol y/o drogas?	Alcohol:	No	Sí
		Uso de drogas:	No	Sí
4.	¿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:*	

D. ¿Usa vaporizadores o productos que contienen nicotina (JUULs, cigarrillos, tabaco de mascar, etc.)? **No Sí**

E. Durante los últimos 12 meses:

¿Se ha sentido inquieto, irritable o ansioso al tratar de abandonar/reducir su adicción al juego? **No Sí**

¿Ha intentado evitar que su familia o amigos averiguaran cuánto dinero ha destinado a las apuestas? **No Sí**

¿Ha experimentado tales dificultades económicas como consecuencia de sus apuestas, que se ha visto obligado a pedir ayuda a familiares, amigos o la asistencia social para sufragar sus gastos básicos? **No Sí**

(1)

F. ¿Se preocupa por algún comportamiento que se le hace difícil controlar? **No Sí**

G. ¿Hay alguién en su vida que le está lastimando o amenazando? **No Sí**

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

Materiales de dominio público – vea a www.samhsa.gov. Basado en los cuestionarios PHQ9, GAD7, PC-PTSD, CAGE-AID y BBGS.

3. SCORING OF SCREENING TOOLS

The purpose of this screening 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**. individuals 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 the results for sections A, B, C and E, we have included a small italicized number in parentheses—e.g., *(10)*—under each tool in the screener. This number is the cutoff score meaning the person has scored at moderate risk and should be referred.

Questions D, F and G are simple Yes/No questions, where Yes answers should be followed up.

SECTION A, TOP: PHQ-9 (DEPRESSION SCREENER)

The first tool (section A, top) 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. Individual 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 requires a discussion with individual. It is recommended to use the **Columbia Suicide Severity Rating Scales (CSSRS)** to investigate further. Visit www.cssrs.columbia.edu to download a tool for your setting.

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

SECTION A, BOTTOM: GAD-7 (ANXIETY SCREENER)

The second tool (Section A, bottom) 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. Individual 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.

SECTION B: PC-PTSD (TRAUMA SCREENER)

The third tool (section B) 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. Individual assigns scores of No or Yes to each question.
2. Provider adds the number of Yes answers.
3. Results should be considered "positive" if individual 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.

SECTION C: CAGE-AID (SUBSTANCE USE SCREENER)

The fourth tool (section C) 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 client interview or self-report in a primary care setting.

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

SECTION D: VAPING & NICOTINE SCREENER

1. **This single Yes/No question (section D)** is simply intended to determine whether the individual is using vapes or nicotine.
2. If Yes, provider follows up to ask whether individual is interested in information on the associated health risks or how to cut back or quit. If so, provide information on the CT Quitline (800-QUITNOW) and the teen vaping cessation textline, (202) 804-9884 (or text DITCHJUUL to 887-09).

SECTION E: BBGS (PROBLEM GAMBLING SCREENER)

The fifth tool (section E) is the Brief Biosocial Gambling Screen developed by Cambridge Health Alliance, an affiliate of Harvard Medical School.

1. Individual assigns scores of No or Yes to each question.
2. A "yes" answer to *any* of the questions means the person is at risk for developing a gambling problem. Refer to the CT Problem Gambling Hotline (888-789-7777 or www.ccpg.org).

SECTION F: OTHER BEHAVIORS

1. **This single Yes/No question (section F)** is intended to provide an opportunity for the individual to indicate any other concerns.
2. If Yes, provider should follow up for more information.

SECTION G: INTIMATE PARTNER VIOLENCE SCREENER

1. **This single Yes/No question (section G)** is a universal screening question to identify risk of domestic violence or intimate partner violence.
2. If Yes, provider should follow up for more information. Fact sheets and more information are available at https://www.ahrq.gov/professionals/prevention-chronic-care/healthier-pregnancy/preventive/partnerviolence.html.

FURTHER INFORMATION ABOUT THE 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 www.SAMHSA.gov. For more information about the BBGS, visit www.ncrg.org.

4. CONNECTING WITH THE INDIVIDUAL SCREENED ("BRIEF INTERVENTION")

When the individual returns the tool to you, you can very quickly determine whether the individual is at risk by looking at the totals and comparing them to the cutoff scores identified in italics and parentheses below each tool [e.g., *(3)*]. he tool is so simple to score, many individuals add up their own totals before handing it back to the clinician.

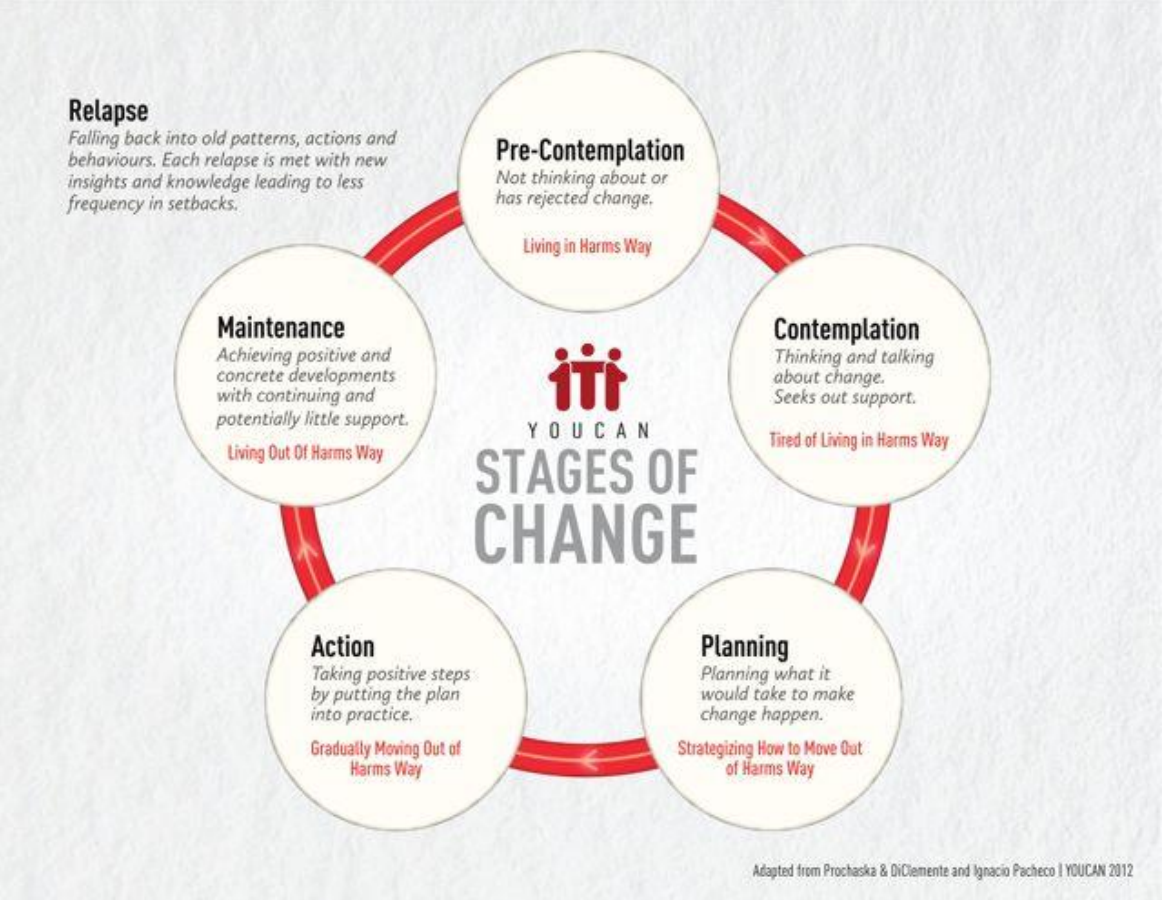
In most cases, when the individual returns the form, he or she is already aware of what it shows and is ready to talk. It is important to take just a couple of minutes to thank the individual for filling it out, review their results with them, and make recommendations. This brief intervention includes:

- **Explain** what the various sections of the tool are looking for.
- **Congratulate** them on the parts where they did not score at risk.
- **For any areas where they scored at risk,** ask if that finding seems right to them. Let them know that *this is not a diagnosis, but rather an assessment of risk,* to help identify areas where they may benefit from taking action.
- **Provide an opening for them to speak,** using non-judgmental and open-ended questions, and validate their response. Even those who do not score at risk may have concerns about a loved one.
- **For those who are at risk,** discuss counseling and/or other options. In high-risk cases, call mobile crisis or 911 or otherwise follow agency protocol. See summary chart on next page.
- **Whether the individual scores at risk or not,** make available brochures about mental illness or substance use. Also consider providing handouts about when to see a therapist (see example further on).
- **Make available information on stress management and wellness practices** to everyone. If there is enough time, practicing a breathing technique may be helpful.

The chart below summarizes the actions to take based on the level of risk identified:

Score	Actions to Take
Low risk (not above cutoff scores)	• Thank individual. • Congratulate individual on their mental wellbeing. • Ask if they have any questions or concerns, including questions about family members or friends. • Make brochures and resource lists available.
At risk (at or above cutoff scores)	• Thank individual. • Tell them their scores indicate some risk & ask them if that seems right. • Recommend talking with a counselor. If possible, help them make an appointment right then. • Provide resource guide & circle a couple of numbers including their town's social services. • Provide list of peer support groups & circle a group that may help.
High risk (e.g., suicidal ideation)	• Thank individual. • Review findings & ask follow-up suicide questions using the Columbia Suicide Severity Rating Scales. • Follow agency protocol to provide a direct connection to help. • Make sure individual is aware of crisis resources (national lifeline, mobile crisis, crisis text line) as well as warmlines.

An individual may not be ready to seek help, but having a conversation will be a positive step forward. Consider the "Stages of Change" graphic below to determine whether the individual is ready for change and/or how ready he or she may be to discuss taking action. Use Motivational Interviewing techniques as appropriate.



Could Counseling Help?

Handout 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.TheHubCT.org, the website of The Hub, the behavioral health action organization for Southwestern CT.

5. MAKING REFERRALS

When a referral is needed, the **best referral is a warm handoff**, where you make a direct connection or help the individual 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 Hub's resource guides. Circle just a few (2 or 3) phone numbers that you recommend for this individual 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 Crisis Text Line (741741), which is available 24/7 and the state's Young Adult Warmline, staffed by young adults who are trained Recovery Support Specialists, which 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 Hub, again circling a few 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 Hub updates its resource guides and peer support group list throughout each year. These can be downloaded from the website, TheHubCT.org, or copies can be mailed upon request. The Hub also has a list of wellness apps and other wellness materials that you may wish to download for distributing to individuals.