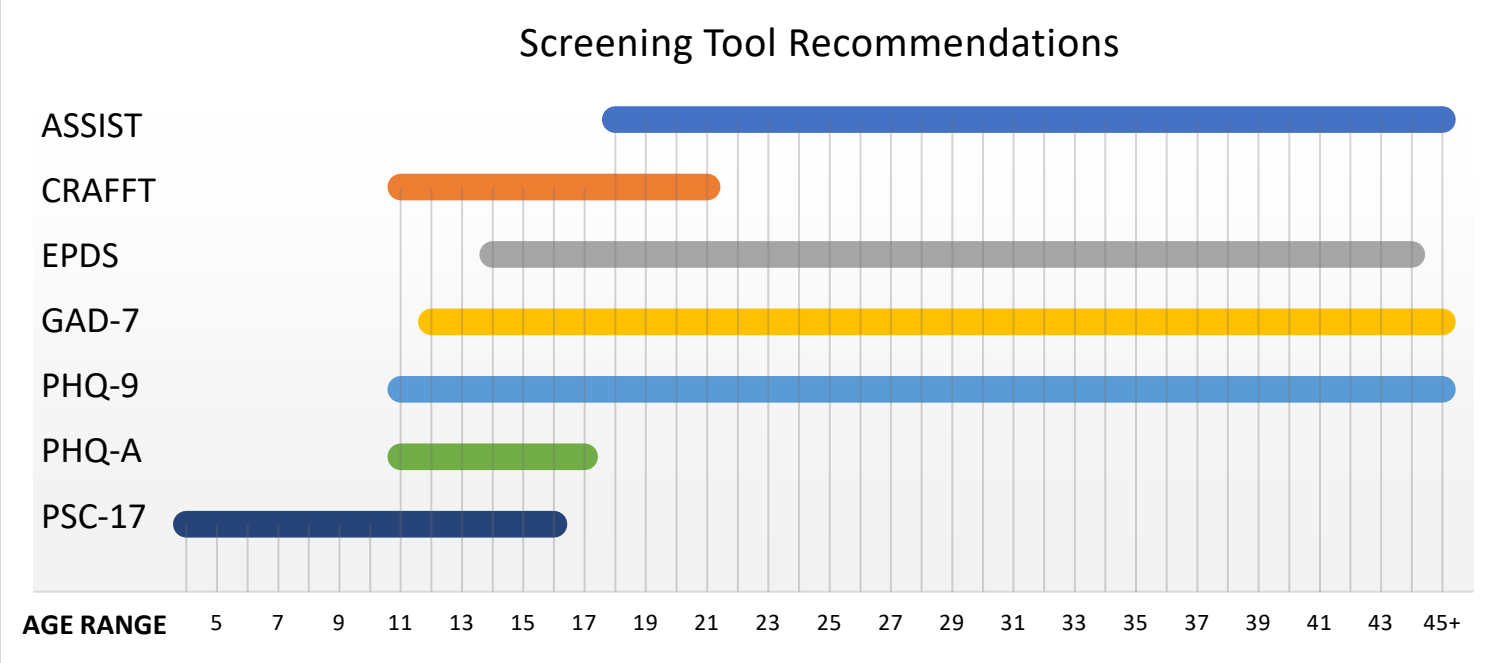
Behavioral Health Screening Tools: Guidance

Last updated June 30, 2021

The following behavioral health screening tools are now available for use in DAISEY:

Acronym	Screening Tool	Risk Assessment
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test	Adult substance use
CRAFFT	Car, Relax, Alone, Forget, Families/Friends, Trouble	Adolescent substance use
EPDS	Edinburgh Postnatal Depression Scale	Perinatal anxiety and depression
GAD-7	General Anxiety Disorder	Anxiety
PHQ-9	Patient Health Questionnaire	Depression
PHQ-A	Patient Health Questionnaire Modified for Teens	Adolescent depression
PSC-17	Pediatric Symptom Checklist	Child and adolescent mental health

The chart, below, reflects the ages of patients that each behavioral health screening tool can be administered with, based on the screening tool's validation study:



Guidance: Creating a Framework for Administering Behavioral Health Screenings

Select screening tools:

1. Identify a validated* screening tool for the population and behavior risk
2. Determine screening frequency based on each tool's guidance and recommendations.

Prepare your agency:

1. Create a universal screening policy for the population. The policy should include a response protocol for positive screens and crisis intervention.
2. Staff should receive training on the screening tool and the policy. Staff should administer the screens consistently during all applicable interactions.
3. Ensure all staff are equipped and trained to explain to clients the purpose of the screening tool, with whom the information will be shared, and who will review and follow-up with the patient regarding their responses and when.
4. Integrate universal screening into office workflow. Determine roles and responsibilities (e.g., who will ask the patient to complete the screen, discuss results with the patient, provide relevant education and resources, coordinate treatment when indicated).

Establish and formalize a local system of care:

1. Ensure the local system of care meets the behavioral health needs of clients and their families. The referral network should consist of a wide range of clinician types and treatment services.
2. Execute Memorandum of Agreements/Understanding (MOA/MOU) with behavioral health clinicians and/or centers for treatment referrals and improving timely access to mental health care.
3. Follow-up with patients and referral partners to ensure the connection was successfully completed.

Capture the data:

1. Enter all screens and action plans into DAISEY, or other electronic health record systems, when applicable.

Support Resources:

In addition to the following guidance, the following resources are available to local programs to support the identification, intervention, referral, and treatment of clients with behavioral health concerns:

Perinatal Behavioral Health

- Perinatal Mental Health Integration Toolkit
- Perinatal Substance Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) Toolkit
- Kansas Connecting Communities (KCC) offers free provider-to-provider psychiatric consultation and care coordination support, access to free trainings, and best practice recommendations, including resources and referral support. For more information, call the Consultation Line at 833-765-2004 or visit the KCC webpage.

Pediatric Behavioral Health

- Pediatric Mental Health Toolkit: *Coming soon!*
- Pediatric Substance Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) Toolkit: *Coming soon!*
- KSKidsMAP supports primary care physicians and clinicians' treatment of children and adolescents with behavioral health concerns through a Consultation Line, mental health and community resources, toolkits and best practices information, and KSKidsMAP TeleECHO Clinic. For more information, call the Consultation Line at 1-800-332-6262 or visit the KSKidsMAP webpage.

*A validated screening tool is an instrument that have been tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition).[1]

[1] The Joint Commission. *Definition of validated and non-validated screening tool for substance use.* Retrieved on 5/10/21 from here.

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

Substance Use Screening	
Risk Assessment	10 substance types including tobacco, alcohol, cannabis, amphetamine stimulants, and opioids
Administration	• 8-item questionnaire • Administered via interview by health worker • Takes about 5-10 minutes to complete
Ages	18-60
Frequency	Annually; pregnant women should be screened in the first trimester
Pre-Screening Tool	NIDA Quick Screen – 1 question assessment
References	• KDHE: Perinatal Substance Use Integration Toolkit • World Health Organization: ASSIST Manual for Use in Primary Care • ASSIST Language Translations
Rationale	Follow the U.S. Prevention Services Task Force recommendation to screen for unhealthy drug use in adults. The recommendation is to ask questions about unhealthy drug use, not testing biological specimens.

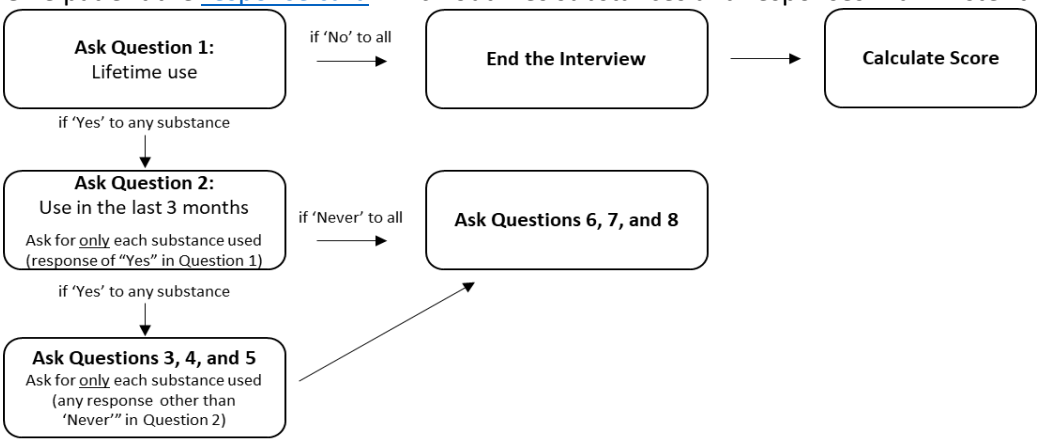
Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script from the ASSIST Manual is included, below. Scripts can be customized for clinic use. If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of drug use.

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

Administer the ASSIST screening.

Give patient the response card which outlines substances and responses. Administer the ASSIST screening via interview:



Scoring the screen and determining risk level.

Each response from questions 2 to 7 has a numerical score. Add the scores together by each individual substance type. Each client will have 10 risk scores (one for each substance type). Complete the feedback report card for the patient.

LOWER Risk *Alcohol 0-10; Other Substances 0-3*	**MODERATE Risk** *Alcohol 11-26; Other Substances 4-26*	**HIGH Risk** *All Substances 27+*
At low risk of health and other problems related to current pattern of use. Provide positive reinforcement.	At moderate risk of health and other problems related to current pattern of use. Provide brief intervention and follow up at upcoming appointments. Brief intervention could include reviewing screening results, providing education on health risks associated with continued use, identifying patient motivation to reduce to stop use, and/or reinforcing self-efficacy.	At high risk of experiencing severe problems (health, social, financial, legal, relationships) as a result of current pattern of use. Provide brief intervention and referral to treatment. Follow up with patient to make sure they accessed and received care.

CRAFFT (Car, Relax, Alone, Forget, Family/Friends, Trouble)

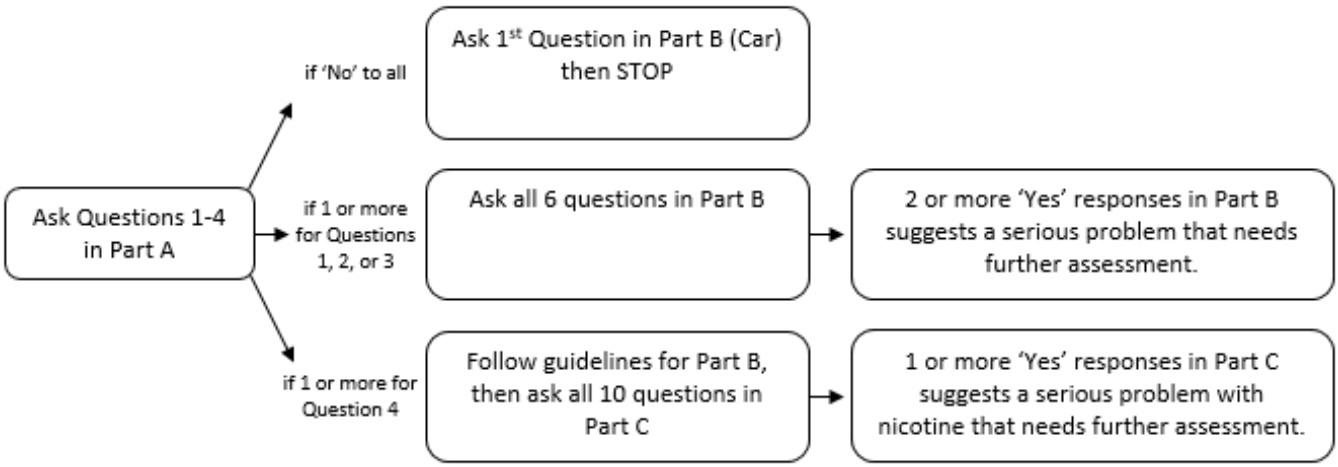
Substance Use Screening	
Risk Assessment	Health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21.
Administration	• 10-item questionnaire + 10-item nicotine questionnaire, when indicated • Administered via interview by health worker or self-administered • Takes about 5-10 minutes to complete
Ages	12-21
Frequency	Annually
Pre-Screening Tool	n/a
References	• CRAFFT Provider Manual • CRAFFT Language Translations
Rationale	Follow the Bright Futures recommendation to screen all adolescents ages 11-21 for substance use.

Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script from the CRAFFT Provider Manual is included, below. Scripts can be customized for clinic use. If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of drug use.

Sample Script: *I'm going to ask you a few questions that I ask all of my patients. Please be honest. All of your answers to these questions will be kept confidential. If I am concerned about your immediate safety, I will let you know so we can discuss further steps.*

Administer the CRAFFT screening.



Scoring the screen and determining risk level.

Part B: Question 1, Car, is asked of all respondents as it is a safety risk screening question. The remaining 5 questions (RAFFT) assess substance-related problems. Each 'Yes' response equals 1 point. Add these points together to determine the CRAFFT score.

Part C: There is not a total score for Part C, the nicotine screening. One or more 'Yes' responses suggests further assessment and/or intervention might be needed.

Sample Script: *Thank you for completing the questionnaire. I have reviewed your results and would like to spend a minute talking with you about them. Would that be okay? Anything you tell me will be kept confidential unless I think there is a risk to your safety, or someone else's safety. Should that happen, I will let you know, and you and I together will figure out what the next steps will be.*

CRAFFT, cont.

LOWER Risk *No use in past 12-months and CRAFFT score of 0*	**MEDIUM Risk** *No use in the past 12 months + "Yes" to Car question OR Use in the past 12 months + CRAFFT score < 2*	**HIGH Risk** *Use in the past 12 months and CRAFFT score ≥ 2*
Provide information about risks of substance use and substance use-related riding/driving; offer praise and encouragement. Give a copy of either the Contract for Life (ages 12-18) or the Pledge for Life (ages 18-21)	Engage in a brief conversation (brief intervention) about the adverse health effects of substance use, along with a clear recommendation to stop. Discuss health risks associated with substance use-related riding/driving. Give a copy of either the Contract for Life (ages 12-18) or the Pledge for Life (ages 18-21)	At high risk of having an alcohol or drug-related disorder, thus requiring further assessment. Review positive responses and discuss each with the patient. Schedule a follow-up visit to review progress.
"I'm glad you're not drinking or using drugs; that's a smart decision for your health. If it ever changes, I hope we can talk about it. I'm here to help keep you healthy, not to pass judgment." (see page 9 of Manual for more low-risk sample scripts)	***"**As your healthcare provider, my recommendation is not to use any marijuana, alcohol, or other drugs because they can harm your developing brain, interfere with learning, and put you in situations that are embarrassing, dangerous, or worse."* (see page 11 of Manual for more medium-risk sample scripts).	Reviewing screening results and considering the need for further assessment sample questions: *"How much do you usually use?" "When did you last use?" "Tell me more about your drinking and marijuana use." 'Can you tell me more about that?"* (see page 15 of Manual for more high-risk sample scripts)

Edinburgh Postnatal Depression Scale (EPDS)

Anxiety and Depression Screening	
Risk Assessment	Anxiety and depression during the perinatal period (pregnancy through 12-months post-delivery)
Administration	• 10-item questionnaire • Administered via interview by health worker or self-administered • Validated for use with both caregivers: maternal cutoff score is 10; paternal cutoff score is 8 • Takes less than 5 minutes to complete
Ages	14-44
Frequency	• ACOG recommends screening for depression and anxiety at least once during the perinatal period; if screened during pregnancy, an additional screening should occur during the postpartum visit • Kansas Medicaid policy supports Postpartum Support International's recommendations: Up to 3 times during the prenatal period, and up to 5 times during the 12-months postpartum period
Pre-Screening Tool	EPDS-3
References	• KDHE Perinatal Mental Health Integration Toolkit • Kansas Medicaid Maternal Depression Screening Policy Guidance • EPDS Language Translations
Rationale	Follow the U.S. Preventive Services Task Force recommendation for depression screening, Women's Preventive Services Initiative's recommendation for anxiety screening, American Congress of Obstetricians and Gynecologists recommendation for perinatal depression and anxiety screening, and Bright Futures recommendation for maternal depression screening during well-child visits.

Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script is included, below. Scripts can be customized for clinic use. If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of unidentified perinatal anxiety and depression.

Sample Script: *Having a new baby is an important and sometimes difficult change. We ask these questions to all families we work with because 1 in 5 women and 1 in 10 men who've recently had a baby are at risk for depression. Expectant and new parents may also experience other mental health symptoms, such as anxiety, which is also covered in this questionnaire. Your responses will help us determine if it would be helpful to talk with a medical provider about how you're feeling. It will also help me understand if there are any additional resources I should help you connect with.*

Administer the EPDS screening.

Patient responds to questions 1-10 based on how they have felt in the past 7 days.

Scoring the screen and determining risk level.

Questions 1, 2, and 4 (without an *) are scored 0, 1, 2, or 3 with top box scored as 0 and the bottom box scored as 3.
Questions 3, 5-10 (marked with an *) are reverse scored, with the top box scored as 3 and the bottom box scored as 0.

LOWER Risk *Score < 10*	**MODERATE Risk** *Score = 10+*	**HIGH Risk** *Score = 12+*	**Crisis** *Q10: Any response other than 'Never'*
At low risk of experiencing perinatal anxiety or depression. Provide positive reinforcement	Indicates further discussion is needed to determine the most appropriate intervention.	Indicates a high possibility of anxiety and/or depression. Provide brief intervention and referral for diagnostic assessment and treatment by a primary care provider and/or mental health specialist. Follow up with patient to verify they accessed and received care.	Indicates **immediate** action is required. Make a plan for **immediate** assessment by a primary care provider, mental health specialist, and/or emergency services, as appropriate. Urgency of referral will depend on whether the suicidal ideation is accompanied by a plan, if there has been a history of suicide attempts, whether symptoms of a psychotic disorder are present, and/or if there is concern about harm to the baby or others.
"Your responses indicate you are at a low risk of experiencing anxiety or depression. Is there anything not on the questionnaire that you want to discuss? If anything changes, please give me a call so we can talk more about how you're feeling."	*"Your responses indicate you might be struggling some right now. Does that sound like how you have been feeling lately?"*	*"A lot of parents experience these feelings! Some find it helpful to talk to a friend or counselor. Have you talked to anyone else about how you're feeling?" "Some effective treatment options include medication and talking to a mental health clinician. Do you think this would be helpful?"*	

Generalized Anxiety Disorder (GAD-7)

Anxiety Screening	
Risk Assessment	Assessment and monitoring for anxiety severity. The GAD-7 also has a good sensitivity and specificity as a screener for panic, anxiety, and posttraumatic stress disorder.
Administration	• 7-item questionnaire • Self-Administered • Takes less than 5 minutes to complete
Ages	12+
Frequency	• Annually • ACOG recommends screening pregnant/postpartum women for depression and anxiety at least once during the perinatal period; if screened during pregnancy, an additional screening should occur during the postpartum visit. ▪ Note: The EPDS is a comprehensive screen for measuring risk of depression and anxiety. If not using the EPDS, the PHQ-9 should be used along with the GAD-7 for perinatal patients.
Pre-Screening Tool	GAD-2
References	• GAD Instruction Manual • Postpartum Support International: Screening Recommendations • GAD-7 Language Translations
Rationale	Follow the Women's Preventive Services Initiative's recommendation to screen all adolescents and adult women age 13 and older for anxiety, including pregnant and postpartum women.

Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script is included, below. Scripts can be customized for clinic use. If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of unidentified anxiety.

Sample Script: *I would like to ask you a few questions about how you have been feeling emotionally that will help me understand how I can provide you with the best care.*

Administer the GAD-7 screening.

Patient responds to questions 1-7 based on how they have felt in the past 2 weeks.

Scoring the screen and determining risk level.

Assign 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. The total GAD-7 score for the 7-items ranges from 0 to 21.

MINIMAL/MILD Risk *Score 0 - 9*	**MODERATE Risk** *Score 10-14*	**SEVERE Risk** *Score 15+*
At low risk of experiencing anxiety. Provide positive reinforcement	Indicates further discussion is needed to determine the most appropriate intervention. Make referral for diagnostic assessment and treatment by a primary care provider and/or mental health specialist. Provide brief intervention and follow up at upcoming appointments. Brief intervention could include reviewing screening results, providing education on health risks associated with continued use, identifying patient motivation to reduce to stop use, reinforcing self-efficacy, etc.	At high risk of experiencing an anxiety condition. Provide brief intervention and referral for diagnostic assessment and treatment by a primary care provider and/or mental health specialist. Follow up with patient to make sure they accessed and received care.

Patient Health Questionnaire (PHQ-9)

Depression Screening	
Risk Assessment	Assessment and monitoring for depression severity.
Administration	• 9-item questionnaire + 1 patient-rated item • Self-Administered • Takes less than 5 minutes to complete
Ages	11+ Note: While the PHQ-9 is validated for use with patients ages 11 and older, the PHQ screener developers also created a PHQ for adolescents (PHQ-A). The PHQ-A is the preferred screening tool for measuring risk of depression in patients ages 11-17.
Frequency	• Annually • ACOG recommends screening pregnant/postpartum women for depression and anxiety at least once during the perinatal period. If screened during pregnancy, an additional screening should occur during the postpartum visit. ▪ Note: The EPDS is a comprehensive screen for measuring risk of depression and anxiety. If not using the EPDS, the GAD-7 should be used along with the PHQ-9 for perinatal patients. • Kansas Medicaid policy supports Postpartum Support International's recommendations: Up to 3 times during the prenatal period, and up to 5 times during the 12-months postpartum period
Pre-Screening Tool	PHQ-2
References	• PHQ Instruction Manual • KDHE: Perinatal Mental Health Integration Toolkit • Kansas Medicaid: Maternal Depression Screening Policy Guidance • PHQ-9 Language Translations
Rationale	Follow the U.S. Preventive Services Task Force recommendation to screen for depression in the general adult population, including pregnant and postpartum women.

Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script is included, below. Scripts can be customized for clinic use. If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of unidentified depression.

Sample Script: *I would like to ask you a few questions about how you have felt over the past 2 weeks. As we take your blood pressure and temperature we also want to assess your mental well-being because it can impact your overall health. Please answer these questions, thinking about how you have been feeling over the past 2 weeks.*

Administer the PHQ-9 screening.

Patient responds to questions 1-10 based on how they have felt in the past 2 weeks.

The final question, #10, asks the patient to report 'how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? This single patient-rated difficulty item is not used in calculating any PHQ score but rather represents the patient's global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

Scoring the screen and determining risk level.

Assign 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. The total PHQ-9 score for the 9-items ranges from 0 to 27.

PHQ-9, cont.

MINIMAL/MILD Risk *Score 0 - 9*	**MODERATE Risk** *Score 10-14*	**MODERATELY SEVERE Risk** *Score 15-19*	**SEVERE Risk** *Score 20+*
At low risk of experiencing depression. Provide positive reinforcement	Indicates further discussion is needed to determine the most appropriate intervention. A treatment plan should be started with the consideration of including counseling, follow-up and/or pharmacotherapy. If needed, make referral for diagnostic assessment and treatment by a primary care provider and/or mental health specialist.	Provide brief intervention and referral for diagnostic assessment and treatment (pharmacotherapy and/or psychotherapy) by a primary care provider and/or mental health specialist. Follow up with patient to make sure they accessed and received care.	Indicates immediate treatment is needed. There should be an immediate initiation of pharmacotherapy[*]** and, if severe impairment or poor response to therapy, expediated referral to a mental health specialist for psychotherapy, collaborative management, and/or emergent services as indicated.

[*] It is important to note the need to complete a diagnostic assessment prior to initiating pharmacotherapy. Diagnostic algorithms for the PHQ are included in the PHQ Provider Manual.

Patient Health Questionnaire – Modified for Teens (PHQ-A)

Depression Screening	
Risk Assessment	Assessment and monitoring for depression severity. Substantially modified version of the PHQ developed for use in adolescents.
Administration	• 9-item questionnaire • Administered via interview by health worker or self-administered • Takes less than 5 minutes to complete
Ages	11-17
Frequency	Annually
Pre-Screening Tool	PHQ-2
References	• PHQ Instruction Manual • PHQ-A Language Translations
Rationale	Follow the Bright Futures recommendation to screen all adolescents ages 12-21 for depression.

Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script is included, below. Scripts can be customized for clinic use. If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of unidentified depression.

Sample Script (parent): *We are screening for symptoms of depressed mood at all well-adolescent visits. Please have your child fill out this questionnaire if he/she wants to, or we can complete the form with him/her. The doctor will discuss the results with all of you together during the appointment.*

Sample Script (adolescent): *I'd like you to answer a few questions about how you have felt lately. I ask everyone to answer these questions because mental health is an important part of overall health. Your responses will be kept confidential. If I am concerned about your immediate safety, I will let you know so we can discuss next steps.*

Administer the PHQ-A screening.

Patient responds to questions 1-9 based on how they have felt in the past 7 days.

Scoring the screen and determining risk level.

Assign 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. The total PHQ-A score for the 9-items ranges from 0 to 27.

MINIMAL/MILD Risk *Score 0 - 9*	**MODERATE Risk** *Score 10-14*	**MODERATELY SEVERE Risk** *Score 15-19*	**SEVERE Risk** *Score 20+*
At low risk of experiencing depression. Provide positive reinforcement	Indicates further discussion is needed to determine the most appropriate intervention. A treatment plan should be started with the consideration of including counseling, follow-up and/or pharmacotherapy. If needed, make referral for diagnostic assessment and treatment by a primary care provider and/or mental health specialist.	Provide brief intervention and referral for diagnostic assessment and treatment (pharmacotherapy and/or psychotherapy) by a primary care provider and/or mental health specialist. Follow up with patient to make sure they accessed and received care.	Indicates immediate treatment is needed. There should be an immediate initiation of pharmacotherapy* and, if severe impairment or poor response to therapy, expediated referral to a mental health specialist for psychotherapy, collaborative management, and/or emergent services as indicated.

* It is important to note the need to complete a diagnostic assessment prior to initiating pharmacotherapy. Diagnostic algorithms for the PHQ are included in the PHQ Provider Manual.

Pediatric Symptom Checklist (PSC-17)

General Mental Health Screening	
Risk Assessment	Covers a broad range of emotional and behavioral problems in children and is mean to provide an assessment of psychosocial functioning.
Administration	• 17-item questionnaire • Self-Administered; a youth version and a parent version are available • Takes less than 5 minutes to complete
Ages	4-16
Frequency	Annually; can be used more frequently to measure change based on clinician judgement
Pre-Screening Tool	n/a
References	• Massachusetts General Hospital: Provider Guidance • PSC-17 Language Translations
Rationale	Follow the Bright Futures recommendation to screen all youth ages 0-21 for psychosocial and behavioral problems.

Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script is included, below. Scripts can be customized for clinic use. If the patient/caregiver declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of unidentified psychosocial and emotional issues.

Sample Script: *The Pediatric Symptom Checklist is a short questionnaire that helps identify and assess changes in emotional and behavioral problems in children. These concerns are relatively common, affecting about 12% of children. Please help us provide the best care possible by completing the questionnaire. Your doctor will go over the results with you during the appointment.*

Administer the PSC-17 screening.

Patient and/or their caregiver responds to questions 1-17 based on how they best describe themselves/their child. The screening can be completed prior to the visit, during check-in on the day of the appointment, or during the visit.

Scoring the screen and determining risk level.

Each item is rated as 'never' (0), 'sometimes' (1), and 'often' (2). The total score for the 17-items ranges from 0 to 34.

Positive Screen *Score 15+*
Indicates the need for further evaluation by a qualified health or mental health professional. Engage the family in a conversation about preferred next steps. Sample Script: *On the checklist you filled out about your child's behavior, you reported a much higher than average number of problems for your child. Would you like to spend a few minutes now exploring what is going on for him/her and whether he/she would benefit from more help?* Ask a few questions about the child's daily functioning with friends and family, at school and in activities, and with his/her general mood. Going over the PSC items marked as "often" can be a productive way to focus the discussion. Then see if the parent would like to discuss further with you or do something else.
Next steps for positive screens: • Many children may already be in therapy or have caregivers who do not want therapy. Let them know that a positive score indicates a high-level of risk and that further assessment is probably needed, but not mandatory. • Offering a visit for a follow-up evaluation by a mental health professional, especially if one is readily available, and/or scheduling a follow-up appointment for further evaluation with the pediatrician in a week to a few months. • For many children, a watchful waiting approach is also an option. This provides time to see whether problems diminish and gives caregivers a chance to consider next steps. Most children who screen positive will screen positive again 6 or 12 months later. Caregivers who are reluctant to seek help initially may be more willing if they see that problems persist. • Whatever the approach, next steps should be determined together by the caregivers, child, and the clinician.