| Measure | Tool | About the Tool | Scoring and Action Steps |
|---|---|---|---|
| Depression | PHQ-2[1] | Depression Screen - 2 Questions | **Score of 0-2** = Negative screen<br>**Action:** None<br>**Score of 3+** = Positive screen<br>Action: Administer the PHQ-9.1 |
| | PHQ-9[1] | Depression Screen- 9 Questions | **Score of 1-4** = Minimal depression<br>**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit.<br>**Score of 5-9** = Mild depression<br>**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive<br>**Score of 10-14** = Moderate depression **Action:** Develop treatment plan, referral to behavioral health care professional for psychotherapy within 30 days<br>**Score of 15-19** = Moderately severe depression<br>**Action:** Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.<br>**Score of 20-27** = Severe depression<br>**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care<br>**Positive score on Item 9.**<br>**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care |
| | PHQ-9 - Modified for Teens[2] | Depression Screen - 9 Questions | **Score of 1-4** = Minimal depression<br>**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit.<br>**Score of 5-9** = Mild depression<br>**Action:** Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive<br>**Score of 10-14** = Moderate depression **Action:** Develop treatment plan, referral to behavioral health care professional for psychotherapy within 30 days<br>**Score of 15-19** = Moderately severe depression<br>**Action:** Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.<br>**Score of 20-27** = Severe depression<br>**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care<br>**Positive score on Item 9.**<br>**Action:** Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care |

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| | Edinburgh Postnatal Depression Scale[3] | Depression Screen - 10 Questions | Score of 0-9 = Low probability of depression Action: Watchful waiting; repeat Edinburgh Postnatal Depression Scale at follow-up visit. Score of 10-30 = High probability of moderate to severe depression<br>Action: Develop treatment plan, possible active treatment with pharmacotherapy<br>and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen.<br>If a patient scores a 1, 2, or 3 on question 10, please address suicidal thoughts immediately. Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management. |
| | Geriatric Depression Scale (GDS)[4] | Depression Screen - 15 Questions | Score of 1-4 = Minimal depression Action: Watchful waiting; repeat GDS at follow-up visit.<br>Score of 5-15 = Mild to severe depression Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management. |
| Anxiety | GAD-21 | Anxiety Screen - 2 Questions | Score of 0-2 = Negative Screen<br>Action: None<br>Score of 3+ = Positive screen<br>Action: Administer the GAD-7.1 |
| | GAD-71 | Anxiety Screen - 7 Questions | Score of 1-4 = Minimal anxiety<br>Action: Watchful waiting; repeat GAD-7 at follow-up visit.<br>Score of 5-9 = Mild anxiety<br>Action: Watchful waiting; repeat GAD-7 at follow-up visit.<br>Score of 10-14 = Moderate anxiety<br>Action: Further diagnostic assessment by PCP or behavioral health care professional.<br>Consider pharmacotherapy and/or psychotherapy.<br>Score of 15-21 = Severe anxiety<br>Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care |
| Substance Abuse/ Dependence | NIDA-Quick Screen[5] | Alcohol/Drug and Tobacco Screen - 4 Questions (Single Question Screener Included) | If respondent indicates "No" for all drugs in prescreen.<br>Action: Reinforce abstinence.<br>If respondent indicates “Yes” to any of the drugs listed.<br>Action: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen. |

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| | AUDIT-C[6] | Alcohol Screen - 3 Questions | Score of 0-3 in Men / Score of 0-2 in Women = Minimal to moderate use. Low probability of abuse or dependence. Action: Reinforce abstinence. Watchful waiting; repeat AUDIT-C at follow-up visit. Score of 4-12 in Men / Score of 3-12 in Women = Moderate to severe use. High probability of abuse or dependence. Action: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within |
| Substance Use | AUDIT[7] | Alcohol Screen - 10 Questions | Score of 1-7 = Minimal to moderate use. Low probability of abuse or dependence. Action: Reinforce abstinence. Watchful waiting; repeat AUDIT at follow-up visit. Score of 8-15 = Moderate to severe use. Moderate probability of abuse or dependence. Score of 16-19 = Moderate to severe use. Moderate to high probability of abuse or dependence. Score of 20-40 = Severe use. High probability of abuse or dependence. Action steps for scores of 8 or higher: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) |
| Suicidality | CSSRS - Clinical Screener[8] | Suicide Severity Screen, Clinical Practice Screener - Recent - 6 Questions | One or more "Yes" responses are a positive screen. Action: Refer to behavioral health care professional to evaluate risk factors and determine appropriate treatment setting. A "Yes" response to question #4 or #5 in the past month or any behavior in question #6 is an indication of severe risk. Action: Refer to behavioral health care professional to evaluate for hospitalization. |

[1]Spitzer, R.; Williams, J. B.W.; Kroenke, K. and colleagues, with an educational grant from Pfizer. No permission required to reproduce, translate, display, or distribute. [2]Johnson J.G., Harris E.S., Spitzer R.L., Williams, J.B.W.: The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolescent Health 30:196–204, 2002. [3]Cox, J.L., Holden, J.M., and Sagovsky, R. 1987.
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[6]Bradley, K. A., Bush, K. R., Epler, A. J., et al (2003). Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female Veterans Affairs patient population. Arch Intern Med. 163:821-9 and Bush, K., Kivlahan, D.R., McDonell, M.B., et al (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Arch Intern Med. 158:1789-95. [7]Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT. The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care. Geneva, Switzerland: World Health Organization, 1992. [8]Developed by Drs. Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.;

## Additional Behavioral Health Screening Resources

| Measures | Tool | About the Tool | Scoring and ActionSteps |
|---|---|---|---|
| Depression | CES-D | Depression Screen - 20 Questions | See instructions for more information. |
| Depression | MFQ | Depression Screen - Several Versions | See instructions for more information. |
| Substance Use | ORT | Opioid Use Screen - 5 Questions | See instructions for more information. |
| Substance Use | CAGE-AID | Alcohol Screen - 4 Questions | See instructions for more information. |
| Substance | MSSI-SA | Alcohol/Drug Screen - 16 | See instructions for more information. |