Correctional Mental Health Screen for Men (CMHS-M)

Name _____ Last, First, MI	**Detainee #** _____	**Date** _ _ /_ _ /_ _ _ _ mm/dd/year	**Time** __:__

QUESTIONS	NO	YES	COMMENTS
1. Have you ever had worries that you just can't get rid of?			
2. Some people find their mood changes frequently – as if they spend everyday on an emotional roller coaster. Does this sound like you?			
3. Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems?			
4. Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings?			
5. Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments?			
6. Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?			
7. Do you tend to hold grudges or give people the silent treatment for days at a time?			
8. Have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed?			
9. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
10. Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed?			
11. Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			
12. Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled?			

TOTAL # YES: _____	**General Comments**:

Refer for further Mental Health Evaluation if the Detainee answered *Yes* to **6** or more items ***OR*** If you are concerned for any other reason

- **URGENT Referral** on _ _/ _ _/ _ _ _ _ to _____
- **ROUTINE Referral** on _ _/ _ _/ _ _ _ _ to _____
- **Not Referred**

Person Completing Screen: _____

INSTRUCTIONS FOR COMPLETING THE CMHS-M

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Men (CMHS-M) with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-M:

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial
Detainee#: Detainee's facility identification number
Date: Today's month, date, year
Time: Current time (24hr or AM/PM)

Questions #1-12 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in his answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says he does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering **"YES" to 6 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-M the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) he should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

Correctional Mental Health Screen for Women (CMHS-W)

Name _____ Last, First, MI	**Detainee #** _____	**Date** _ _ /_ _ /_ _ _ _ mm/dd/year	**Time** __:__

Questions	No	Yes	Comments
1. Do you get annoyed when friends and family complain about their problems? Or do people complain you are not sympathetic to their problems?			
2. Have you ever tried to avoid reminders of, or to not think about, something terrible that you experienced or witnessed?			
3. Some people find their mood changes frequently-as if they spend everyday on an emotional rollercoaster. For example, switching from feeling angry to depressed to anxious many times a day. Does this sound like you?			
4. Have there ever been a few weeks when you felt you were useless, sinful, or guilty?			
5. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
6. Do you find that most people will take advantage of you if you let them know too much about you?			
7. Have you been troubled by repeated thoughts, feelings, or nightmares about something terrible that you experienced or witnessed?			
8. Have you ever been in the hospital for non-medical reasons, such as a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			

TOTAL # YES: _____	**General Comments**:

Refer for further Mental Health Evaluation if the Detainee answered
Yes to **5** or more items ***OR*** If you are concerned for any other reason

- **URGENT Referral** on _ _/ _ _/ _ _ _ _ to _____
- **ROUTINE Referral** on _ _/ _ _/ _ _ _ _ to _____
- **Not Referred**

Person Completing Screen: _____

INSTRUCTIONS FOR COMPLETING THE CMHS-W

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Women (CMHS-W), with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-W:

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial
Detainee#: Detainee's facility identification number
Date: Today's month, date, year
Time: Current time (24hr or AM/PM)

Questions #1-8 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in her answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says she does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering **"YES" to 5 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-W the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) she should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

Bipolar Depression Rating Scale (BDRS)

INSTRUCTIONS: *"I am going to ask you some questions about symptoms you may have. When answering please keep in mind that we are focusing only on how you are now, or have been over the last few days."*

Check or tick (√) one answer for each of the questions below.

1. DEPRESSED MOOD
Self reported and/or observed depression as evidenced by gloom, sadness, pessimism, hopelessness, and helplessness

☐0 Nil
☐1 Mild [brief or transient periods of depression, or mildly depressed mood]
☐2 Moderate [depressed mood is clearly but not consistently present and other emotions are expressed, or depression is of moderate intensity]
☐3 Severe [pervasive or continuous depressed mood of marked intensity]

2. SLEEP DISTURBANCE: score either A or B
Change in total amount of sleep over a 24-hour cycle, rated independent of the effect of external factors

A: Insomnia (reduction in total sleep time)

☐0 Nil
☐1 Mild [up to 2 hours]
☐2 Moderate [2 – 4 hours]
☐3 Severe [more than 4 hours]

OR

B: Hypersomnia (increase in total sleep time, inclusive of daytime sleep)

☐0 Nil
☐1 Mild [less than 2 hours, or normal amount but non-restorative]
☐2 Moderate [greater than 2 hours]
☐3 Severe [greater than 4 hours]

3. APPETITE DISTURBANCE: score either A or B
Change in appetite and food consumption, rated independent of the effect of external factors

A. Loss of appetite

☐0 Nil
☐1 Mild [no change in food intake, but has to push self to eat or reports that food has lost taste]
☐2 Moderate [some decrease in food intake]
☐3 Severe [marked decrease in food intake, hardly eating]

OR

B. Increase in appetite

☐0 Nil
☐1 Mild [no change in food intake, but increased hunger]
☐2 Moderate [some increase in food intake, e.g., comfort eating]
☐3 Severe [marked increase in food intake or cravings]

Bipolar Depression Rating Scale (BDRS)

4. REDUCED SOCIAL ENGAGEMENT
Reports reduced social and interpersonal engagement or interactions

☐$_0$ Nil [normal]
☐$_1$ Mild [slight reduction in social engagement with no impairment in social or interpersonal function]
☐$_2$ Moderate [clear reduction in social engagement with some functional sequelae, e.g., avoids some social engagements or conversations]
☐$_3$ Severe [marked reduction in social interaction or avoidance of almost all forms of social contact, e.g., refuses to answer the phone or see friends or family]

5. REDUCED ENERGY AND ACTIVITY
Reduced energy, drive and goal directed behaviour

☐$_0$ Nil
☐$_1$ Mild [able to engage in usual activities but with increased effort]
☐$_2$ Moderate [significant reduction in energy leading to reduction of some role-specific activities]
☐$_3$ Severe [leaden paralysis or cessation of almost all role specific activities, e.g., spends excessive time in bed, avoids answering the phone, poor personal hygiene]

6. REDUCED MOTIVATION
Reports of subjective reduction in drive, motivation, and consequent goal directed activity

☐$_0$ Nil [normal motivation]
☐$_1$ Mild [slight reduction in motivation with no reduction in function]
☐$_2$ Moderate [reduced motivation or drive with significantly reduced volitional activity or requires substantial effort to maintain usual level of function]
☐$_3$ Severe [reduced motivation or drive such that goal directed behaviour or function is markedly reduced]

7. IMPAIRED CONCENTRATION AND MEMORY
Subjective reports of reduced attention, concentration, or memory, and consequent functional impairment

☐$_0$ Nil
☐$_1$ Mild [slight impairment of attention, concentration, or memory with no functional impairment]
☐$_2$ Moderate [significant impairment of attention, concentration, or forgetfulness with some functional impairment]
☐$_3$ Severe [marked impairment of concentration or memory with substantial functional impairment, e.g., unable to read or watch TV]

8. ANXIETY
Subjective reports of worry, tension, and/or somatic anxiety symptoms e.g., tremor, palpitations, dizziness, light-headedness, pins and needles, sweating, dyspnoea, butterflies in the stomach, or diarrhoea

☐$_0$ Nil
☐$_1$ Mild [transient worry or tension about minor matters]
☐$_2$ Moderate [significant anxiety, tension, or worry, or some accompanying somatic features]
☐$_3$ Severe [marked continuous anxiety, tension, or worry that interferes with normal activity; or panic attacks]

9. ANHEDONIA
Subjectively reduced ability to experience pleasure in usual activities

☐$_0$ Nil
☐$_1$ Mild [slight reduction in pleasure from usually pleasurable activities]
☐$_2$ Moderate [significant reduction in pleasure from usually pleasurable activities; some pleasure from isolated activities retained]
☐$_3$ Severe [complete inability to experience pleasure]

Bipolar Depression Rating Scale (BDRS)

10. AFFECTIVE FLATTENING
Subjective sense of reduced intensity or range of feelings or emotions

☐0 Nil
☐1 Mild [slight constriction of range of affect, or transient reduction in range or intensity of feelings]
☐2 Moderate [significant constriction of range or intensity of feelings with preservation of some emotions, e.g., unable to cry]
☐3 Severe [marked and pervasive constriction of range of affect or inability to experience usual emotions]

11. WORTHLESSNESS
Subjective sense, or thoughts, of decreased self-value or self-worth

☐0 Nil
☐1 Mild [slight decrease in sense of self-worth]
☐2 Moderate [some thoughts of worthlessness and decreased self-worth]
☐3 Severe [marked, pervasive, or persistent feelings of worthlessness, e.g., feels others better off without them, unable to appreciate positive attributes]

12. HELPLESSNESS AND HOPELESSNESS
Subjective sense of pessimism or gloom regarding the future, inability to cope, or sense of loss of control

☐0 Nil
☐1 Mild [occasional and mild feelings of not being able to cope as usual; or pessimism]
☐2 Moderate [often feels unable to cope, or significant feelings of helplessness or hopelessness which lift at times]
☐3 Severe [marked and persistent feelings of pessimism, helplessness, or hopelessness]

13. SUICIDAL IDEATION
Thoughts or feelings that life is not worthwhile; thoughts of death or suicide

☐0 Nil
☐1 Mild [thoughts that life is not worthwhile or is meaningless]
☐2 Moderate [thoughts of dying or death, but with no active suicide thoughts or plans]
☐3 Severe [thoughts or plans of suicide]

14. GUILT
Subjective sense of self blame, failure, or remorse for real or imagined past errors

☐0 Nil
☐1 Mild [slight decrease in self-esteem or increased self-criticism]
☐2 Moderate [significant thoughts of failure, self-criticism, inability to cope, or ruminations regarding past failures and the effect on others; able to recognise as excessive]
☐3 Severe [marked, pervasive, or persistent guilt, e.g., feelings of deserving punishment; or does not clearly recognise as excessive]

15. PSYCHOTIC SYMPTOMS
Presence of overvalued ideas, delusions, or hallucinations

☐0 Nil [absent]
☐1 Mild [mild overvalued ideas, e.g., self-criticism or pessimism without clear effect on behaviour]
☐2 Moderate [significant overvalued ideas with clear effect on behaviour, e.g., strong guilt feelings, clear thoughts that others would be better off without them]
☐3 Severe [clear psychotic symptoms, e.g., delusions or hallucinations]

Bipolar Depression Rating Scale (BDRS)

16. IRRITABILITY
Reports uncharacteristic subjective irritability, short fuse, easily angered, manifested by verbal or physical outbursts

☐0 Nil
☐1 Mild [slight subjective irritability; may not be overtly present]
☐2 Moderate [verbal snappiness and irritability that is clearly observable in interview]
☐3 Severe [reports of physical outbursts, e.g., throwing/breaking objects, or markedly abusive verbal outbursts]

17. LABILITY
Observed mood lability or reported mood swings

☐0 Nil
☐1 Mild [subjective reports of mild increase in mood lability]
☐2 Moderate [mood lability clearly observable, moderate in intensity]
☐3 Severe [marked and dominant mood lability, frequent or dramatic swings in mood]

18. INCREASED MOTOR DRIVE
Subjective reports and objective evidence of increased motor drive and motor activity

☐0 Nil [normal motor drive]
☐1 Mild [slight increase in drive, not observable in interview]
☐2 Moderate [clear and observable increase in energy and drive]
☐3 Severe [marked or continuous increase in drive]

19. INCREASED SPEECH
Observed increase in either the rate or quantity of speech, or observed flight of ideas

☐0 Nil
☐1 Mild [slight increase in the rate or quantity of speech]
☐2 Moderate [racing thoughts, significantly more talkative, clearly distractible, or some circumstantiality; does not impede interview]
☐3 Severe [flight of ideas; interferes with interview]

20. AGITATION
Observed restlessness or agitation

☐0 Nil [normal]
☐1 Mild [slight restlessness]
☐2 Moderate [clear increase in level of agitation]
☐3 Severe [marked agitation, e.g., near continuous pacing or wringing hands]

TOTAL ☐

The Bipolar Depression Rating Scale (BDRS)

Rater Manual

General Instructions

The BDRS is designed to measure the severity of depressive symptoms in bipolar depression. The BDRS is validated for clinical use by trained raters. The following conventions are designed to standardise scoring of the BDRS. Based on a clinical interview, the BDRS items rate the severity of depressive and/or mixed symptoms expressed by patients currently and during the past few days. If there is a discordance between symptoms currently and the last few days, the rating should reflect current symptoms. The scale contains 20 questions and the maximum score possible is 60. Higher scores indicate greater severity.

Individual items may be either subjective (patient report), objective (clinician rated) or a combination. In those combined items where there is a discrepancy between subjective and objective criteria, the objective should be more heavily weighted. If the rater believes the patient's score lies between two points of severity, and is unable to clarify with probing where a particular score lies, the more severe rating should be scored. When the operational definitions and suggestions for an item do not fully describe an individual situation, the categories of mild/moderate/severe should guide rating. Do not however ask patients to pick the right answer e.g. mild/moderate/severe.

In individuals with significant symptom lability, for example with ultra rapid or ultradian cycling, the rating should be weighted to the current mental state. When assessing the patient's current state, assessment should be done if possible without any attribution to environmental variables or medication status, e.g. use of hypnotics in assessing sleep. If a clear medical cause for a symptom is present, e.g. lithium tremor, this should not be rated. Some individuals who have chronic depression or alternate between depression and hypomania, may be unable to recall a period of well being, or be confident of what is normal for them. In items which refer to a person's usual self, it may be necessary for the interviewer to refer to hypothetical norms for those items.

Beware of central tendency error i.e. avoid assessing at a mid range as a "safe" response. Where examples are given e.g., 5 (3), the experience of one example satisfies the criteria. Is not necessary for any of the specific listed examples to be experienced if in the rater's judgement this criteria level is met. Do not take these anchor points too literally. The questions listed are a guide rather than a structured interview, and these need to be contextualised to the individual's clinical situation. Do not assume that because an individual does satisfy a particular anchor point that they will not satisfy the following anchor point. Rater's should consider both the frequency, duration and severity of the symptom, and when appropriate, associated features such as distress and impairment.

Following the generally agreed protocol in clinical interviewing, questions should move from general to specific. Patients generally are given as few prompts as possible to elicit the information required to obtain a rating. Within each item, questions should move from more open ended to more structured as needed. Raters should be aware of maintaining a balance between minimizing prompting but ensuring sufficient information is elicited to make the rating accurate and representative of the patient's symptomatology. Particularly unwell patients may generally be expected to need further prompting whereas higher functioning patients may be able to answer questions with less additional input from raters.

Criteria and components of the individual Items:

Before starting. **I am going to ask you some questions about some symptoms you may have. When answering please keep in mind that we are focusing only on how you are now and over the *last few of days*.**

Item 1. DEPRESSED MOOD

Include self-report **and**/**or** observed behaviour.
To score 3 depression should be severe but need not be extreme.

How has your mood been over the last few days?
Have you felt depressed, sad or flat?
Do you experience emotions other than depression?
Have you had feelings of helplessness or hopelessness?
How do you feel about the future?
How intense are these feelings?
How persistent are these feelings?

1. Depressed Mood *(Self reported and/or observed depression as evidenced by gloom, sadness, pessimism, hopelessness, and helplessness)*

0	Nil
1	Mild [brief or transient periods of depression, or mildly depressed mood]
2	Moderate [depressed mood is clearly but not consistently present and other emotions are expressed, or depression is of moderate intensity]
3	Severe [pervasive or continuous depressed mood of marked intensity]

Item 2. SLEEP DISTURBANCE

Score either **insomnia** 2(a) or **hypersomnia** 2(b), compared to the person's normal sleep pattern. Rate sleep quantity independent of medication. Include daytime sleep and "dozing" as well as intermittent sleep when assessing total sleep time.

How has your sleep been over the last couple of days?
How many hours would you usually sleep when you are well?
Is your sleep broken?
Do you awake feeling refreshed?
How many hours in total have you been sleeping over the last couple of nights?
Do you nap or doze in the day? For how long?
How many hours more or less than usual are you sleeping?

2. Sleep Disturbance: score either A or B *(Change in total amount of sleep over a 24 hour cycle, rated independent of the effect of external factors)*

A: Insomnia (reduction in total sleep time)

0	Nil
1	Mild [up to 2 hours]
2	Moderate [2-4 hours]
3	Severe [more than 4 hours]

OR

B: Hypersomnia (increase in total sleep time, inclusive of daytime sleep)

0	Nil
1	Mild [less than 2 hours, or normal amount but non-restorative]
2	Moderate [greater than 2 hours]
3	Severe [greater than 4 hours]

Item 3. APPETITE DISTURBANCE

Score either 3(a) **or** 3(b) compared to their usual eating and appetite pattern.

How is your appetite?
Currently, do you want to eat more or less than usual?
Has your change in appetite altered the amount you actually have been eating?
Has food lost taste?
Do you have to push yourself to eat?
Are you comfort eating or snacking more than usual?
Do you have cravings, which lead to binges?

3. Appetite Disturbance: score either A or B *(Change in appetite and food consumption, rated independent of the effect of external factors)*

A: Loss of Appetite

0 Nil
1 Mild [no change in food intake, but has to push self to eat or reports that food has lost taste]
2 Moderate [some decrease in food intake]
3 Severe [marked decrease in food intake, hardly eating]

OR

B: Increase in Appetite

0 Nil
1 Mild [no change in food intake, but increased hunger]
2 Moderate [some increase in food intake, e.g., comfort eating]
3 Severe [marked increase in food intake or cravings]

Item 4. REDUCED SOCIAL ENGAGEMENT

Assess any reduction of social and interpersonal interaction the participant experiences due to their avoidance or reluctance to engage in social contact. Rate in the context of what is normal for the individual.

Are you meeting or interacting with other people as usual?
Do you find it easy to be around other people at present?
Are you meeting or seeing the people you would normally meet?
Are you avoiding meeting or making contact with people?
To what extent are you avoiding contact with other people?
Do you avoid answering the phone or seeing visitors?

4. Reduced Social Engagement *(Reports reduced social and interpersonal engagement or interactions)*

0 Nil [normal]
1 Mild [slight reduction in social engagement with no impairment in social or interpersonal function]
2 Moderate [clear reduction in social engagement with some functional sequelae, e.g., avoids some social engagements or conversations]
3 Severe [marked reduction in social interaction or avoidance of almost all forms of social contact, e.g., refuses to answer the phone or see friends or family]

Item 5. REDUCED ENERGY AND ACTIVITY

Reduced energy and activity should be rated on the basis of subjective reports and consequent reduction in goal directed activity.

Do you find you have as much energy and drive as usual?
Do you feel more tired than usual?
Do you find it takes more energy than usual to do things?

Do your limbs feel very tired or heavy?
Has this led to you reducing your usual activities?
Are there things you no longer do at all because of reduced energy?
Are you spending much more time in bed?

5. Reduced Energy and Activity *(Reduced energy, drive and goal directed behaviour)*

0 Nil
1 Mild [able to engage in usual activities but with increased effort]
2 Moderate [significant reduction in energy leading to reduction of some role-specific activities]
3 Severe [leaden paralysis or cessation of almost all role specific activities, e.g., spends excessive time in bed, avoids answering the phone, poor personal hygiene]

Item 6. REDUCED MOTIVATION

Reduced motivation and drive should be rated on the basis of subjective reports and consequent reduction in goal directed activity.

Is your motivation or drive reduced?
Are you less interested in your usual activities?
Do you need to push yourself to do the things you usually do?
Are you doing the things you would usually do?
Have you stopped doing any things you would usually do? Which things?

6. Reduced Motivation *(Reports of subjective reduction in drive, motivation, and consequent goal directed activity)*

0 Nil [normal motivation]
1 Mild [slight reduction in motivation with no reduction in function]
2 Moderate [reduced motivation or drive with significantly reduced volitional activity or requires substantial effort to maintain usual level of function]
3 Severe [reduced motivation or drive such that goal directed behaviour or function is markedly reduced]

Item 7. IMPAIRED CONSENTRATION AND MEMORY

This item examines an individual's concentration, their ability to sustain attention and short-term memory difficulties.

Do you find it hard to concentrate?
Does your attention wander more easily?
Are you more forgetful than usual?
How severe is this?
Do you have any difficulty with reading, driving or watching TV?
Does this affect your ability to function? How much?

7. Impaired Concentration and Memory *(Subjective reports of reduced attention, concentration, or memory, and consequent functional impairment)*

0 Nil
1 Mild [slight impairment of attention, concentration, or memory with no functional impairment]
2 Moderate [significant impairment of attention, concentration, or forgetfulness with some functional impairment]
3 Severe [marked impairment of concentration or memory with substantial functional impairment, e.g., unable to read or watch TV]

Item 8. ANXIETY

This item assesses both reported levels of cognitive anxiety as well as somatic symptoms. The presence of significant somatic symptoms usually reflects higher anxiety unless these symptoms are due to another medical condition.

Have you been more anxious or tense than usual over the last few days?
Have you found yourself worrying about things that wouldn't usually bother you?
Are you experiencing any physical symptoms such as tremors/palpitations/dizziness/light headedness/pins & needles/sweating/flushes/butterflies in the stomach/diarrhoea?
How intense is the anxiety?
How persistent is the anxiety?
Does it interfere with your ability to function?

8. Anxiety ***(Subjective reports of worry, tension, and/or somatic anxiety symptoms e.g., tremor, palpitations, dizziness, light-headedness, pins and needles, sweating, dyspnoea, butterflies in the stomach, or diarrhoea)***

0 Nil
1 Mild [transient worry or tension about minor matters]
2 Moderate [significant anxiety, tension, or worry, or some accompanying somatic features]
3 Severe [marked continuous anxiety, tension, or worry that interferes with normal activity; or panic attacks]

Item 9. ANHEDONIA

Assesses person's reported ability to experience pleasure in usual activities.

Do you find things as enjoyable as usual?
Do you still find any pleasure in the things that you usually enjoy?
Which activities still give you pleasure? To what extent?
Have you completely lost your ability to experience pleasure?

9. Anhedonia ***(Subjectively reduced ability to experience pleasure in usual activities)***

0 Nil
1 Mild [slight reduction in pleasure from usually pleasurable activities]
2 Moderate [significant reduction in pleasure from usually pleasurable activities; some pleasure from isolated activities retained]
3 Severe [complete inability to experience pleasure]

Item 10. AFFECTIVE FLATTENING

This item rates the intensity and range of the individual's usual emotions. When giving examples to a patient, be aware that an example of feeling "unable to cry" may have gender specific connotations

Do you feel your mood is flat or as if your feelings are numbed?
Do you have less feelings for significant people in your life?
Do you find it harder to get excited, angry or worked up about things?
Do you sometimes feel as if you are numb or have no feelings left?

10. Affective Flattening *(Subjective sense of reduced intensity or range of feelings or emotions)*

0	Nil
1	Mild [slight constriction of range of affect, or transient reduction in range or intensity of feelings]
2	Moderate [significant constriction of range or intensity of feelings with preservation of some emotions, e.g., unable to cry]
3	Severe [marked and pervasive constriction of range of affect or inability to experience usual emotions]

Item 11. WORTHLESSNESS

Assesses individual's feelings of self worth or self-confidence, compared to usual levels of self-esteem.

How is your sense of self worth or confidence?
Do you feel you are as worthy a person as anyone else?
Are you still able to see your positive qualities?
Do you feel others would be better off without you?

11. Worthlessness *(Subjective sense, or thoughts, of decreased self-value or self-worth)*

0	Nil
1	Mild [slight decrease in sense of self-worth]
2	Moderate [some thoughts of worthlessness and decreased self-worth]
3	Severe [marked, pervasive, or persistent feelings of worthlessness, e.g., feels others better off without them, unable to appreciate positive attributes]

Item 12. HELPLESSNESS AND HOPELESSNESS

This item assesses feelings of helplessness or hopelessness, gloom and despondency.

Do you feel optimistic or pessimistic about the future?
Do you feel you will be able to cope with the future?
Do you feel helpless or hopeless?
Are those feelings constantly there?
How intense are those feelings?

12. Helplessness and Hopelessness *(Subjective sense of pessimism or gloom regarding the future, inability to cope, or sense of loss of control)*

0	Nil
1	Mild [occasional and mild feelings of not being able to cope as usual; or pessimism]
2	Moderate [often feels unable to cope, or significant feelings of helplessness or hopelessness which lift at times]
3	Severe [marked and persistent feelings of pessimism, helplessness, or hopelessness]

Item 13. SUICIDAL IDEATION

Assesses reported thoughts of death and suicide.

Do you feel that life is not worthwhile or meaningless?
Do you have thoughts of death or dying?
Do you feel that you would be better off dead?
Have you thought about ending your own life?
Have you had thoughts about harming yourself?
Have you made any plans?

13. Suicidal Ideation *(Thoughts or feelings that life is not worthwhile; thoughts of death or suicide)*

0 Nil
1 Mild [thoughts that life is not worthwhile or is meaningless]
2 Moderate [thoughts of dying or death, but with no active suicide thoughts or plans]
3 Severe [thoughts or plans of suicide]

Item 14. GUILT

This item rates guilt, self-blame and remorse for real or past events. Rating varies according to extent to which person feels guilty or deserving of their fate.

Do you find yourself feeling guilty about things that have happened in the past?
Are you self critical about your role in things that have gone wrong?
How intense are these feelings?
Are they there some of the time or all of the time?
Do you think these feelings are excessive?
Do you feel in some ways that having this illness is a punishment?

14. Guilt *(Subjective sense of self blame, failure, or remorse for real or imagined past errors)*

0 Nil
1 Mild [slight decrease in self-esteem or increased self-criticism]
2 Moderate [significant thoughts of failure, self-criticism, inability to cope, or ruminations regarding past failures and the effect on others; able to recognise as excessive]
3 Severe [marked, pervasive, or persistent guilt, e.g., feelings of deserving punishment; or does not clearly recognise as excessive]

Item 15. PSYCHOTIC SYMPTOMS

This item rates psychotic symptoms, increasing from over-valued ideas through to overt psychotic symptoms. Rate on the basis of interview and mental status examination. Some of the information for this item will have bee gleaned from previous items.

Do your feelings of guilt affect the things you do?
Are you feeling suspicious?
Have you had unusual experiences such as hearing voices or seeing visions?
Do you believe things other people regard as unusual?

15. Psychotic Symptoms *(Presence of overvalued ideas, delusions, or hallucinations)*

0 Nil [absent]
1 Mild [mild overvalued ideas, e.g., self-criticism or pessimism without clear effect on behaviour]
2 Moderate [significant overvalued ideas with clear effect on behaviour, e.g., strong guilt feelings, clear thoughts that others would be better off without them]
3 Severe [clear psychotic symptoms, e.g., delusions or hallucinations]

The Mixed Subscale: Items 16-20

Item 16. IRRITABILITY

This item rates irritability and hostility. It is rated on the basis of subjective reports of irritability as well as observed behaviour.

Do you find things irritate you more than they would have previously?
Do you show that you are irritated or can you keep the feelings inside?
Have you acted 'out of character' due to your feelings of irritation?
Have you lost your temper so that you shouted or broke things?

16. Irritability ***(Reports uncharacteristic subjective irritability, short fuse, easily angered, manifested by verbal or physical outbursts)***

0 Nil
1 Mild [slight subjective irritability; may not be overtly present]
2 Moderate [verbal snappiness and irritability that is clearly observable in the interview]
3 Severe [reports of physical outbursts, e.g., throwing/breaking objects, or markedly abusive verbal outbursts]

Item 17. LABILITY

This item rates both reported and observed mood lability.

Have you experienced mood swings over the last couple of days?
How intense are these mood swings?
How frequently does this happen?

17. Lability ***(Observed mood lability or reported mood swings)***

0 Nil
1 Mild [subjective reports of mild increase in mood lability]
2 Moderate [mood lability clearly observable, moderate in intensity]
3 Severe [marked and dominant mood lability, frequent or dramatic swings in mood]

Item 18. INCREASED MOTOR DRIVE

This item rates both subjective and observed increases in motor drive and activity. This should include both goal directed and non-specific activity.

Have you been more active than usual over the past few days?
Do you feel you have more energy and drive then usual? How much more?
Have you done more things because of this?

18. Increased Motor Drive ***(Subjective reports and objective evidence of increased motor drive and motor activity)***

0 Nil [normal motor drive]
1 Mild [slight increase in drive, not observable in interview]
2 Moderate [clear and observable increase in energy and drive]
3 Severe [marked or continuous increase in drive]

Item 19. INCREASED SPEECH

This item scores increased rate and quantity of speech or thought. It is predominantly an observer based rating, although subjective reports are taken into account.

Do you find you want to talk more than you usually would?
Do you find you interrupt people more than you usually would?
Are your thoughts going faster than usual?
Do you find yourself bursting with ideas that you want to tell people?

19. **Increased Speech** ***(Observed increase in either the rate or quantity of speech, or observed flight of ideas)***

0	Nil
1	Mild [slight increase in the rate or quantity of speech]
2	Moderate [racing thoughts, significantly more talkative, clearly distractible, or some circumstantiality; does not impede interview]
3	Severe [flight of ideas; interferes with interview]

Item 20. AGITATION

This item rates observed restlessness and agitation, although subjective reports are taken into account.

Do you find you are more restless than usual?
Do you feel agitated?
Do you find it hard to sit still?
How intense are these feelings?

20 **Agitation** ***(Observed restlessness or agitation)***

0	Nil [normal]
1	Mild [slight restlessness]
2	Moderate [clear increase in level of agitation]
3	Severe [marked agitation, e.g., near continuous pacing or wringing hands]

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate that you are detached from yourself, others, or your environment.

A grand sum between ***22 – 35*** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not "panic" time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

3 4 5 6 7 8 9 10 11 12 A B C D E

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

Scoring the Beck Depression Inventory

After you have completed the questionnaire, add up the score for each of the 21 questions. The following table indicates the relationship between total score and level of depression according to the Beck Depression Inventory.

Classification	Total Score	Level of Depression
Low	**1-10**	**Normal ups and downs**
	11-16	**Mild mood disturbance**
Moderate	**17-20**	**Borderline clinical depression**
	21-30	**Moderate depression**
Significant	**31-40**	**Severe depression**
	Over 40	**Extreme depression**

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

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3 4 5 6 7 8 9 10 11 12 A B C D E

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	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 have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

How to Score the PHQ-9

Major depressive disorder (MDD) is suggested if:

- Of the 9 items, 5 or more are checked as at least 'more than half the days'
- Either item 1 or 2 is checked as at least 'more than half the days'

Other depressive syndrome is suggested if:

- Of the 9 items, between 2 to 4 are checked as at least 'more than half the days'
- Either item 1 or 2 is checked as at least 'more than half the days'

PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally the numbers of all the checked responses under each heading (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for Interpreting PHQ-9 Scores		
Score	Depression Severity	Action
0 - 4	None-minimal	Patient may not need depression treatment.
5 - 9	Mild	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
10 - 14	Moderate	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15 - 19	Moderately severe	Treat using antidepressants, psychotherapy or a combination of treatment.
20 - 27	Severe	Treat using antidepressants with or without psychotherapy.

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, life at home, or relationships with other people. Patient response of 'very difficult' or 'extremely difficult' suggest that the patient's functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

Note: Depression should not be diagnosed or excluded solely on the basis of a PHQ-9 score. A PHQ-9 score ≥ 10 has a sensitivity of 88% and a specificity of 88% for major depression.[1] Since the questionnaire relies on patient self-report, the practitioner should verify all responses. A definitive diagnosis is made taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Reference: Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.