Behavioral Health Engagement for HIV Prevention & Care

SF HIV Frontline Workers
April 25 & May 4, 2017

Thank You


Getting to Zero SF
San Francisco Department of Public Health
Positive Resouce Center

Thank You

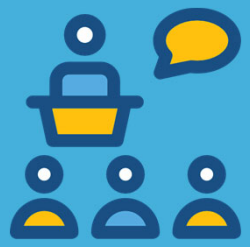
Program Planning Team

- Zachary Davenport, LMFT
- Andy Scheer, LCSW
- Linda Walubengo, MPH
- Christy Camp, MSW
- Tim Sasaki, LCSW, MPH
- Ramon Matos, LMFT

Frontline Organizing Group (FOG)

- Adrienne Mendle
- Andrea Galindo
- Amanda Newstetter, MSW
- Andy Scheer, LCSW
- Beth Mazie
- Christy Camp, MSW
- Chuan Teng
- Dillon Trujillo
- Jessica Price
- Kevin Hutchcroft, MPH
- Kristina Gunhouse-Vigil
- Miguel Ibarra
- Rebecca Levin

SF HIV Frontline Workers



Capacity building

Practical tools

Cross agency collaboration

SF HIV Frontline Workers

Get involved!

email

SFHIVFOG@gmail.com

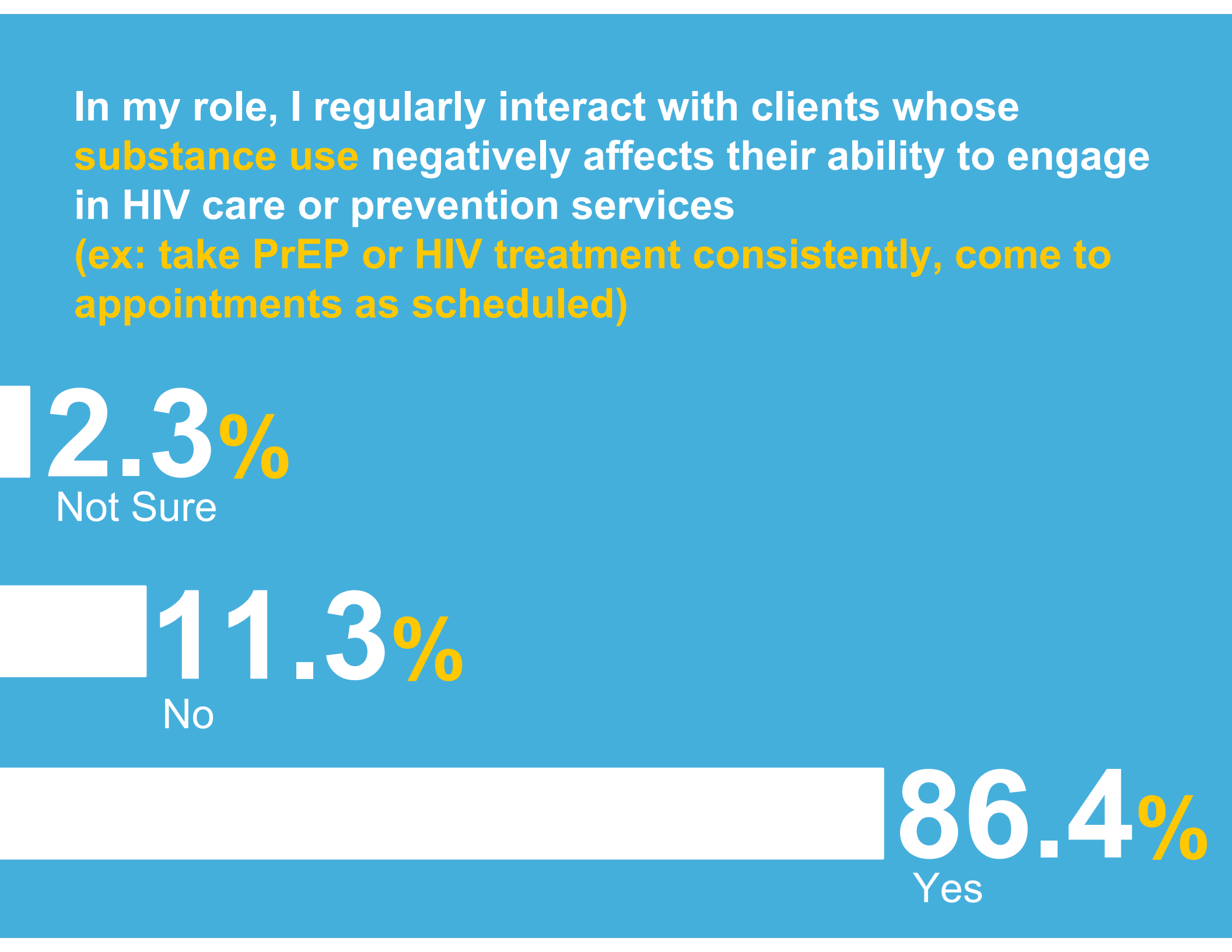
LEARNING OBJECTIVES April 25

- Describe how to incorporate brief mental health screening tools into diverse HIV frontline worker environments
- Demonstrate how to conduct brief interventions that motivate client engagement in mental health wellness services

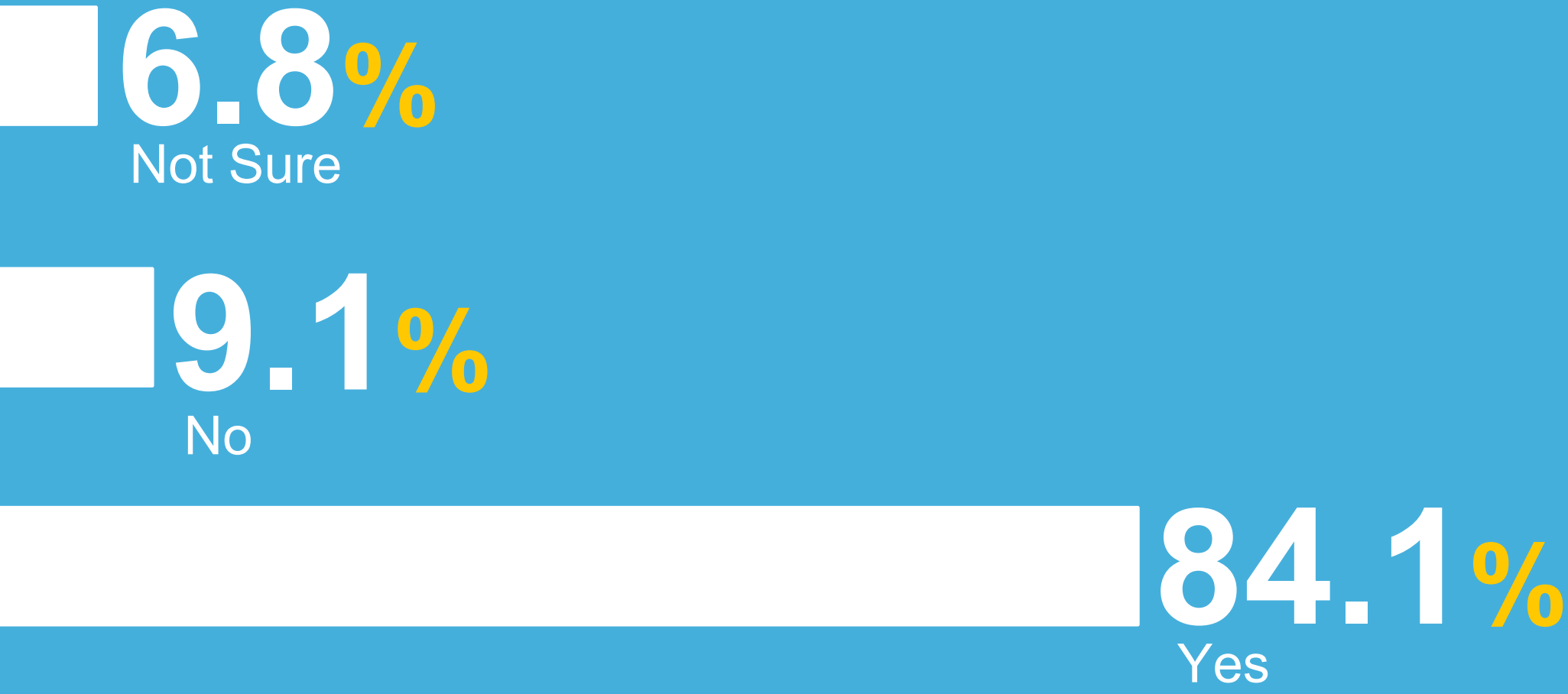
LEARNING OBJECTIVES May 4

- Explain how to navigate clients to behavioral health care services available under both public and private health insurance
- Describe three referrals in SF that support mental health wellness—including how a client can start services

In my role, I regularly interact with clients whose substance use negatively affects their ability to engage in HIV care or prevention services (ex: take PrEP or HIV treatment consistently, come to appointments as scheduled)



In my role, I regularly interact with clients whose mental health condition negatively affects their ability to engage in HIV care or prevention services (ex: consistently use condoms, take HIV meds daily)



Mental Health Care

race ○ ethnicity ○ age ○ culture of origin

sexual orientation ○ gender ○ gender identity

stigma ○ HIV status ○ trauma

1.
Screening

Describe how to incorporate brief mental health screening tools into diverse frontline worker environments

YOU SAID…

Yes, mental health affects my clients	84.1%
Yes, substance use affects my clients	86.4%

LITERATURE SAYS…

Depression in PLWH may be associated with

- Accelerated HIV disease progression
- Decreased immune functioning
- Nonadherence to HIV medication regimens
- Increased risk of mortality [1]

LITERATURE SAYS…

Depression as a barrier to care
Higher PHQ-9 score in un-retained PLWH
12.5% vs. 33.3%

Support - family & social
PLWH retained in care are more likely to report social support and disclosure of HIV status to family [2]

LITERATURE SAYS…

Depression 2-5x higher in PLWH (especially in women) [4]

Anxiety 15.8% PLWH vs 2.1% Gen Public [5]

Trauma and **Serious Mental Illness** increase likelihood for HIV infection
40-70% PLWH have experienced trauma (20x general population) [4]

“

Anxiety, depression, and traumatic stress “increase risk of acquiring HIV and HIV treatment failure” [6]

IAPAC, 2015

Optimizing the HIV Care Continuum

Proactive steps are recommended to identify and manage clinical mental health disorders (e.g., anxiety, depression, and traumatic stress) and/or mental health issues related to HIV diagnosis, disclosure of HIV status, and/or HIV treatment.

CONTRACT COMPLIANCE

ARIES requires annual MH & SU screening

- Level II providers
  medical case management, substance abuse, and mental health services
- Level III providers
  outpatient / ambulatory care

REFERENCES

1. Pyne JM, Fortney JC, Curran GM, et al. Effectiveness of collaborative care for depression in HIV clinics. Arch Intern Med. 2011; 171(1):23-31
2. Colasanti et al (2017) Individual and Structural barriers to retention
3. HIV.gov https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/taking-care-of-yourself/mental-health/
4. Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, The Case for Behavioral Health Screening in HIV Care Settings. HHS Publication No. SMA-16-4999. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.
5. American Psychiatric Association, psychiatry.org (2017) Physicians Resource; HIV and Anxiety fact sheet
6. IAPAC, 2015 – Guidelines for Optimizing the HIV Care Continuum

Icons provided by FlatIcon.com → Prosymbols

PRESENTERS

Zachary Davenport, LMFT

San Francisco Department of Public Health

South Van Ness Adult Behavioral Health Services

&

San Francisco City Clinic

Ramon Matos, LMFT

UCSF

Alliance Health Project

DISCLAIMERS

- You are already doing the screening
- Screening tools are **not** to be used when clients present **suicidal / homicidal ideation** or **grave disability**
- Information presented today is **not** a training on how to administer and/or interpret these screening tools **for clinical diagnostic purposes** (e.g. for mental health diagnosis)

INFORMAL SCREENING

- **Observation**
  What you observe about the client's presentation
- **Interaction**
  What the client discloses and **how they respond** to questions

BRIEF MENTAL STATUS EXAM

- Appearance
- Behavior
- Attitude
- Eye contact
- Orientation
- Mood

- Affect
- Speech & Language
- Thought process & content
- Suicidality & Homicidality

- Insight & Judgment
- Attention span
- Memory
- Intellectual functioning

Conducting a Mental Status Exam

- What do you observe?
- What might be going on for this person?
- How might you help them and attend to their immediate needs?
- Where might you direct/refer them next?

COMMON FORMAL SCREENING TOOLS

- PHQ-9
- SAMISS
- GAD-7
- CAGE-AID

PHQ-9

Patient Health Questionnaire

- Patient self-report; scored by the clinician or staff
- Administer at registration or while with the provider
- Assesses symptom criteria for Major Depressive Disorder (DSM-IV) including levels of severity
- Should not be used as a sole means to apply a diagnosis
- Diagnosis and further assessment should be done by licensed mental health or medical professional

SAMISS

Substance Abuse & Mental Illness Symptoms Screener

- 16 questions
- Screens for mental health and substance abuse conditions
- Takes under 15 minutes to administer

GAD-7

Generalized Anxiety Disorder (7-item scale)

- Based on the diagnostic criteria for Generalized Anxiety Disorder in DSM-IV
- Also screens for possible social phobia, post-traumatic stress disorder, and panic disorder
- Patient self-report; designed for use by a health professional
- Should not be used as a sole means to apply a diagnosis
- Diagnosis and further assessment should be done by licensed mental health or medical professional

CAGE-AID

- 4-item scale
  - Ever felt you needed to **cut down?**
  - Have people **annoyed** you by criticizing your drinking?
  - Ever felt **guilty** about drinking?
  - Ever needed an **eye-opener** to steady your nerves in the morning?
- Screens for problems related to alcohol and drug use

References

Endicott J, Spitzer RL. A diagnostic interview: the schedule for affective disorders and schizophrenia. Arch Gen Psychiatry 35:837-844 (1978).

Ewing JA. Detecting alcoholism: The CAGE questionnaire. JAMA 252:1905-1907 (1995).

Generalized Anxiety Scale - Cary Behavioral Health. (n.d.). Retrieved April 20, 2017, from http://carybehavioralhealth.com/wp-content/uploads/2011/06/Generalized-Anxiety-Scale.pdf

Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001, 16:606-61

Mental Status Exam (Worksheet). (n.d.). Retrieved April 20, 2017, from http://www.therapistaid.com/therapy-worksheet/mental-status-exam

Patient Health Questionnaire (PHQ) Screeners from Pfizer. (n.d.). Retrieved April 20, 2017, from http://www.phqscreeners.com/

SAMISS: The Substance Abuse and Mental Illness Symptoms ... (n.d.). Retrieved April 20, 2017, from http://ccoe.rbhs.rutgers.edu/online/ARCHIVE/12HC03/pdf/CAGE.pdf

Substance Abuse and Mental Illness Symptoms Screener ... (n.d.). Retrieved April 20, 2017, from https://www.cdph.ca.gov/programs/aids/Documents/SAMISSQuestionnaire.pdf

References

Screening Tools. (n.d.). Retrieved April 20, 2017, from http://www.integration.samhsa.gov/clinical-practice/screening-tools

Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, The Case for Behavioral Health Screening in HIV Care Settings. HHS Publication No. SMA-16-4999. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

Kroenke K, Spirtzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001, 16:606-616

Whetten, K. , Reif, S. , Swartz, M. , & Stevens, R. (2005). A brief mental health and substance abuse screener for persons with hiv. *AIDS Patient Care & STDs*, *19*(2), 89-99.

Brown RL, Rounds, LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wisconsin Medical Journal. 1995:94(3) 135-140

2.

Motivating Engagement

Demonstrate how to conduct brief interventions that motivate client engagement in mental health wellness services

ABBIE ZIMMERMAN

LCSW in private practice

Abbie.ZimmermanLCSW@gmail.com

3.

Linkage

Explain how to navigate clients to behavioral health care services available under both public and private health insurance

3.

Linkage

Describe three referrals in SF that support mental health wellness—including how a client can start services

PRESENTERS

Beth Chiarelli, LCSW
360 Wellness
Women's Specialty
Clinic
private insurance

Anjali George, Ph.D.
Post-doctoral fellow
Access Institute
sliding scale

Kip Williams, LMFT
Gaylesta
private practice

Sara Soul, LMFT
Executive Director
Queer Life Space
sliding scale

Adrienne Elias
HIV Services Manager
Shanti
psychosocial support

Patient Label

Patient Health Questionnaire – 9 (PHQ – 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	None at All	Several Days	More than ½ 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, that you are a failure, or have let you and/or your family/friends 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 o 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

If you checked off <u>any</u> problems, <u>how difficult</u> 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
☐	☐	☐	☐

For office coding				
Total of all columns:	0			
Total Score from all columns:				

Patient Label

Encuesta de Salud Paciente – 9
(PHQ – 9, siglas en Ingles)

Durante las últimas 2 semanas ¿Con qué frecuencia le han afectado los siguientes problemas?	Nunca	Varios días	Más de la mitad de los días	Casi todos los días
10. Tener poco interés o placer en hacer las cosas	0	1	2	3
11. Sentirse desanimado/a, deprimido/a, o sin esperanza	0	1	2	3
12. Con problemas en dormir o en mantenerse dormido/a, o en dormir demasiado	0	1	2	3
13. Sentirse cansado/a o tener poco energía	0	1	2	3
14. Tener poco apetito o comer en exceso	0	1	2	3
15. Sentir falta de amor propio – o que sea un fracaso o que decepcione a si mismo/a o a su familia	0	1	2	3
16. Tener dificultad en concentrarse en cosas tales como leer el periódico o mirar el televisor	0	1	2	3
17. Se mueve o habla tan lentamente que otra gente se podría darse cuenta – o de lo contrario, esta tan agitado/a o inquieto/a que se mueve mucho más de lo acostumbrado	0	1	2	3
18. Se le han ocurrido pensamientos de que sería mejor estar muerto/a o de que haría daño de alguna manera	0	1	2	3

Si usted se identificó con cualquier problema en esta encuesta ¿Qué tanta dificultad le han presentado en cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

Nada en absoluto	Algo difícil	Muy difícil	Extremadamente difícil
☐	☐	☐	☐

Para la oficina				
Total of all columns:	0			
Total Score from all columns:				

Mental Status Exam

Client Name	Date

OBSERVATIONS

Appearance	□ Neat	□ Disheveled	□ Inappropriate	□ Bizarre	□ Other
Speech	□ Normal	□ Tangential	□ Pressured	□ Impoverished	□ Other
Eye Contact	□ Normal	□ Intense	□ Avoidant	□ Other	
Motor Activity	□ Normal	□ Restless	□ Tics	□ Slowed	□ Other
Affect	□ Full	□ Constricted	□ Flat	□ Labile	□ Other

Comments:

MOOD

□ Euthymic □ Anxious □ Angry □ Depressed □ Euphoric □ Irritable □ Other

Comments:

COGNITION

Orientation Impairment	□ None	□ Place	□ Object	□ Person	□ Time
Memory Impairment	□ None	□ Short-Term	□ Long-Term	□ Other	
Attention	□ Normal	□ Distracted	□ Other		

Comments:

PERCEPTION

Hallucinations	□ None	□ Auditory	□ Visual	□ Other
Other	□ None	□ Derealization	□ Depersonalization	

Comments:

THOUGHTS

Suicidality	□ None	□ Ideation	□ Plan	□ Intent	□ Self-Harm
Homicidality	□ None	□ Aggressive	□ Intent	□ Plan	
Delusions	□ None	□ Grandiose	□ Paranoid	□ Religious	□ Other

Comments:

BEHAVIOR

□ Cooperative	□ Guarded	□ Hyperactive	□ Agitated	□ Paranoid
□ Stereotyped	□ Aggressive	□ Bizarre	□ Withdrawn	□ Other

Comments:

INSIGHT	□ Good	□ Fair	□ Poor	Comments:
JUDGMENT	□ Good	□ Fair	□ Poor	Comments:

CAGE Questionnaire

This is a commonly-used screening to identify problematic use of alcohol.

1. Have you ever felt you should cut down on your drinking? Yes☐ No☐
2. Have people annoyed you by criticizing your drinking? Yes☐ No☐
3. Have you ever felt bad or guilty about your drinking? Yes☐ No☐
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? Yes☐ No☐

Scoring: Responses on the CAGE are scored 0 for "no" and 1 for "yes," with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

Reference: Ewing, J. A. (1984). Detecting alcoholism: The CAGE Questionnaire. Journal of the American Medical Association, 252, 1905–1907. Retrieved from http://pubs.niaaa.nih.gov/publications/assesing%20alcohol/InstrumentPDFs/16_CAGE.pdf

Primary Care PTSD Screen (C-PTSD)

This is a commonly-used screening for Post-Traumatic Stress Disorder.

Post-Traumatic Stress Disorder has been identified as a significant contributor to mental illness and cognitive impairment. This 4-question screen was developed for use with veterans, but is appropriate for use with all patients.

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? Yes☐ No☐
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Yes☐ No☐
3. Were constantly on guard, watchful, or easily startled? Yes☐ No☐
4. Felt numb or detached from others, activities, or your surroundings? Yes☐ No☐

Scoring: The results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Reference: Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F.D., Sheikh, J. I. (2004). The primary care PTSD screen (PC–PTSD): Corrigendum. *Primary Care Psychiatry*, 9, 151

Resources: US Dept. of Veterans Affairs, National Center for PTSD: http://www.ptsd.va.gov/professional/pages/assessments/pc-ptsd.asp

Depression Screen

This two-question depression screen is designed for use in medical visits.

This screening was designed for use with chronically ill patients, but was adapted for use by primary care clinicians, for use with all patients.

1. During the past month have you often been bothered by feeling down, depressed, or hopeless? Yes☐ No☐
2. During the past month have you often been bothered by little interest or pleasure in doing things? Yes☐ No☐

Scoring: "A positive response to either question is extremely sensitive and identifies more than 90 percent of patients with major depression. However, it is only approximately 60 percent specific and requires confirmation using a detailed clinical interview or a more specific tool such as the Patient Health Questionnaire (PHQ-9)."

Reference: American Association of Family Physicians: http://www.aafp.org
Point of Care Guides: Routine Screening for Depression, Alcohol Problems, and Domestic Violence
http://www.aafp.org/afp/2004/0515/p2421.html

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
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 Score: ☐ = **Add Columns** _____+_____+_____

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 at all	**Somewhat difficult**	**Very difficult**	**Extremely Difficult**
_____	_____	_____	_____

Interpreting the Score:

Total Score	**Interpretation**
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety

The Patient Health Questionnaire (PHQ-9) Scoring

Use of the PHQ-9 to Make a Tentative Depression Diagnosis:
The clinician should rule out physical causes of depression, normal bereavement and a history of a manic/hypomanic episode

Step 1: Questions 1 and 2
Need one or both of the first two questions endorsed as a "2" or a "3"
(2 = "More than half the days" or 3 = "Nearly every day")

Step 2: Questions 1 through 9
Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count. (Questions 1-8 must be endorsed as a "2" or a "3"; Question 9 must be endorsed as "1" a "2' or a "3")

Step 3: Question 10
This question must be endorsed as "Somewhat difficult" or "Very difficult" or "Extremely difficult"

Use of the PHQ-9 for Treatment Selection and Monitoring
Step 1
A depression diagnosis that warrants treatment or a treatment change, needs at least one of the first two questions endorsed as positive ("more than half the days" or "nearly every day") in the past two weeks. In addition, the tenth question, about difficulty at work or home or getting along with others should be answered at least "somewhat difficult"

Step 2
Add the total points for each of the columns 2-4 separately
(Column 1 = Several days; Column 2 = More than half the days; Column 3 = Nearly every day. Add the totals for each of the three columns together. This is the Total Score
The Total Score = the Severity Score

Step 3
Review the Severity Score using the following TABLE.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation *Patient Preferences should be considered*
5-9	Minimal Symptoms*	Support, educate to call if worse, return in one month
10-14	Minor depression ++ Dysthymia* Major Depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant or psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
>20	Major Depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

* *If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")*

++ *If symptoms present ≥ one month or severe functional impairment, consider active treatment*

The Patient Health Questionnaire (PHQ-9) - Overview

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression:

- The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation.
- A follow up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient's level of function.

Clinical Utility

The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which can reflect improvement or worsening of depression in response to treatment.

Scoring

See PHQ-9 Scoring on next page.

Psychometric Properties

- The diagnostic validity of the PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics.
- PHQ scores ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression.
- PHQ-9 scores of 5, 10, 15, and 20 represents mild, moderate, moderately severe and severe depression.[1]

1. Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001, 16:606-616

SUBSTANCE ABUSE AND MENTAL ILLNESS SYMPTOMS SCREENER (SAMISS)

Pt label

FOR EACH QUESTION, PLEASE CHECK ONLY ONE BOX

SUBSTANCE USE

1. HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?
   - ☐ NEVER
   - ☐ MONTHLY OR LESS
   - ☐ 2-4 TIMES/MONTH
   - ☐ 2-3 TIMES/WEEK
   - ☐ 4 OR MORE TIMES/WEEK

2. HOW MANY DRINKS DO YOU HAVE ON A TYPICAL DAY WHEN YOU ARE DRINKING?
   - ☐ NONE
   - ☐ 1 OR 2
   - ☐ 3 OR 4
   - ☐ 5 OR 6
   - ☐ 7 TO 9
   - ☐ 10 OR MORE

3. HOW OFTEN DO YOU HAVE 4 OR MORE DRINKS ON ONE OCCASION?
   - ☐ NEVER
   - ☐ LESS THAN MONTHLY
   - ☐ MONTHLY
   - ☐ WEEKLY
   - ☐ DAILY OR ALMOST DAILY

4. IN THE PAST YEAR, HOW OFTEN DID YOU USE NON-PRESCRIPTION DRUGS TO GET HIGH OR TO CHANGE THE WAY YOU FEEL?
   - ☐ NEVER
   - ☐ LESS THAN MONTHLY
   - ☐ MONTHLY
   - ☐ WEEKLY
   - ☐ DAILY OR ALMOST DAILY

5. IN THE PAST YEAR, HOW OFTEN DID YOU USE DRUGS PRESCRIBED TO YOU OR TO SOMEONE ELSE TO GET HIGH OR CHANGE THE WAY YOU FEEL?
   - ☐ NEVER
   - ☐ LESS THAN MONTHLY
   - ☐ MONTHLY
   - ☐ WEEKLY
   - ☐ DAILY OR ALMOST DAILY

6. IN THE PAST YEAR, HOW OFTEN DID YOU DRINK OR USE DRUGS MORE THAN YOU MEANT TO?
   - ☐ NEVER
   - ☐ LESS THAN MONTHLY
   - ☐ MONTHLY
   - ☐ WEEKLY
   - ☐ DAILY OR ALMOST DAILY

7. HOW OFTEN DID YOU FEEL YOU WANTED OR NEEDED TO CUT DOWN ON YOUR DRINKING OR DRUG USE IN THE PAST YEAR AND WERE NOT ABLE TO?
   - ☐ NEVER
   - ☐ LESS THAN MONTHLY
   - ☐ MONTHLY
   - ☐ WEEKLY
   - ☐ DAILY OR ALMOST DAILY

MENTAL HEALTH

8. IN THE PAST YEAR, WHEN NOT HIGH OR INTOXICATED, DID YOU EVER FEEL EXTREMELY ENERGETIC OR IRRITABLE AND MORE TALKATIVE THAN USUAL?
   - ☐ YES
   - ☐ NO

9. IN THE PAST YEAR, WERE YOU EVER ON MEDICATION OR ANTIDEPRESSANTS FOR DEPRESSION OR A NERVE PROBLEM?
   - ☐ YES
   - ☐ NO

10. IN THE PAST YEAR, WAS THERE EVER A TIME WHEN YOU FELT SAD, BLUE, OR DEPRESSED FOR MORE THAN TWO WEEKS IN A ROW?
   - ☐ YES
   - ☐ NO

11. IN THE PAST YEAR, WAS THERE EVER A TIME LASTING MORE THAN TWO WEEKS WHEN YOU LOST INTEREST IN MOST THINGS LIKE HOBBIES, WORK, OR ACTIVITIES THAT USUALLY GIVE YOU PLEASURE?
   - ☐ YES
   - ☐ NO

12. IN THE PAST YEAR, DID YOU EVER HAVE A PERIOD LASTING MORE THAN 1 MONTH WHEN MOST OF THE TIME YOU FELT WORRIED AND ANXIOUS?
   - ☐ YES
   - ☐ NO

13. IN THE PAST YEAR, DID YOU HAVE A SPELL OR AN ATTACK WHEN ALL OF A SUDDEN YOU FELT FRIGHTENED, ANXIOUS OR VERY UNEASY WHEN MOST PEOPLE WOULD NOT BE AFRAID OR ANXIOUS?
   - ☐ YES
   - ☐ NO

14. IN THE PAST YEAR, DID YOU EVER HAVE A SPELL OR AN ATTACK WHEN FOR NO REASON YOUR HEART SUDDENLY STARTED TO RACE, YOU FELT FAINT, OR YOU COULDN'T CATCH YOUR BREATH? (IF IT WAS ONLY WHEN HAVING A HEART ATTACK OR DUE TO PHYSICAL CAUSES, MARK "NO".)
   - ☐ YES
   - ☐ NO

15. DURING YOUR LIFETIME, AS A CHILD OR ADULT, HAVE YOU EXPERIENCED OR WITNESSED TRAUMATIC EVENT(S) THAT INVOLVED HARM TO YOURSELF OR OTHERS?
   - ☐ YES
   - ☐ NO

   IF YES: IN THE PAST YEAR, HAVE YOU BEEN TROUBLED BY FLASHBACKS, NIGHTMARES, OR THOUGHTS OF THE TRAUMA?
   - ☐ YES
   - ☐ NO

16. IN THE PAST 3 MONTHS, HAVE YOU EXPERIENCED ANY EVENT(S) OR RECEIVED INFORMATION THAT WAS SO UPSETTING IT AFFECTED HOW YOU COPE WITH EVERYDAY LIFE?
   - ☐ YES
   - ☐ NO

SUBSTANCE ABUSE AND MENTAL ILLNESS SYMPTOMS SCREENER (SAMISS)

MARQUE UNA RESPUESTA POR PREGUNTA

Pt label

SUBSTANCE USE

1. ¿CON QUE FRECUENCIA TOMA UNA BEBIDA ALCOHÓLICA?
   - ☐ NUNCA
   - ☐ MENSUALMENTE O MENOS
   - ☐ 2-4 VECES/MES
   - ☐ 2-3 VECES/SEMANA
   - ☐ 4 VECES O MAS/SEMANA

2. ¿CUANTAS BEBIDAS ALCOHÓLICAS CONSUME EN UN DÍA TÍPICO EN EL QUE TOMA?
   - ☐ NINGUNA
   - ☐ 1 O 2
   - ☐ 3 O 4
   - ☐ 5 O 6
   - ☐ 7 A 9
   - ☐ 10 O MAS

3. ¿CON QUE FRECUENCIA TOMA 4 BEBIDAS O MÁS EN UNA OCASIÓN?
   - ☐ NUNCA
   - ☐ MENOS DE MENSUALMENTE
   - ☐ MENSUALMENTE
   - ☐ SEMANALMENTE
   - ☐ A DIARIO O CASI A DIARIO

4. EL AÑO PASADO ¿CON QUÉ FRECUENCIA USÓ FÁRMACOS NO RECETADOS PARA DROGARSE O CAMBIAR COMO SE SIENTE?
   - ☐ NUNCA
   - ☐ MENOS DE MENSUALMENTE
   - ☐ MENSUALMENTE
   - ☐ SEMANALMENTE
   - ☐ A DIARIO O CASI A DIARIO

5. EL AÑO PASADO ¿CON QUÉ FRECUENCIA USÓ FÁRMACOS QUE LE RECETARON A USTED O ALGUIEN MÁS PARA DROGARSE O CAMBIAR COMO SE SIENTE?
   - ☐ NUNCA
   - ☐ MENOS DE MENSUALMENTE
   - ☐ MENSUALMENTE
   - ☐ SEMANALMENTE
   - ☐ A DIARIO O CASI A DIARIO

6. EL AÑO PASADO ¿CON QUÉ FRECUENCIA BEBIÓ O USÓ DROGAS MÁS QUE LO QUE INTENTABA?
   - ☐ NUNCA
   - ☐ MENOS DE MENSUALMENTE
   - ☐ MENSUALMENTE
   - ☐ SEMANALMENTE
   - ☐ A DIARIO O CASI A DIARIO

7. EL AÑO PASADO ¿QUE TANTO DESEABA O PENSABA EN REDUCIR PERO NO PUDO SU CONSUMO DE BEBIDAS ALCOHÓLICAS O USO DE DROGAS?
   - ☐ NUNCA
   - ☐ MENOS DE MENSUALMENTE
   - ☐ MENSUALMENTE
   - ☐ SEMANALMENTE
   - ☐ A DIARIO O CASI A DIARIO

MENTAL HEALTH

8. EL AÑO PASADO, AL NO ESTAR DROGADO O EBRIO ¿LLEGÓ A SENTIRSE EXTREMADAMENTE LLENO DE ENERGÍA O COLÉRICO Y MÁS CONVERSADOR DE LO NORMAL?
   - ☐ SÍ
   - ☐ NO

9. EL AÑO PASADO, ¿FUE MEDICADO O TOMÓ ANTIDEPRESIVOS PARA LA DEPRESIÓN O PROBLEMAS NERVIOSOS?
   - ☐ SÍ
   - ☐ NO

10. EL AÑO PASADO, ¿LE TOCÓ ALGÚN PERIODO EN EL QUE SE SINTIÓ TRISTE O DEPRIMIDO POR MÁS DE 2 SEMANAS SEGUIDAS?
    - ☐ SÍ
    - ☐ NO

11. EL AÑO PASADO, ¿LE TOCÓ ALGÚN PERIODO DE MÁS DE 2 SEMANAS EN EL QUE PERDIÓ INTERÉS EN LA MAYORÍA DE LAS COSAS, COMO PASATIEMPOS, TRABAJO, Y/O ACTIVIDADES QUE GENERALMENTE LE BRINDAN PLACER?
    - ☐ SÍ
    - ☐ NO

12. EL AÑO PASADO, ¿PASÓ UN PERIODO DE MÁS DE 1 MES EN EL QUE LA MAYORÍA DEL TIEMPO SE SINTIÓ PREOCUPADO Y ANSIOSO?
    - ☐ SÍ
    - ☐ NO

13. EL AÑO PASADO, ¿LE TOCÓ UN MAREO O UN ATAQUE QUE LE HIZO SENTIRSE DE REPENTE CON MIEDO, ANSIEDAD O INQUIETUD CUANDO LA MAYORÍA DE LA GENTE NO TENDRÍA MIEDO NI ANSIEDAD?
    - ☐ SÍ
    - ☐ NO

14. EL AÑO PASADO, ¿LE TOCÓ UN MAREO O UN ATAQUE QUE POR NINGUNA RAZÓN SU CORAZÓN DE REPENTE EMPEZÓ A LATIR RÁPIDAMENTE, SE SENTÍA MAREADO, O NO PODÍA RESPIRAR?
    - ☐ SÍ
    - ☐ NO

15. EN SU VIDA, DE NIÑO O ADULTO, ¿HA EXPERIMENTADO O PRESENCIADO ALGÚN EVENTO O EVENTOS TRAUMÁTICOS QUE TUVIERON QUE VER CON HACERSE DAÑO A USTED MISMO O A LOS DEMÁS?
    - ☐ SÍ
    - ☐ NO

DE SER ASÍ: EL AÑO PASADO, ¿HA SUFRIDO DE RETROSPECCIONES ("FLASHBACKS") PESADILLAS, O PENSAMIENTOS RELATIVOS AL TRAUMA?
    - ☐ SÍ
    - ☐ NO

16. EN LOS ÚLTIMOS 3 MESES ¿LE HA EXPERIMENTADO EVENTOS O SE HA ENTERADO INFORMACIÓN QUE LE ALTERÓ TANTO QUE LE AFECTÓ LA MANERA EN QUE LIDIA LA VIDA DIARIA?
    - ☐ SÍ
    - ☐ NO

SCORING THE SUBSTANCE ABUSE AND MENTAL ILLNESS SYMPTOMS SCREENER (SAMISS)

Substance Abuse

Respondent screens **positive** if...

- Sum of responses to **question 1–3** is equal to or **greater than 5**
- Response to **question 4 or 5** is **equal to or greater than 3**
- Response to **question 6 or 7** is **equal to or greater than 1**

Questions 1-3 look at alcohol use

A total score of 5 or greater on these three questions equals a positive screen.

1. How often do you have a drink containing alcohol?
   - Never = **0**
   - Monthly or less = **1**
   - 2–4 times/mo = **2**
   - 2–3 times/wk = **3**
   - 4 or more times/wk = **4**
2. How many drinks do you have on a typical day when you are drinking?
   - None = **0**
   - 1 or 2 = **1**
   - 3 or 4 = **2**
   - 5 or 6 = **3**
   - 7 to 9 = **4**
   - 10 or more = **5**
3. How often do you have 4 or more drinks on 1 occasion?
   - Never = **0**
   - Less than monthly = **1**
   - Monthly = **2**
   - Weekly = **3**
   - Daily or almost daily = **4**

Questions 4 and 5 look at substances other than alcohol

A score of 3 or greater on either question equals a positive screen.

4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel?
   - Never = **0**
   - Less than monthly = **1**
   - Monthly = **2**
   - Weekly = **3**
   - Daily or almost daily = **4**
5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?
   - Never = **0**
   - Less than monthly = **1**
   - Monthly = **2**
   - Weekly = **3**
   - Daily or almost daily = **4**

Questions 6-7 look at the effects of substance use on daily living

A score of 1 or greater on either question equals a positive screen

6. In the past year, how often did you drink or use drugs more than you meant to?
   - Never = **0**
   - Less than monthly = **1**
   - Monthly = **2**
   - Weekly = **3**
   - Daily or almost daily = **4**
7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year and were not able to?
   - Never = **0**
   - Less than monthly = **1**
   - Monthly = **2**
   - Weekly = **3**
   - Daily or almost daily = **4**

Mental Illness

Respondent screens **positive** if response to **any question is "Yes."**

Question 8 looks at the manic side of bipolar disorder

Question 9 - 11 look at **depression**

Questions 12 - 14 look at **anxiety**

Question 15 looks at **PTSD-like symptoms**

Question 16 could be a few things, **PTSD or depression**

This questionnaire is based on the validated screening instrument developed by the University of North Carolina at Chapel Hill, Departments of Psychiatry, Medicine, Public Policy, and Community and Family Medicine; and the Health Inequities Program of Duke University.