Pediatric Mental Health Screening Tools

Michelle Jorgensen, MD

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Depression PHQ-A

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf

Columbia Suicide Severity Rating Scale

	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Life-time**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Any YES indicates that someone should seek a behavioral health referral. However, if the answer to 4, 5 or 6 is YES, seek immediate help: go to the emergency room, call 1-800-273-8255, text 741741 or call 911 and STAY WITH THEM until they can be evaluated.

Columbia Protocol app available

https://www.columbiapsychiatry.org/news/simple-set-6-questions-screen-suicide

Short Mood and Feeling Questionnaire

Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks.*

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. I felt miserable or unhappy	❑	❑	❑
2. I didn't enjoy anything at all	❑	❑	❑
3. I felt so tired I just sat around and did nothing	❑	❑	❑
4. I was very restless	❑	❑	❑
5. I felt I was no good any more	❑	❑	❑
6. I cried a lot	❑	❑	❑
7. I found it hard to think properly or concentrate	❑	❑	❑
8. I hated myself	❑	❑	❑
9. I was a bad person	❑	❑	❑
10. I felt lonely	❑	❑	❑
11. I thought nobody really loved me	❑	❑	❑
12. I thought I could never be as good as other kids	❑	❑	❑
13. I did everything wrong	❑	❑	❑

Parent Report Version — SMFQ

Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks.*

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	❑	❑	❑
2. S/he didn't enjoy anything at all	❑	❑	❑
3. S/he felt so tired that s/he just sat around and did nothing	❑	❑	❑
4. S/he was very restless	❑	❑	❑
5. S/he felt s/he was no good any more	❑	❑	❑
6. S/he cried a lot	❑	❑	❑
7. S/he found it hard to think properly or concentrate	❑	❑	❑
8. S/he hated him/herself	❑	❑	❑
9. S/he felt s/he was a bad person	❑	❑	❑
10. S/he felt lonely	❑	❑	❑
11. S/he thought nobody really loved him/her	❑	❑	❑
12. S/he thought s/he could never be as good as other kids	❑	❑	❑
13. S/he felt s/he did everything wrong	❑	❑	❑

Scoring the SMFQ

Note: the SMFQ has been validated for use in children age 6 years and up.

The SMFQ should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child's symptom severity and treatment response over time.

Scoring:

ssign a numerical value to each answer as follows:

Not true = 0

Sometimes = 1

True = 2

dd up the assigned values for all 13 questions. Record the total score.

total score on the child version of the SMFQ of 8 or more is considered significant.

Sensitivity of 60% and specificity of 85% for major depression at a cut off score of 8 or higher. Source is ngold , Costello EJ, Messer SC. "Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents." *International Journal of Methods in Psychiatric Research* (1995), 5:237-249.

Sensitivity/specificity statistics of the parent version is not reported in the literature. If your patient does not complete the child version of SMFQ, repeated administration of the parent version over time should still be useful for symptom tracking.

https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/ratings/smfq-rating-scale.pdf

ADHD Vanderbilt ADHD Assessment Scale

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

Parent Assessment Scale

Predominantly Inattentive subtype
- Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND
- Score a 4 or 5 on any of the Performance questions 48–55

Predominantly Hyperactive/Impulsive subtype
- Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND
- Score a 4 or 5 on any of the Performance questions 48–55

ADHD Combined Inattention/Hyperactivity
- Requires the above criteria on both inattention and hyperactivity/impulsivity

Oppositional-Defiant Disorder Screen
- Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND
- Score a 4 or 5 on any of the Performance questions 48–55

Conduct Disorder Screen
- Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND
- Score a 4 or 5 on any of the Performance questions 48–55

Anxiety/Depression Screen
- Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND
- Score a 4 or 5 on any of the Performance questions 48–55

https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/NICHQ_Vanderbilt_Assessment_Follow_Up-PARENT-Informant.pdf

Anxiety

GAD-7

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	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

(For office coding: Total Score T____ = ____ + ____ + ____)

https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf

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SCARED

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ **Date**: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When my child feels frightened, it is hard for him/her to breathe	0	0	0
2.	My child gets headaches when he/she is at school	0	0	0
3.	My child doesn't like to be with people he/she doesn't know well	0	0	0
4.	My child gets scared if he/she sleeps away from home	0	0	0
5.	My child worries about other people liking him/her	0	0	0
6.	When my child gets frightened, he/she feels like passing out	0	0	0
7.	My child is nervous	0	0	0
8.	My child follows me wherever I go	0	0	0
9.	People tell me that my child looks nervous	0	0	0
10.	My child feels nervous with people he/she doesn't know well	0	0	0
11.	My child gets stomachaches at school	0	0	0
12.	When my child gets frightened, he/she feels like he/she is going crazy	0	0	0
13.	My child worries about sleeping alone	0	0	0
14.	My child worries about being as good as other kids	0	0	0
15.	When he/she gets frightened, he/she feels like things are not real	0	0	0
16.	My child has nightmares about something bad happening to his/her parents	0	0	0
17.	My child worries about going to school	0	0	0
18.	When my child gets frightened, his/her heart beats fast	0	0	0
19.	He/she gets shaky	0	0	0
20.	My child has nightmares about something bad happening to him/her	0	0	0

Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worrier.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	○	○	○
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	○	○	○
41. My child is shy.	○	○	○

SCORING:
A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.
A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.
A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.
A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.
A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.
A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/ScaredParent.pdf

Autism

MCHAT- R

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**For Example**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**For Example**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**For Example**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**For Example**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**For Example**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**For Example**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**For Example**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**For Example**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**For Example**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**For Example**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**For Example**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**For Example**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**For Example**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**For Example**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**For Example**, being swung or bounced on your knee)	Yes	No

https://www.hopkinsmedicine.org/community_physicians/patient_information/_docs/form_mchatr.pdf

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Trauma

ACE-Q

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

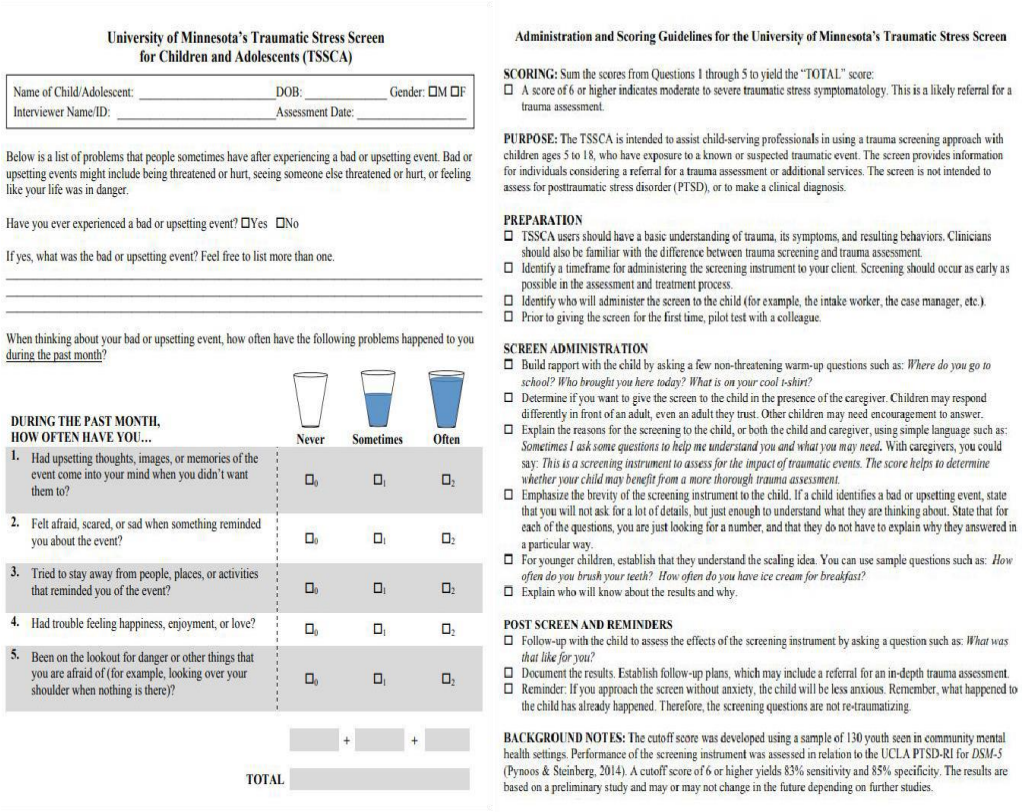
2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

https://centerforyouthwellness.org/wp-content/uploads/2018/06/CYW-ACE-Q-TEEN-1-copy.pdf

Traumatic Stress Screen for Children and Adolescents



University of Minnesota's Traumatic Stress Screen for Children and Adolescents (TSSCA)

Name of Child/Adolescent: _____ DOB: _____ Gender: ☐M ☐F
Interviewer Name/ID: _____ Assessment Date: _____

Below is a list of problems that people sometimes have after experiencing a bad or upsetting event. Bad or upsetting events might include being threatened or hurt, seeing someone else threatened or hurt, or feeling like your life was in danger.

Have you ever experienced a bad or upsetting event? ☐Yes ☐No

If yes, what was the bad or upsetting event? Feel free to list more than one.

_____
_____
_____

When thinking about your bad or upsetting event, how often have the following problems happened to you during the past month?

DURING THE PAST MONTH, HOW OFTEN HAVE YOU…	Never	Sometimes	Often
1. Had upsetting thoughts, images, or memories of the event come into your mind when you didn't want them to?	☐0	☐1	☐2
2. Felt afraid, scared, or sad when something reminded you about the event?	☐0	☐1	☐2
3. Tried to stay away from people, places, or activities that reminded you of the event?	☐0	☐1	☐2
4. Had trouble feeling happiness, enjoyment, or love?	☐0	☐1	☐2
5. Been on the lookout for danger or other things that you are afraid of (for example, looking over your shoulder when nothing is there)?	☐0	☐1	☐2
	+	+	
TOTAL			

Administration and Scoring Guidelines for the University of Minnesota's Traumatic Stress Screen

SCORING: Sum the scores from Questions 1 through 5 to yield the "TOTAL" score:
☐ A score of 6 or higher indicates moderate to severe traumatic stress symptomatology. This is a likely referral for a trauma assessment.

PURPOSE: The TSSCA is intended to assist child-serving professionals in using a trauma screening approach with children ages 5 to 18, who have exposure to a known or suspected traumatic event. The screen provides information for individuals considering a referral for a trauma assessment or additional services. The screen is not intended to assess for posttraumatic stress disorder (PTSD), or to make a clinical diagnosis.

PREPARATION
☐ TSSCA users should have a basic understanding of trauma, its symptoms, and resulting behaviors. Clinicians should also be familiar with the difference between trauma screening and trauma assessment.
☐ Identify a timeframe for administering the screening instrument to your client. Screening should occur as early as possible in the assessment and treatment process.
☐ Identify who will administer the screen to the child (for example, the intake worker, the case manager, etc.).
☐ Prior to giving the screen for the first time, pilot test with a colleague.

SCREEN ADMINISTRATION
☐ Build rapport with the child by asking a few non-threatening warm-up questions such as: *Where do you go to school? Who brought you here today? What is on your cool t-shirt?*
☐ Determine if you want to give the screen to the child in the presence of the caregiver. Children may respond differently in front of an adult, even an adult they trust. Other children may need encouragement to answer.
☐ Explain the reasons for the screening to the child, or both the child and caregiver, using simple language such as: *Sometimes I ask some questions to help me understand you and what you may need.* With caregivers, you could say: *This is a screening instrument to assess for the impact of traumatic events. The score helps to determine whether your child may benefit from a more thorough trauma assessment.*
☐ Emphasize the brevity of the screening instrument to the child. If a child identifies a bad or upsetting event, state that you will not ask for a lot of details, but just enough to understand what they are thinking about. State that for each of the questions, you are just looking for a number, and that they do not have to explain why they answered in a particular way.
☐ For younger children, establish that they understand the scaling idea. You can use sample questions such as: *How often do you brush your teeth? How often do you have ice cream for breakfast?*
☐ Explain who will know about the results and why.

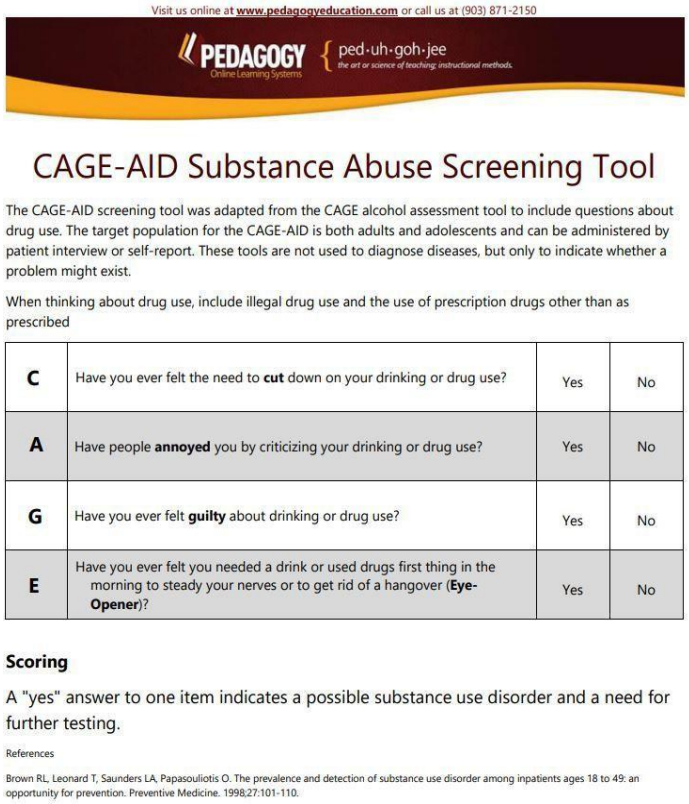
POST SCREEN AND REMINDERS
☐ Follow-up with the child to assess the effects of the screening instrument by asking a question such as: *What was that like for you?*
☐ Document the results. Establish follow-up plans, which may include a referral for an in-depth trauma assessment.
☐ Reminder: If you approach the screen without anxiety, the child will be less anxious. Remember, what happened to the child has already happened. Therefore, the screening questions are not re-traumatizing.

BACKGROUND NOTES: The cutoff score was developed using a sample of 130 youth seen in community mental health settings. Performance of the screening instrument was assessed in relation to the UCLA PTSD-RI for *DSM-5* (Pynoos & Steinberg, 2014). A cutoff score of 6 or higher yields 83% sensitivity and 85% specificity. The results are based on a preliminary study and may or may not change in the future depending on further studies.

https://reachinstitute.asu.edu/sites/default/files/PDF/TSSCA.pdf

Substance Use

CAGE-AID



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PEDAGOGY Online Learning Systems { ped·uh·goh·jee *the art or science of teaching; instructional methods.*

CAGE-AID Substance Abuse Screening Tool

The CAGE-AID screening tool was adapted from the CAGE alcohol assessment tool to include questions about drug use. The target population for the CAGE-AID is both adults and adolescents and can be administered by patient interview or self-report. These tools are not used to diagnose diseases, but only to indicate whether a problem might exist.

When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed

C	Have you ever felt the need to **cut** down on your drinking or drug use?	Yes	No
A	Have people **annoyed** you by criticizing your drinking or drug use?	Yes	No
G	Have you ever felt **guilty** about drinking or drug use?	Yes	No
E	Have you ever felt you needed a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-Opener**)?	Yes	No

Scoring

A "yes" answer to one item indicates a possible substance use disorder and a need for further testing.

References

Brown RL, Leonard T, Saunders LA, Papasouliotis O. The prevalence and detection of substance use disorder among inpatients ages 18 to 49: an opportunity for prevention. Preventive Medicine. 1998;27:101-110.

https://www.pedagogyeducation.com/Main-Campus/Resource-Library/Correctional-Nursing/CAGE-AID-Substance- Abuse-Screening-Tool.aspx

CRAFFT

The CRAFFT Questionnaire (version 2.0)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	# of days
2.	Use any **marijuana** (pot, weed, hash, or in foods) or "**synthetic marijuana**" (like "K2," "Spice") or "vaping" **THC oil**? Put "0" if none.	# of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or "huff")? Put "0" if none.	# of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

		No	Yes
4.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
5.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
6.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
7.	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
8.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
9.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

http://crafft.org/wp-content/uploads/2019/02/CRAFFT-2.0_Selfadministered_2018-01-16.pdf