3.5 Screening Tool for Depression, Substance Abuse, and Domestic Violence

Screening Tool for Depression

Note to the Coordinator: The PHQ-9 is a tool that screens for depression. It can also be found online on sites such as this one:
https://www.ementalhealth.ca/index.php?m=survey&ID=42
You can read the text below to the person you are screening, then score the results as explained below.

This survey is designed to provide a quick assessment of whether you might have signs and symptoms of depression. However, no test is 100% accurate. No matter what your score is, you should seek help if you have any concerns about yourself or your loved ones.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	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

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made if 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
▫	▫	▫	▫

SCORING:

Each response from the PHQ9 has a score ranging from 0 to 3. The score for each response is next to the check box. After you have completed the PHQ9, add up each column score, and then sum all four columns for the score. Below are the scoring guidelines for the PHQ9.

Scoring Guidelines. Add up questions 1-9

Guidelines for Interpretation of PHQ9*

Score	Risk Level	Intervention
0-4	No to Low risk	None, rescreen if needed in the future
5-9	Mild	Watchful waiting; repeat PHQ9 as needed
10-14	Moderately	Consider counseling or refer to medical care provider
15-19	Moderately Severe	Recommend active treatment with medication and/or psychotherapy
20+	Severe	Recommend immediate initiation of medication and if, severe impairment expedited referral to a mental health specialist for psychotherapy and/or collaborative management with medical care provider

*Kroenke K, Spitzer RL. (2002). The PHQ-9: A new depression and diagnostic severity measure. Psychiatric Annals, 32, 509-521.

NOTE: If the person responds to question 9 with any answer other than “not at all,” a suicide risk assessment needs to be completed. This can be done by calling 988 mental health hotline or immediately contacting their therapist or medical care provider

Screening Tool for Substance Use

Do you ever drink more than 2 drinks in a sitting or use any kind of drugs? Yes No
If yes, then complete this (CAGE)

1. Have you ever felt you ought to Cut down on your drinking or drug use?	Yes	No
2. Have people Annoyed you by criticizing your drinking or drug use?	Yes	No
3. Have you felt bad or Guilty about your drinking or drug use?	Yes	No
4. Have you ever had 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

If yes to any screen question try the AUDIT. https://auditscreen.org/check-your-drinking/

Or CUDIT-R for pot use. https://prevention.dasa.ncsu.edu/aod/about-aod/cannabis-use-disorder-test/
Or the DAST-10 for drug use. https://qxmd.com/calculate/calculator_835/drug-abuse-screen-test-dast-10

Screening Tool for Domestic Violence

1. In your home/ relationship, within the past few years, have you given or received a hit, slap, kick, push, shove, or otherwise physically hurt?	Yes	No
2. Within the past few years, have you participated in sexual activities against your will or will of partner?	Yes	No
3. (If yes to either above): Are you afraid that this may happen again?	Yes	No
4. Do children (anyone under 18) live in the home? Even part-time	Yes	No
5. Have children been involved in any hit, slap, kick, push, shove, or otherwise physically hurt? Or participated in sexual activities?	Yes	No

If yes to any questions, the National Domestic Violence hotline can help with further information and guidance. https://www.thehotline.org/ If children are involved you will need to report child abuse to your local child abuse reporting hotline.

Note: This screening tool is intended to help church ministry leaders with understanding the needs of people in their congregation. It cannot provide a diagnosis and may not be accurate. If issues of self-harm, violence, aggression, and substance abuse are arising we recommend seeking help through mental health providers in your community, through 988 mental health hotline.

What to do with screening information:

You can care about someone who is in high distress. How to respond to each area:

1. Self-harm. If a person answered anything except for 0 on question 9 on the PHQ (about being better off dead) then listen to them for a while about that. Have them call their therapist (if they have one), their medical doctor, or 988, the mental health crisis line. You can call 988 with them or for them if you are deeply concerned. If the person was making statements that make you highly concerned about their safety, call 988 yourself and ask for advice on what you should do next.

2. Violence or Aggression where children are present. If they answered yes to questions about domestic violence, you can ask more and pray with them. However, if there is domestic violence and there are children in the home, you may need to call Child Protective Services in your area. You are responsible, as a church, to the reporting laws of your state. Talk immediately with your pastor about what you learned and ask them what to do next. Most states have a child abuse hotline, or you and the ministry leader can google how to report abuse to child protective services in your city to find the phone number to call. It is important to understand this, as not reporting promptly can lead to great harm and can also be a crime.

3. Violence or aggression without children. If they answered yes to questions about domestic violence, and there are no children in the home, you can listen to them, pray with them, and consult with local ministry leaders about further resources in your area such as domestic violence shelters.

4. Substance abuse. If they answered yes regarding substance abuse, you can ask if they have received any support or help from their doctor, a mental health provider, or a support group. If not, connect them to further resources for substance abuse recovery in your community

As noted in the Counseling Ministry Intake Form and Guidance document, those with significant/severe concerns in any of the above areas should be referred to a trained professional for evaluation. At that point, they may also receive lay-listening peer support and spiritual care in your church from someone who is comfortable with that level of need.