MEDICAL MUTUAL®

Depression and Alcohol Abuse

Screening

Using standardized screening tools to screen patients for depression and alcohol and/or drug abuse often makes diagnosis easier. We hope you find the following screening methods and tools helpful when working with your patients.

Depression Screening

The diagnosis of a Major Depressive Disorder depends on recognizing a variety of physical and psychological symptoms that are not considered normal reactions to life stressors and also meet the criteria for Major Depression as defined by the DSM-5. In addition to evaluating for the presence of comorbid medical illness, other psychiatric illnesses must be evaluated and ruled out before a Major Depressive Disorder is diagnosed (e.g., substance abuse, bipolar illness). Diagnosis is often easier using validated screening tests available for use in the office setting. There are several reliable, standardized screening tools available at no cost.

Whooley Depression Screening

The Whooley Depression Screening is a simple two-question tool that has been proven to quickly and effectively screen patients for depression.

Whooley Questions

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

Standardized Screening Tools

If the patient answers yes to one or both questions, further screening with a more detailed screening tool is recommended. Below are some examples of standardized screening tools that can be found online:

Hamilton Depression Rating Scale (HAM-D)

17- or 21-item (depending on the version selected) provider-administered tool that provides an indication of depression severity and progress over time.

Patient Health Questionnaire (PHQ-9)

Nine-item depression scale designed for use in the primary care setting and administered by a provider.

Burns Depression Checklist

15-item self-screening tool.

Beck Depression Inventory

21-item multiple choice tool (must be purchased).

Note: Go to Neurotransmitter.net/DepressionScales for links to a variety of depression screening tools that can either be printed at no cost or purchased.

Alcohol and Drug Screening

Screening for alcohol and drug disorders can vary from asking one simple question to an extensive assessment using a standardized questionnaire. The level of screening typically depends on the patient and comorbid conditions.

Patient inquiries about alcohol and drug use should be performed annually or in response to possible alcohol- or drug-related problems. If the patient appears to be at risk and minimizing his or her substance use, more extensive questioning should be used to determine the cause and extent of the problem.

CAGE and CAGE-AID Testing

The CAGE and CAGE-AID are popular screening methods used in the primary care setting because they are short, simple, easy to remember and proven effective for detecting a range of alcohol and drug problems.

For clinicians under strict time constraints, the CAGE or CAGE-AID should be preceded by two questions:

1. Do you drink alcohol?

2. Have you ever experimented with recreational or prescription drugs?

If the patient only drinks alcohol, then ask the CAGE questions. If the patient has also experimented with drugs, then ask the CAGE-AID questions.

CAGE Questions		CAGE-AID Questions	
Cut Down	Have you ever felt you ought to cut down on your drinking?	**Cut Down**	Have you ever felt you ought to cut down on your drinking or drug use?
Annoyed	Have people annoyed you by criticizing your drinking?	**Annoyed**	Have people annoyed you by criticizing your drinking or drug use?
Guilty	Have you ever felt bad or guilty about your drinking?	**Guilty**	Have you ever felt bad or guilty about your drinking or drug use?
Eye-Opener	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	**Eye-Opener**	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" and answers with a higher score indicate alcohol or drug problems. A score of two or greater is considered clinically significant.

Note: Many standardized screening tools, along with a wealth of information on alcohol use disorders, are available on the NIAAA website at NIAAA.NIH.gov. You can also access the NIAAA's *Helping Patients Who Drink Too Much—A Clinician's Guide* from Provider.MedMutual.com.