TRAINING MANUAL

# Use of Client Diagnostic Questionnaire (CDQ)

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A Mental Health Screening Tool for Use in HIV/AIDS Service Settings


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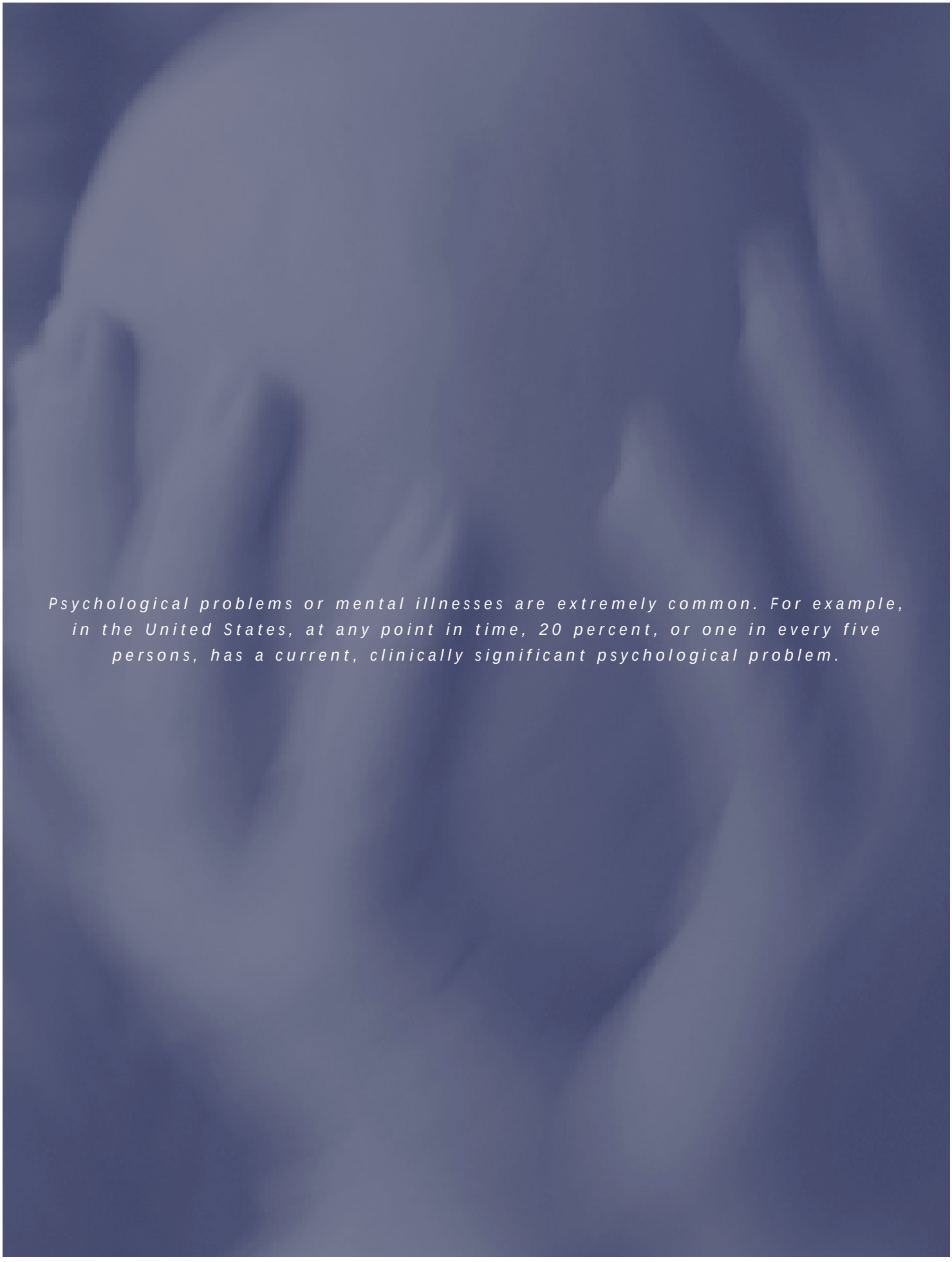

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# I Defining Mental Health and Mental Illness/Disorders

The terms "mental illness" and "mental disorder" imply a separation between the operation of mind and body. This view is increasingly challenged by research that shows there is much physical in mental disorder and much mental in physical illness. However, we use these terms to direct our attention to that dimension of our psychological health or ill health that has to do primarily with ways of thinking, feeling, or behaving: how we feel about ourselves, how we feel about others, and how we are able to meet and handle the demands of life. A mental health problem or disorder is defined as a clinically significant behavioral or psychological pattern that is associated with distress (causes us emotional pain) or disability (impairment in one or more areas of life functioning) or with a significantly increased risk of pain, suffering, disability, or even death.

We can think of mental illnesses as diseases that cause mild to severe disturbances in the way a person thinks, feels, and acts, that go beyond the everyday ups and downs in moods, or in the degree to which one tends to worry. These disturbances cause problems with the ability to cope with life's ordinary demands and routines (family, school, work, and friends). Some psychological disorders are inherited, and some are related to biological bodily processes such as a deficit of certain chemicals in the brain. Others may be emotional or psychological reactions to situations such as acute trauma or a high level of ongoing stress. Most such problems are temporary but—like other illnesses—some can be long lasting and disabling.

Whatever the original cause, a mental disorder is a behavioral or emotional dysfunction in the individual. Mental illness or disorder is *never* merely an expected and culturally supported response to a particular event—for example, extreme sadness in response to the death of a loved one or, for a deeply religious person, hearing God speak to her when in church. Mental illness or disorder is NOT simply deviant behavior or acting outside of usual social conventions. An extreme emotional response or behavior that goes against social conventions may be a symptom of disorder but only if it is a manifestation of dysfunction as defined above.

Psychological problems or mental illnesses are extremely common. For example, in the United States, at any point in time, 20 percent, or one in every five persons, has a current, clinically-significant psychological problem. Over half of all persons will have a psychological disorder at some point in their lifetime (Frances & First, 1998). Mental illness affects 40 million adults and 12 million children in the United Sates alone (Surgeon General's Report, 1999). Mental illness affects one out of every four families and fills more hospital beds than heart disease (NIMH 2001).

It is important to understand that many mental disorders are an exaggeration or a distortion of basic human tendencies that have an important survival value when they work well.

For example, anxiety disorders are based in inborn adaptive fears that have become exaggerated. We would not have survived very long as a species if early humans did not have a healthy worry about saber-toothed tigers and other threats from the environment—but sometimes fears and worries get out of hand. Depression can be understood as a consequence of our inborn ability to love and be attached to others, making us vulnerable to the loss of a loved one, loss of status, guilt and other interpersonal stressors that can trigger a depressive episode.

Many people feel ashamed or embarrassed because they have a mental illness or disorder, even though mental illnesses are in many ways just like physical illnesses (cold, diabetes, arthritis, etc.). They can affect anyone at any time. However, unlike physical illnesses, people who experience a psychological problem are far less likely to seek help or receive treatment. Dr. David Satcher, Surgeon General of the United States, recently issued a report summarizing many research studies. The report shows that fewer than half of individuals with a psychiatric illness recieves any treatment (see: Mental Health: Report of the Surgeon General, 1999). Some people feel that when they are affected by a mental illness, they can just shake it off. This is especially true in cases of depression. The fact is that people cannot just shake off a mental illness. Counseling, psychotherapy, and/or medication may be necessary to help someone through the illness. If a person fractures a leg, it would be foolish to think it would heal by ignoring it; the same is true of mental illness.

There are now very effective tools for treating mental disorders. However, getting the right treatment depends on getting the correct diagnosis—similar to medical diagnosis of physical problems. That is why much effort has gone into developing systems for classifying emotional and psychological problems. However, it is important to keep in mind that the classification of mental disorders is not a way of classifying people; it is a way of classifying illnesses. To experience psychological or emotional difficulties means that a person may have a type of illness or disorder, not that he or she is any particular type of person.

# II Types of Mental Health Problems

## A. Depression

Depression as an illness goes beyond normal feelings of sadness experienced in everyday life. It is very common and can appear in several different forms. These forms range from low levels of sadness that people may experience over long periods of time, to a severe form of depression known as Major Depressive Disorder. Animals in the wild sometimes withdraw from life and die of grief after losing a cherished loved one. In a similar way, normal grief in a person who has experienced a significant loss may progress to a depressive illness. Losing a struggle for status or position can also provoke depression and withdrawal from others throughout the animal kingdom and in the human workplace. It is also possible for depression to occur without any identifiable cause or precipitant. Depression is one of the most frequently encountered psychiatric disorders. As many as 20 percent of women and 10 percent of men will suffer an episode of depression at some point in their lives. At any given time, 5 to 10 percent of women and 3 percent of men are clinically depressed (Frances & First). It is estimated that four out of five cases of depression go undiagnosed and untreated(Surgeon General's Report). Unfortunately, most people suffer in silence and without help.

One of the most striking aspects of depression is that many people have little or no insight into the way in which it affects their self-perception as well as their perception of the past and the future. Every day may seem gray or black, turbulent, and dreary to someone with depression. Even worse, all previous sunny days may be forgotten and it appears that the dreariness will never change. Depression, in essence, may alter people's perceptions of themselves and the world around them, making things appear bleaker than they may be in reality. Related to this, people with serious depression are at risk for suicide even though they may have many real successes in their lives and many people around them who love and support them.

The various types of depression are listed below with accompanying symptoms. It is important to note that anyone can have one or two or three of these symptoms without being clinically depressed. The average stress and strain we all encounter cause the inevitable emotional aches and pains of everyday life. Depressive episodes go far beyond this. As with all types of mental disorder, many symptoms must occur in the same time period and be present for a specified length of time before a diagnosis of an illness or disorder is indicated.

**Acknowledgement**

Much of the material that follows on the description of different mental health problems is taken from the excellent and highly readable book, *Our Mental Health: The Lay Person's Guide to DSM-IV, the Psychiatrists' Bible,* by Richard Frances and Michael First, published by the American Psychiatric Association, 1997.

We all feel a little sad or depressed now and then. Sadness or grief is a normal reaction to losses in our lives. People who are experiencing grief may also experience lack of interest in things and sluggishness. What distinguishes this from clinical depression is the intensity of the symptoms (how severe they are) and the length of time the symptoms are present.

Events that trigger a depressed mood can take more or less recovery time. For example, it may take a day or two to bounce back from losing a ball game. If a person loses a job, it may take weeks to feel completely better. Sadness and mourning following the death of loved one may last for several months. With normal sadness, the sad feelings eventually pass. If a person doesn't recover, it's likely that they have a clinical condition known as Major Depressive Disorder and should see a doctor or counselor.

What follows is a description of the common mood disorders: Dysthymia, Major Depression, Bipolar Disorder and Post Partum Depression.

**Dysthymia or Chronic Mild Depression.** This type of depression is characterized by the ability to continue to function while sad most of the time. Dysthymia may be linked to an event but often there is no specific event to which its onset can be attributed. That is, there may not be an identifiable loss or life change. A person with Dysthymia may not be able to remember having felt better, and people around them may attribute their pessimism to their personality. Though symptoms are mild, they last for long amounts of time, even years. In order to be diagnosed woth Dysthymia, the feelings of sadness and/or lack of interest in life must be present for at least two years for adults, and one year for adolescents. The person also experiences several of the following symptoms in an ongoing way:

- low energy
- low self-esteem
- poor concentration or memory
- sleeping too much or too little
- appetite disturbabces (poor appetite or overeating),
- feelings of hopelessness or helplessness,
- in adolescents, irritability or feelings of anger

**Major Depressive Disorder (MDD)** In MDD, the symptoms listed above are experienced with more intensity and occur most every day over at least a two week period. Major Depression often causes intense despair and hopelessness so that the person loses interest in life and may not be able to get out of bed or eat for days at a time. Persons with Major Depression don't find pleasure in things that brought them pleasure in the past. Their child's laughter, for example, no longer makes them smile. They often report that they feel little or no sexual arousal. It is not unusual for the person to report overwhelming feelings of guilt.

Major Depression can occur without any clear cause or event. Because symptoms are so striking and extreme, this can sometimes be confusing and frustrating for the person affected and for his her loved ones. Often they cannot figure out what is wrong. A mojor risk that accompanies Major Depression is suicide. A significant number of people who have suffered from

Major Depression attempt suicide (NiMH 2001). Major Depression is a serious condition that requires professional help, especially if there is any indication of suicidal thoughts or feelings. Often, people with Major Depressive Disorder let others know when they are thinking about killing themselves. Take any talk of suicide very seriously. If you are service provider, call your supervisor or the person's doctor immediately (see "Suicide Assessment, "Appendix 1A below).

Often people with depression do not seek help because of the stigma associated with mental health problems. Family and friends may erroneously try to help by telling the depressed person to "just pull yourself together." A clinically depressed person needs medical atentiion; they are not able to telk themselves out of being depressed.

**Bipolar Disorder.** Another type of mood disorder is associated with episodes of depression alternating with episodes of euphoric or irritable mood. The ability to feel good, bad, or angry provides us with important information about our environment and how we should respond to it. Usually our emotions are responsive to our current circumstances in the real world. However, in Bipolar Disorder, the regulation of emotion is out of control. The human brain, usually reliable and stable, produces wildly fluctuating, unpredictable, and extreme mood states. The "highs" or periods of feeling jazzed up or hyperarousal are often accompanied by a dangerous combination of poor judgment, irritability, and feelings of superiority that can lead people to engage in wild or aggressive behaviors (excessive sexual adventures, spending sprees, etc.). Bipolar disorder is different from a person that is "moody" in that the mood fluctuations are extreme and can cause significant impairment in work and family life.

Bipolar Disorder is a very serious mental illness that needs to be treated with medications. It is not at all rare: estimates of its frequency in the general population range from 1 to 3 percent. The lifetime risk of suicide is significant (10 to 15 percent) and aggressive behavior in Bipolar Disorder is at least three times more common than in the general population.Since behaviors threatening to self and others are more likely during the first few years of the illness, early recognition and intervention is crucial (American Psychiatric Association).

**Post-Partum Depression.** This is a sub-type of Major Depression that can occur in women after childbirth. Hormonal changes as well as responsibilities involving caring for the new baby can be factors leading to postpartum depression in some women. Symptoms include those noted in the above section on Major Depressive Disorder and occur within four weeks after delivery. While temporary feelings of depression are common in new mothers, a full–blown depressive episode is not a normal response and requires treatment in order for for the mother to recover her physical and mental well-being and ability to care for her child.

## B. Anxiety Disorder

Depression and Bipolar Disorder are classified as "Mood Disorders" because they describe disruptions or imbalances in our moods or feelings. Another broad classification of mental health problems is "Anxiety Disorder" which refers to disturbances in the experience of fear or worry.

Responding to danger adaptively is probably the most basic of all survival skills. Anxiety is a normal part of a person's life, especially during times of stress, and in many situations it can actually be helpful. It can make one more alert and prepares the body for action. The presence of "worry" can be a great motivator. For example, worry may prompt one to prepare adequately for an upcoming exam, submit taxes on time, and save money for the future. These worries help focus attention and motivate behavior. Anxiety or fear, however, is not normal when it becomes so overwhelming as to interfere with a person's daily life, relationships and performance at work, school or family life. What are outlined next are some mental health problems that are classified as Anxiety Disorders. People with anxiety disorders have fears that occur for no reason at all or the fears occur out of proportion to any realistic danger.

**1. Generalized Anxiety Disorder (GAD)**

People with Generalized Anxiety Disorder (GAD) suffer with chronic, unrealistic, exaggerated or extreme anxiety. People with Generalized Anxiety Disorder are anxious most of the time. They often feel "shaky" or "on edge." People who have this disorder may think that danger is lurking around every corner, or worry a great deal about their health, money, family or work. The source of this worry is hard to find, and sometimes the thought of just getting through the day creates anxiety.

People with Generalized Anxiety Disorder can't seem to get rid of their worrying, even though they usually realize that they are more anxious than they should be. Their worries are wildly excessive, uncontrolled, misplaced, counterproductive, and interfere with their ability to handle life's problems effectively

Generalized Anxiety Disorder is not uncommon. The best estimate is that 3.4 percent, or approximately 4 million Americans suffer from GAD (NIMH, 2000).

**2. Panic Disorder**

Panic disorder is the experience of anxiety that results in near explosive attacks—sudden and terrifying bursts of both psychological and physical symptoms. Panic disorder is characterized by sudden feelings of terror and a fear that he or she is going crazy, losing control, or on the verge of death (First et al., 1998). People often think they are having a heart attack since symptoms include a pounding or racing heart, shortness of breath or trouble breathing, chest pain, excessive sweating and dizziness.

Panic attacks appear out of the blue, and many times the person cannot predict when they will happen. In between attacks the person constantly worries that another attack could happen any minute. If panic disorder is not treated it can become a very serious problem and can lead to disabling phobias or intense fears about objects, places, people or events. Especially common is agoraphobia, or a fear of being in open spaces, going out of the house, or being in crowds. In a desperate attempt to figure out what might be causing the attacks, people begin avoiding any situations or places that they think might be triggering the attacks. These fears and preoccupations place serious limits on a person's enjoyment of life. Unfortunately, many people do not realize that panic disorder is a disease, and they suffer in shame.

In the US, it is estimated that 1.6% of the population has Panic Disorder — between 3 and 6 million Americans. It is twice as common in women as in men (Surgeon General's Report).

**3. Post-Traumatic Stress Disorder (PTSD)**

When someone experiences an extremely traumatic event, long-lasting emotional and psychological effects can occur. These events could be something that threatened the person's life or the life of someone close to him or her, or it could be something that the person witnessed (like seeing someone violently assaulted or killed). Such traumatic experiences can result in a clinical condition known as Posttraumatic Stress Disorder (PTSD). Causes of PTSD include events that involve death or the threat of death or serious injury, or threats to a person's physical integrity such as child abuse, rape, combat, torture, car accidents, natural disasters (flood, fire), shootings, assaults or other extremely stressful events. The reaction to these events sometimes does not occur for weeks or even years after the actual event happened.

People with PTSD can show a range of reactions in response to horrible experiences. If a person's life is threatened, for example, the image of the event may be played over and over again in their minds and appear in dreams. If confronted with a similar situation, the person experiences overwhelming anxiety. The person attempts to stay far away from that type of danger or anything that reminds them of it. Another common way of dealing with traumatic events is to split the event off from conscious awareness, something known as dissociation. This serves the important function of protecting the person from the terror associated with the event(s).

Most people experience considerable distress and engage in avoidance behavior after being exposed to a severely traumatic experience. For people with PTSD, the emotional fallout of the traumatic or violent event is intense and stays with them a long time. The images and responses to the traumatic event can dominate day-to-day existence, no matter how much the person tries to blot out the terrifying memories and avoid anything connected with the event. For them, the world is experienced as unsafe. Symptoms of PTSD include:

- recurrent upsetting memories or nightmares
- flashbacks, a sudden feeling that the event is happening again
- feelings of emotional numbness, feeling detached from everyday life
- being jumpy, excessively vigilant or on guard
- trouble falling or staying asleep
- difficulty concentrating
- irritability, angry outbursts
- hopelessness, feeling like a normal life is not possible

These symptoms cause distress or problems in how the person functions in life, especially with regard to relationships with other people. Most people with PTSD feel alone, isolated and reluctant to discuss the trauma, which often results in a prolonged experience of symptoms. In order to attempt to recover from traumatic experiences, it is important for survivors to share their stories with mental health professionals. In a therapeutic environment, the person with PTSD is encouraged to re-experience the full range of painful feelings associated with the event(s) rather than avoiding situations that are reminders. Adequate support

for confronting the traumatic experience and processing the emotional consequences are part of the therapeutic treatment of PTSD.

Posttraumatic Stress Disorder can develop at any age, even in childhood, and sometimes persists throughout life. Rates of PTSD vary greatly in the general population (1 to 14 percent). PTSD is more common in communities characterized by high rates of poverty, crime and exposure to violence (Frances & First, 1998).

## C. Substance Abuse and Dependence (Alcohol and/or Drugs)

Another major classification of mental health problems is Substance Abuse Disorders. Our ancestors discovered a whole assortment of ingenious methods for producing alcohol and a number of other mood-altering drugs. Folk medicine offered alleviation of psychic or physical pain. Tinctures and herbs also offered recreation, relaxation, solace, and a way to enhance performance and sociability. Most people can occasionally enjoy the pleasurable effects of alcohol or drugs without becoming addicted or suffering significant negative consequences. A significant minority, however, cannot maintain an occasional, controlled relationship with these substances, and abuse or become dependent upon them.

People who abuse substances can't control their use of alcohol or drugs. They become intoxicated or high on a regular basis: daily, every weekend, or in binges. They often need alcohol or drugs to help them get through the day. They may try to stop using on a regular basis but fail, despite the fact that their alcohol or drug use interferes with their family life, social relationships and/or work performance, or that it adds to and/or causes a psychological or physical health problem.

People who have substance dependence have all the symptoms of abuse. In addition, they develop a tolerance for the drug, so that they need to take the drink or drug in greater and greater

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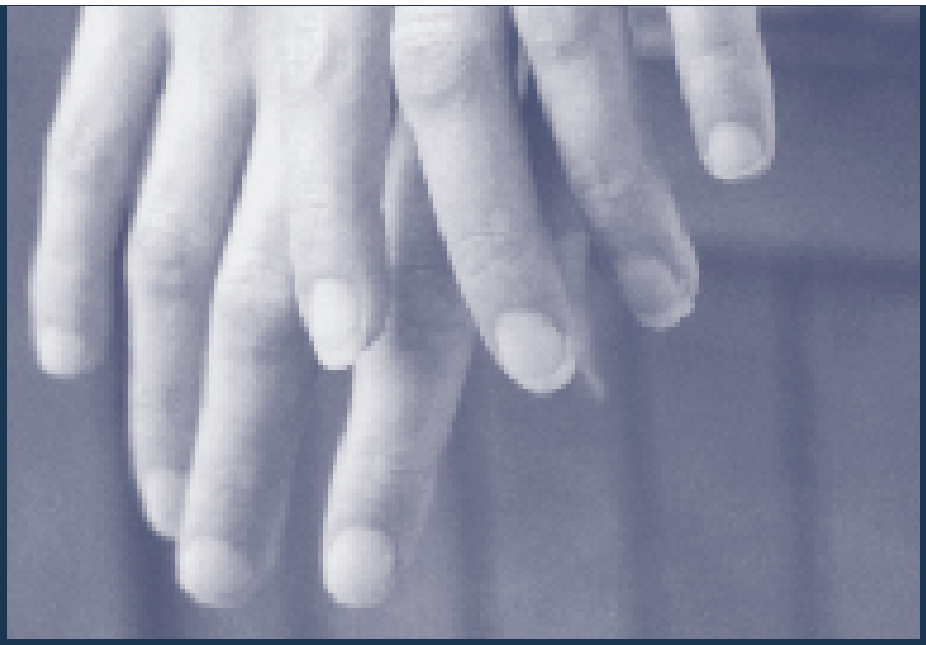


quantities to achieve the desired effect. They also become psychologically and, for some substances, physically dependent on the drug. Heroin and other opiates, alcohol, and amphetamines are drugs that lead to physical dependence, whereby users develop unpleasant physical withdrawal symptoms when they stop using the drug. The essence of psychological dependence is loss of control over one's drug use. Users give up almost all other sources of satisfaction and all of life centers on experiencing drug-induced feelings of pleasure or relaxation and avoiding the unpleasant feelings experienced when they don't have access to the drug.

Many researchers characterize addiction as a brain disease because there are differences in brain functioning when you compare addicted and non-addicted persons (NIJ, 1998). However, addiction is not just a brain disease but one that interacts with social and environmental factors. Clearly there are biological, behavioral, and social context elements that need to be taken into consideration in our attempts to understand and respond effectively to substance abuse disorders.

Substance dependence usually lasts for many years with recurring relapses and remissions. However, recovery is a realistic and attainable goal. It is important to keep in mind that the cyclical up-and-down course of substance dependence is not really different from the course of most other chronic illness. In diabetes and hypertension, for example, there are also alternating episodes of greater and lesser control and an occasional relapse. Alcohol dependence or alcoholism is one of the most common medical illnesses seen by doctors (American Medical Association, 2000). Nearly 14 million people in the United States, or 1 in every 13 adults, abuse alcohol or are alcoholics (National Institute on Alcohol Abuse and Alcoholism, 2000). Substance abuse is less common. However, the consequences for individual users can be even greater due to the illegality of substances (such as heroin, cocaine, crack, methamphetamines) and the risk of serious diseases including HIV/AIDS and hepatitis which are associated with injection drug use and with exchanging sex for drugs.

*People living with HIV/AIDS often face other difficulties as well, including poverty, racially and ethnically based discrimination, drug addiction, and the need to manage illness while caring for children.*

## D. Psychotic Disorders/Psychoses

A fundamental aspect of normal mental functioning is the ability to distinguish between inner thoughts from the stimuli that come from the outside world. This ongoing process is called "reality testing." Most of us maintain a fairly strong grasp on reality, except when we dream at night or if we take a psychedelic drug. In contrast, a person who has a psychotic disorder has lost the ability to distinguish fact from fantasy, reality from imagination, and internal fears from actual threats. Psychotic Disorders (also known as Psychoses) are extreme mental disturbances that involve an actual break with reality. It is important to remember that temporary psychosis can occur as the result of serious medical illness or intoxication. For example, a person who has ingested large amounts of cocaine may develop psychotic symptoms for a brief period of time.

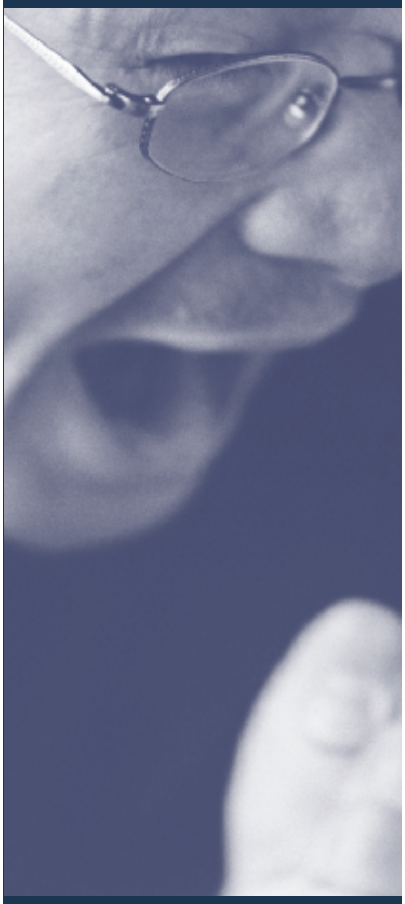
**Schizophrenia.** The most well known psychotic disorder is Schizophrenia. Schizophrenia is a brain disease that has a genetic component (family members have a higher risk than the general population). This is a type of psychotic disorder that causes severe problems in thinking, feeling, and behavior. People with Schizophrenia also have trouble relating to other people, communicating through language, controlling their emotions, and making everyday decisions. Schizophrenia is a word used to describe a complicated psychotic process that is often chronic in nature. It is the most severe and disabling of the major mental illnesses. A person with "chronic schizophrenia" often does not fully recover to normal functioning. This person needs long-term treatment in most cases and almost always requires medications to control the symptoms. Schizophrenia affects approximately two million Americans, or almost one percent (1%) of the entire U.S. population (NIMH, 2001)).

Symptoms of Schizophrenia are:

- normal functioning until first episode which is usually in late teens or early adulthood;
- significant decline in adaptive functioning (ability to care for oneself);
- lack of motivation and ability to organize self;
- speech that is disorganized and hard to follow;
- poverty of speech (lack of content);
- blunted affect - limited expression of emotion, the person becomes " robot-like;"
- behavior that doesn't make sense (i.e., excessive collecting of objects, wearing clothes that are inappropriate for weather conditions);
- psychotic symptoms such as delusions and hallucinations.

**Delusions.** These are fixed beliefs that are false and bizarre and that usually involve distortions or misinterpretations of perceptions or experiences. There are several types of delusions:

- A person with a persecutory delusion might believe that he or she is being followed, spied on, tricked, tortured, or subjected to ridicule. For example, a man is convinced that a neighbor is out to control his behavior by implanting a computer in his brain.
- A person with a referential delusion believes that other people's gestures, comments, even song lyrics and newspaper headlines are specifically directed at him or her. For example, a young woman is convinced that the words on street signs are a secret message to her.



*Often people who have symptom of mental health problems don't recognize them as symptoms of a treatable disorder.*

- A person with a grandiose delusions believe they have extraordinary power, fame or religious significance. For example, a man in his 30s is convinced that he is Jesus Christ sent to save the world from sin.

The essential feature is that the delusions are clearly implausible, and do not derive from ordinary life experiences. For example, delusions that express a person's brain or body being taken over (e.g., that one's brain has been removed and replaced by another person's) or that one's movements or thoughts are being controlled by forces outside oneself (e.g., by aliens) are usually judged to be bizarre. Delusions are strongly held despite overwhelming evidence to the contrary. The man insists on the absolute certainty of the computer in his brain despite repeated negative X-rays, "I know it's there…he is using X-ray proof metal to hide it!" (First et al., 1998).

**Hallucinations.** These are distortions or exaggerations of perceptions and may occur in any sensory modality, (i.e., the person hears, sees, smells, or touches things that are not really there, such as hearing voices or seeing shadows). Auditory hallucinations are the most common. Hearing a voice keeping a running commentary on a person's behavior or thoughts, or hearing two or more voices talking with one another, is characteristic of schizophrenia. Auditory hallucinations are experienced as genuine sounds coming from outside the person's head. The most disturbing are "command hallucinations" or voices that issue direct commands that the person is to follow, often telling the person to perform aggressive or self-destructive acts, such as "jump out of the window."

## E. Co-Occurrence of Mental Illness and Drug Use/Dependence

Many individuals who have mental health problems such as depression, anxiety, or even schizophrenia, also abuse drugs or alcohol. For example, between one half and two thirds of patients with Bipolar Disorder abuse drugs—most typically alcohol, cocaine, or amphetamines[12]. Substance abuse is so regularly found among individuals with Posttraumatic Stress Disorder that they are considered associated conditions. The clear pattern of co-occurrence of mental disorder and substance abuse suggests that some individuals use street drugs to "self-medicate"—to help lessen the distressing symptoms of mental disorder. Even the ancient Greeks observed that "people drink to alleviate fear and terror." Unfortunately, people who use substances to feel better often end up with psychiatric symptoms that make them feel much worse. Drug use and depression, anxiety and even psychotic symptoms influence one another. For example, an episode of depression may cause or increase drug or alcohol use, and withdrawal from drugs can cause depression and anxiety.

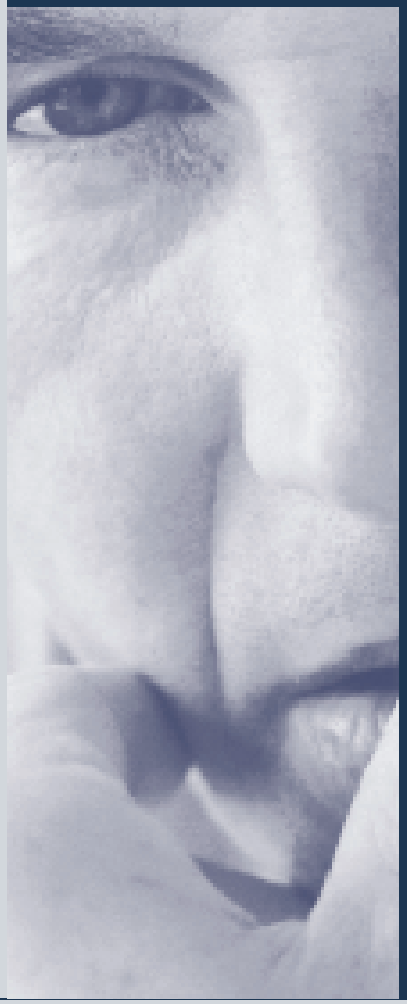
As discussed in the next section, depression, anxiety disorders, and substance abuse disorders are unfortunately relatively common among persons living with HIV/AIDS. Schizophrenia is less common, but we see higher rates among the HIV-positive population than the general U.S. population.

# III Mental Health Problems Among Persons Living with HIV/AIDS

The stress factors of living with a chronic, unpredictable, and potentially terminal illness such as HIV/AIDS would present a challenge even to those with an abundance of resources. However, people living with HIV/AIDS often face other difficulties as well, including poverty, racially and ethnically based discrimination, drug addiction, and managing illness while caring for children. The combination of these factors provide the backdrop for a group of people with significant mental health needs, and a group whose mental health needs were generally poorly served prior to their becoming HIV-infected.

Studies of the populations affected by HIV/AIDS reveal high rates of depressive and anxiety disorders. Psychiatric and emotional problems are particularly prominent among those HIV-infected individuals with co-occurring substance use disorders. Additionally, the growing number of HIV-infected women must cope not only with their own problems but with the mental health problems of their children and families (Havens et al., 1996).

While considerable progress has been made toward increasing access to the health care system for HIV-infected individuals, significant limitations and barriers remain in accessing needed mental health care. These obstacles, which can be separated into client-based factors and provider-based factors, contribute to reducing the accessibility to mental health treatment. Mental health problems, when untreated, have a number of negative impacts. They cause significant suffering, make it harder for people to function on a day-to-day basis, and can interfere with a person's ability to care for themselves and their family. Mental health problems can also pose barriers to medical treatment access and adherence to treatment regimens, which can make it difficult for people to benefit from the significant advances in HIV medical treatment. (See U.S. Department of Health and Human Services, Mental Health Care for People Living with or Affected by HIV/AIDS.)



# IV Under-Recognition of Mental Health Problems

## Client Factors

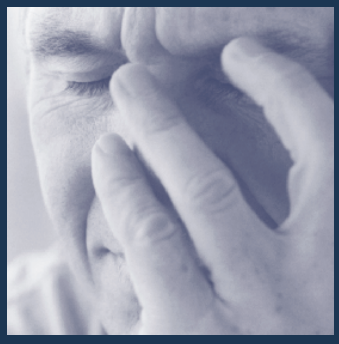
There are many factors underlying client lack of recognition or acknowledgment of mental health problems. A basic issue is confusion about what constitutes a mental health problem. Some of the problems confronting persons living with HIV are reasonable and normal reactions to having a chronic illness, such as anxiety about the next episode of sickness or sadness over losses. Other problems are specific to HIV disease itself, such as the shock of learning one's HIV serostatus or the fear of disclosure. Struggling with problems associated with inadequate basic resources like food or housing can be quite distressing and depressing. In general, the feelings associated with these issues can be handled by supportive interventions, utilizing case management services and becoming educated about HIV and its medical management.

However, more serious mental health problems that occur in HIV-infected people require specialized mental health services. The most common among these are depression and anxiety disorders. As discussed, major depression is a serious illness that affects one's ability to concentrate and to function on a day-to-day basis. Prolonged disturbance in sleeping and eating can interact with negative thought patterns and result in feelings of hopelessness and thoughts of suicide. Severe life traumas can lead to immobilizing fears and recurring flashbacks of the traumatic event. Often people who have symptoms of mental health problems don't recognize them as symptoms of a treatable disorder.

Despite the remarkable advances over the last two decades in the understanding and treatment of depression and anxiety disorders, stigma and lack of knowledge about these conditions are pervasive. Even when recognized and labeled, symptoms of depression and anxiety are often construed as character flaws or personal weakness, rather than an illness. In the most extreme form of stigma, people resist seeking care from mental health professionals for fear that they will be labeled crazy.

Difficulties with mental illness symptom recognition is even more complex in individuals who are also using drugs. Often these people do not recognize the role that mental health problems have played in their drug use until they have entered and maintained recovery for a prolonged period of time.

The Community Health Advisory & Information Network (CHAIN) project is an ongoing scientific study of the needs and service utilization of HIV-infected New York City residents (see box). Although the study used a random sample of people receiving non-mental health services (health and case management), more than 80 percent of the participants manifested some need for mental health services. On a scale assessing symptoms of depression and anxiety, more than half (54 percent) of respondents scored below the point indicating clinically relevant symptomatology, and 39 percent scored below the low-low cut point typically found



The Community Health Advisory & Information Network (CHAIN) project is an ongoing longitudinal study of over 900 HIV-infected individuals in New York City. Funded by Ryan White CARE Act Title I as part of New York City's evaluation of HIV service needs and utilization, the CHAIN study conducts interviews every six to 12 months with a representative sample of men and women living with HIV/AIDS. Embedded in the questionnaire are standardized scales that assess their emotional and psychological symptoms (the MOS SF-36 Mental Component Summary Scale), their levels of drug use, and their self-perception of the need for help with emotional/psychological problems and/or drug use. A sub-study of the CHAIN Project examines the needs and service utilization of a group of HIV-infected people who are unconnected to service—those with no regular source of medical care or case management.

among populations of psychiatric patients. One quarter of the sample who scored low on the mental health measure also have recent history of probable alcohol or drug abuse or dependence (the "dually diagnosed").

However, large numbers of CHAIN study respondents who manifested the need for mental health services are not receiving them. Almost half (46 percent) of individuals with low scores on the mental health measure were receiving no mental health services at all. The gap between service need and utilization appears greatest for ethnic minority clients.

The most striking difference between those who do and do not access mental health services is the self-perception of their emotional or psychological problems and/or the need for or benefit of mental health treatment in addressing those problems. Although clients not receiving mental health services could acknowledge problems, they did not acknowledge a need or desire for mental health treatment ("I'd like to talk to someone but not like a therapist or anything."). Additionally, almost 40 percent of clients who scored in the low range—indicating a need for mental health services—responded "No" or "None" to direct questions about emotional problems or the need for mental health services.

Particularly troubling are the results of the sub-study that focuses on people outside the service system. Participants who are not connected to the HIV care system have the highest need for both mental health and drug treatment services, as indicated by their interview responses. However, less than 10 percent of these respondents who have a need for mental health services are receiving these services. The "unconnected" are the least likely to identify their need for mental health services and thus under-utilize services designated for those with psychological problems. (For further information about the CHAIN Study, see Aidala et al., 1999; Aidala, 1997.)

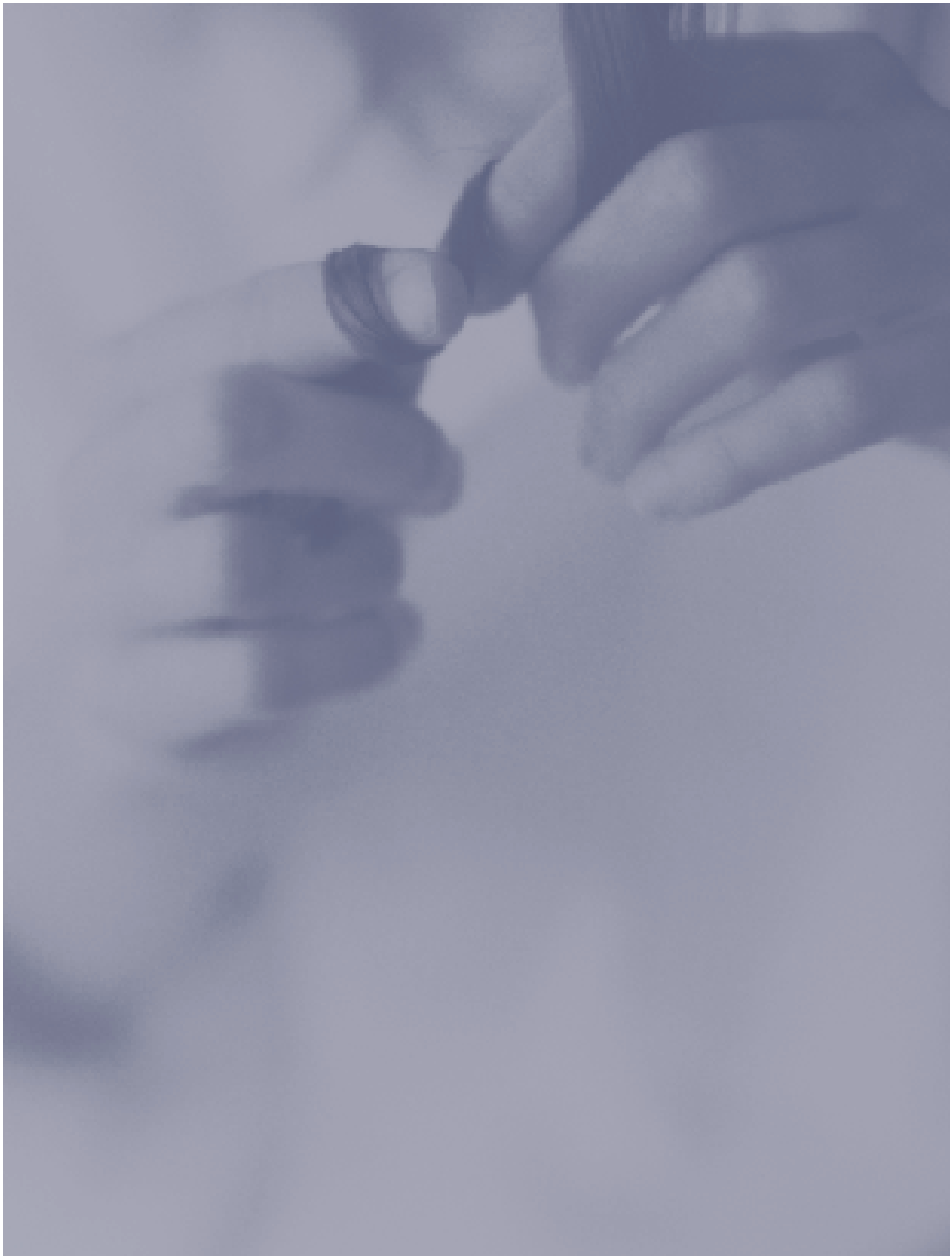
## Provider Factors

Client under-recognition of mental health problems is reinforced when their HIV care providers lack the tools, the time or motivation to adequately assess their mental health needs. The most common contexts within which people with HIV receive care include medical and social service settings. In order to provide adequate medical services, the mental health needs must also be determined and addressed both upon entry into the care system and throughout the course of the disease.

However, there are few guidelines and standards for primary care providers to follow regarding mental health assessment and treatment of mental health problems. Many medical clinicians rely on the psychosocial providers working in their agencies to meet these needs, although these providers are often overburdened and under-trained. However, the primary care provider is often in the best position to assess, and, when appropriate, manage these mental health needs, particularly in areas where access to mental health professionals is limited.

A similar lack of guidelines and standards plagues the social service delivery system. Case management is an important and widely available component of the assessment and coordination of HIV-related services. While the assessment of psychosocial service needs is considered a routine part of the case management function, again there are minimal guidelines for or training in the systematic assessment of client's mental health needs. One screening method often utilized in these settings includes collecting information regarding the client's reported history of treatment and/or hospitalization. This is problematic in the sense that many people who are in need of mental health services do not access them. In fact a report issued by Dr. David Satcher, Surgeon General of the United States, indicates that more than half of those who need treatment for mental health problems do not receive treatment (Report of the Surgeon General, 1999).

As with primary care providers, case managers vary enormously in their capacity to assess the signs and symptoms of mental health disorders so without the appropriate tools to guide providers in their assessments, the outcome is often less than optimal.



## V The Need for Systematic Screening Methodologies

Given both client and provider barriers to the appropriate recognition and assessment of mental health problems, we believe it is essential to use a screening instrument that guides staff (especially non-mental health providers) in assessing the mental health needs of HIV-infected clients. These screening tools provide a baseline assessment of mental health functioning and indicate which clients need additional mental health services, either further assessment or direct referral for treatment.

In general, there are two different commonly used methodologies for mental health screening. The first approach involves the collection of data related to symptoms of mental health distress (most commonly symptoms of depression or anxiety) using self-reports or interview-administered questionnaires. The total number of reported symptoms is generally used to indicate whether a respondent does or does not meet the definition of a particular concern. For example, the Hamilton Depression Scale uses questions that relate to specific symptoms of depression. The client's answers to the questions are assessed and summarized, and a particular cut-off score indicates someone who may have more serious or clinical depression.

The second option involves the use of brief instruments that collect data in symptom clusters that are organized to yield, with scoring, the likelihood of a particular diagnosis. These instruments usually ask about the presence of symptoms relevant to the diagnosis that occur within a specified period of time. These screeners utilize the diagnostic criteria specified by the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, the standard diagnostic schema used by mental health professionals in the United States (American Psychiatric Association, 1994). Most commonly, these screeners assess for depressive disorders, anxiety disorders, and alcohol and substance abuse disorders.

The second approach is preferable to the first, for the following reasons. Statistically, screeners that yield data relevant to diagnosis provide more power to describe the mental health needs of the evaluated population. In addition, these screeners are much more useful as a clinical tool in that they more provide a more precise description of the mental health treatment needs of the client and can play a role in referral and treatment planning.

A diagnostic screener such as the CDQ assists the provider in more precisely identifying a clients' service and treatment needs. For example, a client with clinical depression is different from a client who feels depressed (perhaps due to a recent death of a loved one). One client might require treatment by a psychiatrist and/or a psychologist while the other would be well served by supportive counseling by a social worker or by participating in a support group. Use of the CDQ will allow programs to allocate what are often scarce resources to the neediest clients, and/or identify where links with other agencies may be required.

# VI History and Development of The Client Diagnostic Questionnaire (CDQ)

## History

The Client Diagnostic Questionnaire is a brief, structured interview used to screen for the existence of mental health problems in persons living with HIV/AIDS. The CDQ is based on the Patient Health Questionnaire (PHQ) version of the PRIME-MD, a mental health tool developed for use in primary care settings by a team of experts in psychiatric assessment led by Robert Spitzer[16]. The CDQ collects data in symptom clusters that are organized to yield the likelihood of a particular diagnosis. The screener follows diagnostic criteria specified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which, as mentioned previously, is the standard diagnostic schema used by mental health professionals in the United States.

The original PHQ screened for depression, panic, and other anxiety disorders, alcohol abuse, and somatoform and eating disorders. Revisions were necessary in both the range of disorders addressed, and the language used in asking symptom questions in order to create a screening tool appropriate for use with HIV-infected populations. The Columbia University Evaluation and Technical Assistance Center (ETAC), funded by HRSA to support the Special Projects of National Significance (SPNS) Program, undertook the adaptation. Modules have been added to screen for drug abuse, post-traumatic stress disorder, and psychosis, disorders frequently seen in HIV-infected populations. Somatoform and eating disorders were dropped. In addition to alcohol and substance abuse questions referring to the past six months, the ETAC/ CDQ also asks about use in the past 30 days, a format consistent with the Addiction Severity Index[17], an assessment tool widely used by substance use treatment facilities. Revisions were made in consultation with the developers of the original instrument. Additional modules were based upon existing work done in developing screening questionnaires for drug abuse, PTSD and psychosis.

### Empirical Support for the Instrument

A large validation study provided data on the PRIME-MD, which is the basis for the CDQ. (Spitzer et al. 1994) reported on the validation of this instrument for use by primary care physicians on a sample of 1000 adults in a range of primary care settings. Outcome measures included the diagnoses yielded by the PRIME-MD, independent diagnoses made by mental health professionals, and correlations between the PRIME-MD and other self-report standardized measures of mental health, including the Zung Depression Scale, and the Zung Anxiety Scale. In addition, functional status measures were examined including the number of disability days, health care utilization and treatment/referral decisions. Results indicated good agreement between Prime-MD diagnoses and those of independent mental health professionals (the overall accuracy rate = 88 percent). Patients with PRIME-MD diagnoses had lower functioning, more disability days, and higher rates of health care utilization than did patients without PRIME-MD diagnoses (for all measures, $P<.005$). With respect to the relationship of the PRIME-MD Diagnosis to Symptom Severity Measures, the partial correlation between the scores on inventories and the corresponding PRIME-MD diagnosis were are all highly significant ($P<.001$).

The study also reported that physicians found information provided by the instrument useful, and that a new treatment or referral was initiated for 62 percent of the patients with a PRIME-MD diagnosis who were not already being treated. Patients reported that they felt the information provided by the questionnaire was valuable in helping their physicians better understand and treat their problems.

The sample for this validation study included patients in primary care settings across the U.S. This sample of patients typically seen in doctors' offices were more often white, better educated, better integrated into medical care, and less often substance involved than clients seen in HIV/AIDS clinics or service settings. In addition, adjustments in the original modular structure of the PRIME-MD were made so that the CDQ reflects disorders commonly found in HIV-infected populations. Thus, it is necessary to conduct a separate validation study to examine the reliability and validity of the CDQ for screening HIV- infected populations.

## CDQ Validation Study

On the basis of this early promise, HRSA has funded a multi-site, formal validation study for the CDQ that is currently in progress (Aidala et al., 1998). The methodology will follow the protocol used by the original developers of the PRIME-MD and PHQ instruments in establishing the reliability and validity of the instrument in terms of sensitivity, specificity, and positive predictive value in screening for mental disorders.

This is an instrument validation study using a cross-sectional sample cohort of HIV-infected individuals. Data are being collected through personal, face-to-face interviews. An initial interview, using the structured CDQ, is conducted by a lay interviewer (i.e. personnel who have not received formal training in mental health assessment and treatment such as a case manager or intake worker) as part of the normal, routine flow of care/services. Additional information (demographics, health status/quality of life, and mental health services/treatment utilization) will also be obtained. A second, study-specific interview is then conducted within three days of the initial interview by an experienced mental health clinician (i.e., psychiatrist, psychologist, or clinical social worker). This interview uses a semi-structured version of the CDQ that includes an overview, questions about rule-outs, and guidelines about probing to uncover symptoms not revealed by the more structured and limited CDQ.

Clients presenting to the study sites for services who meet the inclusion criteria will be eligible for participation in this study. The inclusion criteria are: (1) confirmed HIV seropositivity; (2) age 18 or older, and (3) conversant in English. Subjects will be excluded from participation in this study if they do not meet the inclusion criteria, have a medical or mental condition that does not permit the interviews, or do not consent to participation. The study cohort is comprised of 300 clients who have been recruited from both primary care clinics and HIV service organizations located in New York City, Baltimore, Miami, Los Angeles, Birmingham, and Durham.

Preliminary results of the validation study suggest that the CDQ instrument performs well as a triage instrument, directing attention to clients with clinically relevant symptoms that cohere

in a pattern consistent with diagnosed disorders. Several measures were used to test the agreement between the diagnosis made by the experienced mental health clinician and screening result of the CDQ used by a non mental health professional. "Sensitivity" refers to the proportion of cases diagnosed with disorder by the mental health professional that were correctly identified by the screener. This statistic checks for the danger of false negatives – the danger that a person with a clinically significant mental health problem would pass though the screening process unidentified. The sensitivity for "Any Diagnosis "including alcohol or drug abuse or dependence is 91%. This means that over 90% of who do in fact have a psychciatric disorder would be detected by use of the CDQ as a screening tool.

With regard to feasibility, the instrument has been well received by staff and clients at all service sites. Most screenings are completed in 20 minutes or less, and there have been very few reports of clients becoming emotionally distraught or wanting to discontinue the screening. In the validation study, only 2%, or approximately 1 in 50 clients screened were rated by interviewers as uncomfortable or at all upset by answering the screening questions. Far more individuals expressed their appreciation that the interview allowed them to talk about emotional issues that were of concern to them.

The next section discusses the CDQ in detail, with specific instructions for administering the instrument, followed by a section containing a copy of the CDQ itself.

# VII Administering the CDQ: Question-by-Question Review

## Introduction

The Client Diagnostic Questionnaire (CDQ) is a structured interview designed to facilitate the recognition of the most common mental disorders presenting in clients who are living with HIV/AIDS. These include depression, anxiety disorders, post-traumatic stress disorder, and alcohol and other drug use disorders. Instructions to the interviewer appear in italics inside a box. Questions asked by the interviewer are in plain type. Read all questions as written. Additional probes may be used to ensure client understanding of the item and to explore ambiguous responses. If after using probing questions, the interviewer is still unsure how to mark the questionnaire, write out exactly what the respondent said in the space provided or in the margin of the questionnaire. Each diagnostic module begins with initial screening questions. Within each module, proceed sequentially from question to question unless instructed either to skip to another question or to go to the next page. At the end of each diagnostic module (at the bottom of the page) is a shaded area with instructions indicating the criteria for positive screen for the disorder. Scoring is done after the entire interview is completed, and it is recorded on the CDQ summary sheet. Space is provided throughout the questionnaire for additional notes or observations.

**Beginning the Interview.** Begin the interview by introducing yourself and confirming the identity of the client as indicated on the CDQ cover sheet. Next, briefly explain the context of the interview and thank the client for his or her participation. The following points should be made: (1) The questionnaire will help create a better understanding of the issues and difficulties often faced by people living with HIV/AIDS. (2) It is important to try to answer every question. (3) All answers are completely confidential; information is shared only with individuals who are helping the client get the services he or she needs. Studies have shown that giving a brief introduction, explaining the purpose of the questions, and assuring the confidentiality of the answers will increase respondent willingness to answer truthfully.

Be careful NOT to make reference to mental health problems or the need for mental health treatment unless the client uses this terminology.

**Overview.** The purpose of the overview is to begin to get a sense of the respondent's mental health functioning over the past six months, before inquiring systematically about specific symptoms in the later modules. These questions help develop rapport with respondents as they discuss their lives in their own terms, before they are asked what may be more difficult questions. The overview also provides information about any past disorder likely to affect current functioning. Ask each question and pause where indicated to let the client answer before going on to the next question.

Listen carefully to this introductory material, but do not probe for details at this time. The overview is meant to be a brief introduction, not the basis for your screening assessment. All questions in the questionnaire must be asked, even though the topic was discussed in the overview. When you come to an area of questioning for which you may already have some information (e.g., recent depressed mood), confirm your understanding of the information and let the respondent correct you, if necessary. Never score an item based on your recollection of what a client has already described. Ask the question while acknowledging that it relates to issues already discussed: "You were telling me before about feeling jittery and nervous recently. In the past four weeks, how often have you been bothered by feeling nervous, anxious, on edge or worried about different things? Would you say not at all, several days, more than half the days, or nearly every day?"

**Time Structuring.** The reliability and validity of the information obtained when using the CDQ depends on knowing not only that certain events occurred in a person's life, but also when they occurred. To diagnose an episode of a disorder, you must always be certain of the time frame a respondent is using when he or she is reporting symptoms related to that disorder. Thus, one of your jobs as an interviewer is to help respondents remember when events or symptoms occurred in their lives.

The CDQ provides a specific time reference for the overview and for each diagnostic module, and you must direct the respondent's attention to the appropriate time period. Often respondents do not pay close attention to a change in the relevant time period (ever, past six months, past four weeks, etc.), or they say they don't know when something took place. By using effective probes and supplemental clarifying questions, you can help the subject narrow the time range during which an event or symptom might have occurred.

Before the start of an interview, calculate the six-month reference date (i.e., six months prior to the date of the interview) and use this in framing the reporting period for the overview, alcohol and drug abuse/ dependence, and PTSD symptoms. For example, you might say, "During the past six months, that is, around the middle November." For depression, panic, anxiety, alcohol or drug abuse, the time period is *the past 30 days*, and for psychosis screens, the screening period is *the past four weeks or 30 days*. To clarify the time frame, you might refer to events that are relevant to the respondent (holidays, birthdays or anniversaries, a particularly positive or negative personal event, etc.) to help structure the respondent's recall.

**Asking Questions and Probing.** The CDQ is a semi-structured instrument. Questions are designed to systematically elicit information about symptoms relevant to clinical diagnoses following DSM-IV criteria. You must read the symptom questions exactly as written including answer categories, where appropriate. Allow the respondent to answer, and then code appropriately. However, remember that you are coding whether a symptom criterion is present or absent. You are *not* coding your respondent's literal answers to questions. For instance, you ask Sally if she has been bothered by concentrating on things such as reading the newspaper, watching television, or listening to somebody give you directions, and she

answers "Not at all—I never read the newspaper and I don't have a TV." In this case, you may have to ask more questions to determine whether a diagnostic criterion is met.

When probing, ask specific questions to clarify ambiguous responses, perhaps paraphrasing the wording of the criterion to make the concept understandable to the respondent, or giving different examples more relevant to his or her situation. For example, say to Sally: "What about other things that take some concentration or focus, like listening to somebody give directions about how to get somewhere, or telling you how to take your pills the night way?" Avoid probes such as, "Tell me more about that." This kind of probe allows for and may encourage rambling digressions. The data you need to collect is highly specific. The goal is to determine whether a symptom occurred within the appropriate time period and its persistence over time.

You may also need to probe to assist the respondent in answering within the response categories given. If the respondent gives an answer that does not fit clearly into one and only one response category (e.g., he or she answers "sometimes" when that is not a possible answer choice), then probe using the answer categories: "Would that be several days, more than half the days or nearly every day in the past four weeks?" Read the two or three response categories closest to the answer the respondent gave. If it is not clear which responses are close, read all answer categories.

NEVER choose an answer category for a client based on what you think they have already said or what you think they mean by their spoken response.

**Inconsistencies and Contradictions.** It is extremely important to listen very carefully, to remember what your respondent tells you, and to be alert to inconsistencies or contradictions. Sometimes respondents will answer quickly without hearing the entirety of your question or probe. Sometimes they do not understand the question. Sometimes they are deliberately attempting to deny or minimize problems or socially undesirable behaviors. Sometimes they may not be aware of their denial. For example, during the overview, Bill told you about a period of severe depression, and when describing this time, he says it was so hard for him to keep his mind on things that he could not watch his favorite television show for the entire episode. Then during symptom review for major depression, you ask if he has "trouble concentrating on things," and he answers: "No, not at all."

You should probe inconsistent or contradictory information; however, you must be careful not to make the client feel threatened by your questioning of an apparent inaccuracy. The best technique is to communicate that you would like to clarify what could be a misunderstanding. For example, you might say "I might have misunderstood your response to an earlier question, when you said...." The key is that you communicate the importance of collecting accurate information. Also, your probe lets the client know you are listening very closely to what he or she is saying.

Begin by simply repeating both the question and the subject's answer and pausing, allowing them to correct you or add some clarification: "So I asked if you had difficulty concentrating or keeping your mind on things, and you said not at all...." This approach usually takes care of problems that arise from the subject's not hearing or understanding the exact question asked. If an inconsistency remains, point it out as possibly your problem: "Perhaps I didn't understand what you said before. I thought you said that during this time, it was so hard for you to concentrate on anything, and that you could not even pay attention to your favorite television show for the entire program." In this way you give the respondent a more focused opportunity to listen to the question again, with the help of your clarifying probe.

If the respondent has denied or misrepresented his or her problems, by questioning your accuracy rather than his or hers, you are providing a relatively non-threatening vehicle for him to correct himself or retract statements: "Well, I have had some difficulties concentrating—but it was not like I could not do my job or anything...."

**Scoring the Instrument.** The CDQ summary sheet is scored according to the instructions printed in the shaded area at the bottom of the last page of each diagnostic module. Space is provided to record any information concerning possible rule outs (e.g., symptoms due to medical illness or a particular medication being taken for a medical problem), past episodes, and/or treatment history. Interviewers without formal mental health training are not expected to probe for this information. However, it may come up during your discussion of symptoms and treatment history. If it does, please record it.

## Diagnostic Modules

**Depression.** Initial questions are designed to determine whether the respondent has had a period of depressed mood and/or loss of interest in activities within the past month (four weeks) or had an earlier onset but persisted into the past month. However, a period of two weeks' duration is necessary to meet the criteria for diagnosis.

**Common Pitfalls**. Be sure the respondent is focused on symptoms occurring within the past four weeks. Answers must be coded within the categories given: "No, not at all," "Several days," "More than half the days," "Nearly every day." If the respondent gives an answer such as "sometimes" or "often," you must probe to help him or her answer within the categories provided.

Many symptoms are indicated by opposite behavioral manifestations. Sleeping, for example, is a symptom if it is too much or too little, as evidenced by the questions: "Trouble falling or staying asleep?" Or "Sleeping too much?" Pause after asking the first question and allow the client to answer. Be sure to ask the second part of the question even if the respondent has answered "Not at all" to the first part.

**Question 8.** This question should be scored positive when the respondent indicates feelings of worthlessness or excessive or inappropriate guilt, not just feeling bad about oneself or experiencing reasonable levels of guilt for past behaviors (e.g., continuing to use drugs, infecting partner with HIV).

**Question 9**. Question 9 often needs probing or rephrasing for respondents who never read newspapers or watch television. It is usually helpful to ask about respondents' difficulties focusing, paying attention, or keeping their mind on things. It may also help to give examples from their current situation (e.g. paying attention to the doctor or the case manager).

**Question 11.** This question concerns immediate danger or risk to the client. It is unlikely that a respondent will present an immediate suicidal risk. Remember that the subjects with whom you speak are "together" enough to schedule and keep their appointment for an interview. However, if you have any concerns, a supervisor should be notified immediately upon termination of the interview, and agency protocol should be followed. (See Guidelines for Suicide Assessment, Appendix A.)

**Panic Disorder**. The period of time asked about for the initial screening question is the past four weeks. You are asking whether or not the client has experienced a panic attack during this time period. However, Question 2 asks "Has this ever happened before?" This question refers to the client's lifetime, not just the prior month's experience. Similarly, the "last really bad attack" does not have to have been within the past month.

**Common Pitfalls**. Respondents may not understand the word "anxiety." Terms such as "feeling fear," "feeling terror," or "being really frightened" are useful paraphrases. The term "panic attack" is often used incorrectly to describe any escalating anxiety. The defining characteristic of a panic attack is the sudden and intense onset of symptoms, not in response to a real threat. Make sure the respondent is focusing on a single specific attack when answering questions about symptoms.

To meet criteria for panic disorder, at least two attacks must have been unexpected, which can be complicated because patients commonly believe the situations in which the attacks developed actually caused the attacks, and thus the attacks were not unexpected. Probing may be necessary to rate Question 3 correctly. Ask if attacks happen in situations that other people would not usually find frightening.

**Question 4.** Ask as two separate questions: Do these attacks bother you a lot? Are you worried about having another attack? Score symptoms present if "yes" to either question.

**Other Anxiety Disorders.** The initial screening question and all symptom questions refer to symptoms present over the last four weeks. Answers are scored using frequency codes: "Not at all," "Several days," "More than half the days," "Nearly every day." If respondent answers "sometimes" or "often," you must probe to help him or her answer within the categories provided.

**Common Pitfalls**. Question 5, sleep disturbance, is indicated only by trouble falling or staying asleep. Unlike depression, the opposite manifestation (sleeping too much) is not a symptom for this disorder.

**Question 6**. This question often needs probing or rephrasing for respondents who never read newspapers or watch television. It is helpful to ask about difficulties focusing, paying attention, or keeping their mind on things. Giving examples from their current situation is also helpful.

**Alcohol Abuse/Dependence**. It is important to give a brief introduction to this section. The following points must be made:

- Next are some questions about drinking alcohol and use of other substances.
- These questions are asked as part of everyone's health profile.
- Everything the client says is strictly confidential and protected and would only be used to help them get the services they need. (Do not belabor the issue of confidentiality. It is supposed to be a reminder, not to raise concerns where perhaps there were none before.)

Initial screening questions for alcohol abuse/dependence concern the *frequency* of drinking (how often) as well as the *quantity* (number of drinks per day on days alcohol was consumed). Respondents often minimize their alcohol consumption; thus symptom questions are asked of everyone who has had *any alcohol at all* during the past six months. Note that initial symptom questions require that the experience has happened more than one time in the preceding six-month period. However, both pattern of use and symptom questions are repeated with a focus on the past 30 days. As the interviewer, you must help respondents answer questions for the appropriate time period. If a respondent's answer falls between two response categories, code up, e.g., "Between 3 and 4 beers" is coded "4."

**Common Pitfalls**. Note that there is the same amount of alcohol in a 12 oz can of beer, a glass of wine, or a mixed drink of hard liquor; however, "jumbos" or "40s" count as more than one drink. Probing may be necessary.

Note that standard items used to determine continued use of alcohol despite "significant impairment or distress" refer to indicators that may not be relevant to many individuals seen in HIV care settings (e.g., problems at work, or with parenting). However, remember that you are coding whether a symptom criterion is present or absent. You are NOT coding your respondent's literal answers to questions.

In addition, a rating of "Yes" on any of the alcohol abuse items generally depends upon the respondent's recognizing the problem and reporting it to the interviewer. If you suspect that

the respondent is minimizing consequences, you may need to gently probe to determine the likely significance of drinking. For example: "Is there any difference in your ability to take care of your daughter after drinking a six pack compared to when you're not drinking?" or, "Are you as likely to get into arguments when you are not drinking or drunk?"

**Question 3**. If respondent says that no doctor discussed drinking with him or her, ask if he or she drinks even though he or she is aware that it causes problems with his or her health. Code "yes" if this is the case.

**Question 4**. Many respondents will answer that they don't work or take care of children. The symptom is coded "Yes" if *any* responsibilities were not taken care of because of drinking, being drunk or hung over. All persons have some responsibilities, e.g., a doctor's appointment, being on time at their appointed look-out spot for a local drug dealer, etc., that alcohol and drug use can interfere with.

**Question 5**. Respondents may insist that they have nothing important to miss or be late for. Similar to Question 4, probe to find issues relevant to respondent's current life situation. For example, "Were you late or did you miss medical appointments?" or "Did you need to meet somebody and weren't there on time because of drinking or being drunk?"

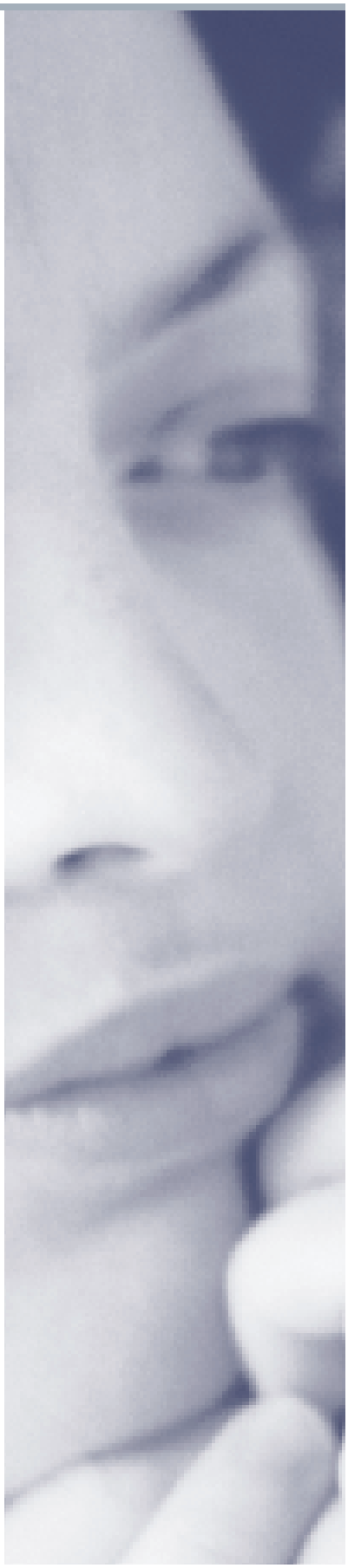
**Question 6**. Respondents may attribute all their problems to the horrible "other" in their environment. Probe to find out patterns of arguments and fighting beyond a specific villain named.

**Question 7**. If a respondent never drives a car, code "No," but write "Not applicable" in the margin.

**Questions 10-14**. Note that these questions refer to alcohol use and symptoms during the past 30 days. *Be sure to alert respondent to the change in the time frame.* If relevant, note how many days respondent has been in a controlled environment, (e.g., jail, in-patient treatment, etc.) during the past 30 days.

**Drug Abuse/Dependence.** At this point it is important that the interviewer reiterate that all information is confidential, and move directly to asking drug use questions. If the respondent refuses or appears reluctant to answer, explain that many people have used or experimented with drugs at some time in their lives and we would like to know their experiences, again, as part of obtaining an overall health profile.

Note that initial screening questions for drug abuse/dependence ask about *frequency of use* (how often), but not the *quantity used*. Respondents often minimize their drug use, thus symptom questions are asked of everyone who has had any drug use at all during the past six months. Note that initial symptom questions require that the experience has happened more than one time in the six-month period. However, both pattern of use and symptom questions are repeated with a focus on the past 30 days. The interviewer must assist the respondent in answering questions for the appropriate time period.



Note that for polydrug users, it may not be possible to associate abuse or dependence with a specific substance.

**Common Pitfalls**. To determine the pattern of drug use over the past six months, *go down the entire list of drugs*, asking if respondent has *ever* used the drug (marijuana, powdered cocaine, crack, heroin, etc.) even one time. Then, for every question answered "yes," go back and elicit information about pattern use *over the last six months*: "You said you have used crack. During the past six months, how often did you use crack?" The format of this question takes a bit longer to ask, but significantly improves the willingness of clients to report more recent drug use. Use terminology that the client uses to refer to specific drugs (e.g., reefer, ice, etc.).

If the respondent has ever used any illicit drugs even one time, ask about injecting drugs or skin-popping. Do not make assumptions about needle use from the types of drugs reported.

Note that as with alcohol use, many standardized items used to determine continued use of drugs despite "significant impairment or distress" refer to indicators that may not be relevant to many individuals seen in HIV care settings (e.g., problems at work, or with parenting). However, remember that you are coding whether a symptom criterion is present or absent. You are NOT coding your respondent's literal answers to questions.

A rating of "Yes" on any of the drug abuse items generally depends on the respondent's recognizing the problem and reporting it to the interviewer. If you suspect that the respondent is minimizing consequences, you may need to gently probe to determine the extent of drug use. For example, "Are there any difficulties at all taking care of your daughter when you're using heroin everyday?" or "Are you as likely to get into arguments when you are not using crack?"

**Question 12**. If the respondent says he or she has no doctor, or that no doctor discussed drug use with him or her, ask if he or she has used drugs even though he or she is aware that it causes problems with his or her health. Code "yes" if this is the case.

**Question 13**. Many respondents will answer that they don't work or take care of children. The symptom is coded 11, "Yes" if any responsibilities were not taken care of because of using drugs or being high or hung over. This could include meeting appointments for services, taking care of one's usual means of economic support, etc.

**Question 14**. Respondents may insist that they have nothing important to miss or be late for. Similar to Question 13, probe to find issues relevant to the respondent's current life situation. For example, "Were you late or did you miss medical appointments or meetings with your case manager?" or "Did you need to meet somebody and weren't there on time because of needing to get drugs or being high?"

**Question 15**. Respondents may ascribe all sources of interpersonal conflict to the horrible "other" in their environment. Probe to find out patterns of arguments and fighting beyond a specific villain named.

**Question 16**. If the respondent never drives a car, code "No," but write "Not applicable" in the margin.

**Questions 20-31**. *Please note that these questions refer to drug use and symptoms during the past 30 days. Be sure to alert respondent to the change in time period.* If relevant, note how many days the respondent has been in a controlled environment (e.g., jail, in-patient treatment, etc.) during the past 30 days.

**Post-Traumatic Stress Disorder**

The assessment of PTSD begins with a review of the individual's lifetime exposure to violence and trauma. As these can be sensitive questions, be sure to give the introduction to the section that acknowledges the terrible or frightening nature of these events, and be especially warm, kind, and supportive when discussing them. If the client hesitates, it is appropriate to acknowledge that these experiences can be difficult to talk about, but do not belabor the point. You will make the client more uncomfortable. (See Guidelines for Asking Sensitive Questions, Appendix B.) There have been few reports of respondents becoming extremely uncomfortable with the process or becoming emotionally distraught if the questions are presented in a straightforward, professional manner as part of a client assessment. Nonetheless, interviewers should be aware of the standard protocols for managing clients who become distraught or who are judged to be a danger to self or others, as it is important for an interviewer to feel supported in the unlikely event that an emergency arises.

Note that for the list of events, "adult" is considered age 18 and older. Events taking place in early adolescence are coded as during childhood. Note that all reports of the events listed are coded on the trauma list. However, to qualify as a potential source of PTSD, an event has to comprise a serious threat to life, limb, or physical integrity that is experienced, witnessed, or confronted. Ongoing stress factors such as living on the streets do not qualify, nor does the expected death of a loved one of natural causes at an advanced age. The experience of fear, helplessness or horror, as in Question 2, has to be explicitly verbalized.

**Common Pitfalls**. Symptoms of PTSD must be associated with a specific traumatic event or related series of events (e.g., ongoing sexual abuse). If more than one traumatic experience is reported, ask the respondent to determine which was the most terrible or frightening for the respondent, and be sure to direct his or her attention to symptoms experienced during the past six months. Many individuals have experienced scattered symptoms associated with different events; this would not qualify as PTSD.

**Questions 3 & 4**. Re-experiencing the event has to be persistent and intrusive. Probe if the respondent indicates one nightmare or intrusive memories only now and then.

**Question 8**. Avoidance of a stimulus associated with the traumatic event should be because it reminds the respondent of the event. This is distinct from avoidance of a victimizer (e.g., someone who assaulted, molested, or raped the respondent) because he or she is an undesirable person and/or because the client fears further victimization.

**Question 10**. This question refers to feelings of isolation not due to environmental constraints on social contact (e.g., jail, hospital treatment).

**Question 12**. Hypervigilance must be beyond what would be expected for an individual in the respondent's situation. For example, being jumpy or on guard when dealing drugs would not be considered inappropriate, and thus would not be considered indicative of hypervigilance.

**Psychosis**. Be sure to read the introductory material to the psychosis module. *The time frame for symptoms is the past four weeks.* Be sure that your respondent is not reporting feelings or experiences occurring while under the influence of alcohol or drugs. Probe to determine this if it is not clear.

Symptom questions are designed to screen for delusions or hallucinations. The checklist for interviewer observations (last page) contains provisions for recording symptoms of disorganized speech and behavior and should also be considered when assessing psychotic disorder.

For each symptom question, you must determine if it occurred once or more than once during the assessment period (past four weeks). For example, Question 1 should read, "During the past four weeks, have you heard noises or voices that other people say they can't hear?" If the respondent answers "Yes," you ask, "How often?" and then probe using the probes indicated, such as, "Tell me what was it that you heard?" You may have to probe further to clarify answers.

**Common Pitfalls**. Not all experiences that are listed as possible indicators of psychosis are necessarily indicative of a mental disorder. Many respondents will answer "Yes" to the initial screening question as written. However, information must be elicited to distinguish between reasonable concern for personal safety versus paranoid delusions; between involvement in non-conventional subgroups and bizarre delusions about alternative realities; or between hallucinations and religious experiences that may be common in the respondent's culture. Symptoms should be scored "Yes" only if the experiences described are implausible, not understandable, and do not derive from ordinary life experiences. Many respondents will find this section of the screening instrument amusing. Be sure that all questions are asked and probed appropriately nonetheless.

Write out the respondent's descriptions of answers to probe for every coded symptom present in the space provided after each symptom question. Additional space is provided at the end of the module.

## Ending the Interview

**Treatment history and use of mental health services.** Ask all respondents the questions about past use of mental health services. If you are aware of treatment history as a result of information already provided, confirm answers with the respondent and record here.

If respondent answers that he or she talked to a "counselor," probe to determine what type of counselor. If respondent refers to this person as a "worker" or "case manager," ask if this is a person who helps them arrange for different types of services, or someone they talk with only about emotional or psychological issues.

If client does not know the names of medications, ask for a description of pills.

For alcohol or drug treatment, include AA, NA, or other types of self-help or support groups as well as detox experiences.

Note that Q. 1 through Q. 4 ask about lifetime experience with different types of mental health or substance abuse treatment. Q. 5 asks about treatment experience during the past six months. "Other" types of mental health services could include speaking with a religious or spiritual counselor or participating in a support group.

**Demographics.** One page of questions about basic demographic information is included. It lets us know something about the people who complete the interview. Ask all the questions, confirming information with the client if already known. For Q.3, race/ethnic background, and Q.7, sexual orientation, read the question as printed as well as the answer categories. For the other questions, read the question and pause to let the client answer, coding his or her response in the categories given. *Note: the Demographics page may not be used at your agency if this information is already collected via an intake or other assessment form.*

**Client follow-up.** Follow the protocol established at your agency to address a respondent's requests or apparent need for help (further help) with emotional or psychological difficulties. Stay with the client if you feel that immediate attention is indicated (e.g., discussion of a suicide plan). If the client requests help, write out the request in his or her own words in the space provided after Q.6, page 15. Follow the protocol established at your individual agency with regard to referral assistance or any other appropriate client follow-up.

## Scoring the CDQ

Review each section of the questionnaire and score the CDQ following the instructions in the shaded box on the bottom of the page at the end of each diagnostic module. Record all disorders for which the client scores positive on the "Summary Sheet" at the end of the questionnaire. Do not leave the Summary Sheet blank. If the client does not score positive for any module, place a check mark in the space provided.

**Positive Screen for Major Depressive Disorder**

Major Depressive Syndrome. Scoring instructions on page 3.

- Client answers "yes" for Q. 4 - the mood disturbance lasted for at least 2 weeks
  AND
- Client answers in the shaded area, "more than half the days" or "nearly every day" for either Q.1) feeling sad, depressed or Q. 2) little interest in things
  AND
- Client answers in the shaded area for a total of 5 or more of Q. 1,2,5 - 11. Note that this would be "more than half the days" or "nearly every day" for the questions about 1) depressed mood, 2) disinterest, 5) sleep disturbance, 6) low energy, 7) appetite disturbance, 8) feelings of failure, 9) trouble concentrating or 10) moving slowly or too fidgety. For question 11) having suicidal thoughts even for "several days" is counted as a symptom.

Other Depressive Syndrome. Scoring instructions on page 3.

- Client answers "yes" for Q. 4 - the mood disturbance lasted for at least 2 weeks
  AND
- Client answers in the shaded area, "more than half the days" or "nearly every day" for EITHER Q.1) feeling sad, depressed or Q. 2) little interest in things
  AND
- Client answers in the shaded area for a total of 2 or more of Q. 1,2,5 - 11.

**Positive Screen for Anxiety Disorder**

Panic Syndrome. Scoring instructions on page 4.

- Client answers "yes" to each of Q. 1,2,3 and 4. He or she: 1) has had a panic attack in the past 4 weeks and 2) it has happened before and 3) attacks come in nonthreatening situations, and 4) client is worried about attacks
  AND
- Client answers "yes" to 4 or more of Q. 5 - 15. He or she has had 4 or more physical symptoms during the last really bad attack.

General Anxiety Syndrome. Scoring instructions on page 5.

- Client answers in the shaded area, "more than half the days" or "nearly every day" for Q.1) feeling anxious, worrying a lot
  AND
- Client answers in the shaded area, "more than half the days" or "nearly every day" for Q.2 - Q.7, e.g., 2) restlessness, 3) tiredness, 4) muscle tension, 5) trouble sleeping, 6) trouble concentrating, or 7) irritability.

**Positive Screen for Alcohol Abuse**

Alcohol Abuse Past 6 months. Scoring instructions on page 6.

- Client answers "yes" to 1 or more of Q. 3 - 7. He or she continues to drink although 3) aware of health consequences, or 4) not fulfilling responsibilities, 5) missing important things, 6) having relationship problems or 7) drinking and driving
  OR
- Client reports drinking 5 or more drinks a day, weekly or more often.

Alcohol Abuse Past 30 days. Scoring instructions on page 7.

- Client answers "yes" to 2 or more of Q. 9 - 12. During the past 30 days, he or she 9) thought s/he should cut down, 10)others complained, 11) s/he felt guilty about drinking or 12) drank 5 or more drinks in a single day

**Positive Screen for Drug Abuse**

Drug Abuse Past 6 months. Scoring instructions on page 9.

- Client answers "yes" to 1 or more of Q. 12 - 17. He or she continues to use drugs although 12) aware of health consequences, or 13) not fulfilling responsibilities, 14) missing important things, 15) having relationship problems, 16) driving while high or 17) having legal problems
  OR
- Client reports using "hard drugs" 3 times a week or more often: heroin, speedball, cocaine, crack, or methamphetamine.

Drug Abuse Past 30 days. Scoring instructions on page 10.

- Client answers "yes" to 2 or more of Q. 22 - 25. During the past 30 days, he or she 9) thought s/he should cut down, 10)others complained, 11) s/he felt guilty about use or 12) used drugs 3 or more times a week or more often.

**Positive Screen for Post Traumatic Stress Disorder**

PTSD. Scoring instructions on page 12.

- Clients answers in the shaded area for Q. 2. Client's fear during the most frightening traumatic event was "bad" or worse
  AND
- Client answers "yes" to one or more of Q. 3 - 6. During the past 6 months s/he 3) has intrusive memories, 4)has nightmares, 5) is upset by reminders or 6) has flashbacks
  AND

- Client answers "yes" to 2 or more of Q. 8 - 11. During the past 6 months s/he 8) avoids things that remind of event, 9) has trouble remembering event 10)feels cut off from people, 11) feels numb or 12) is excessively jumpy or on guard.

**Positive Screen for Psychosis**

Psychosis Scoring instructions on page 14.

- Client reports experiences that are implausible and outside of ordinary or culturally supported experiences. Do not score experiences that are reasonable or culturally appropriate given the circumstances described
  AND
- Client scores in the shaded area (experienced more than one time) for 2 or more of Q. 1 - 10. In the past 4 weeks, while not on drugs or drinking, the client experienced 1) hearing voices, 2) people wanting to harm him/her, 3) something odd going on 4) having visions, 5) special powers, 6) possession by the devil or a spirit, 7) thoughts taken away, 8) ideas no one could understand, 9) thoughts put into his/her head, or 10) mind taken over by external forces
  OR
- Client has experienced 3 or more of Q. 1 - Q.10 one time only in the past 4 weeks, while not on drugs or drinking.

Note that interviewer observations during client assessment may also be considered when screening for psychosis. If client denies all symptoms in questionnaire but manifests delusional thinking and reasoning (aliens/ movie stars made me do it..), and/or withdrawn or inappropriate affect (emotions not consistent with situation, inappropriate for experiences reported) and/or exceedingly odd or bizarre appearance (e.g. wearing multiple overcoats in warm weather) or mannerisms (e.g. repeated, inappropriate gestures, incoherent talking to self), note observations in the "Psychosis: other comments" section of the Summary Sheet.

## Clinical Notes

A blank ruled page is left at the end of the CDQ. This space can be used by the interviewer or other agency personnel for clinical notes or other information that may be useful for understanding Client's mental health and treatment needs. This page can be adapted for recording case review and client follow-up and referral arrangements.

# CLIENT DIAGNOSTIC QUESTIONNAIRE - SHORT SCREENER WITH INSTRUCTIONS

***ETAC/ CDQ- SHORT FORM WITH INSTRUCTIONS***

*This version of the ETAC/ CDQ- SHORT FORM contains crucial instructions specific to the interviewer. This version of the form is for instruction and guidance only. It should not be shown to the client. A loose, clean copy of the ETAC/ CDQ- SHORT FORM has been provided within the packet and can be photocopied as needed.*

Be sure to introduce yourself before asking the client's name.

## ETAC/ CDQ- SHORT FORM

*Client Diagnostic Questionnaire - Short Screener 2/1/01*

***1. Agency/ Program:***_____ ***2. Interviewer*** _____

***3. Today's Date :***_____ /_____/_____
Month/ Day/ Year

***4. Client ID:*** |___|___|___|___|___|___|___|___|___|___|

***5. Client Name or Initials*** _____

May be filled out before the interview

***Instructions to interviewer:***
This questionnaire is designed to facilitate the recognition of the most common mental health problems found in HIV/AIDS primary care or other service settings: mood, anxiety, alcohol and drug abuse, PTSD and thought disorder. Since the questionnaire relies on respondent self-report, definitive diagnoses must be verified by a clinician, taking into account how well the client understood the questions in the questionnaire, as well as other relevant information from family, client records, or other sources.

1. Interviewer instructions are printed in bold italics. Questions that you ask or statements that you make to the client are printed in plain type. Read questions as written. Additional probes may be used to ensure client understanding of the question or explore ambiguous answers.
2. For anything other than a yes/no answer, read the answer categories. The interviewer may need to assist the client in answering within the categories given. Never choose an answer category based on what you think the client means by their spoken response.
3. Be sure that the client is reporting symptoms experienced within the specified time period: past 4 weeks, past 6 months, or in some instances, past 30 days.
4. Within each module, proceed sequentially from question to question unless instructed either to skip to another question or to go to the next page.
5. At the end of each diagnostic module is a shaded area with instructions for scoring Positive Screen for each disorder. Scoring can be done by the interviewer or left for office use only.
6. A Summary Sheet is provided to record positive screen or positive for syndrome in the spaces provided for each diagnostic module. If no positive screen in any module, indicate in the space provided on the top of the summary sheet.
7. Space is also provided for interviewer observations and comments. Interviewer should write as detailed as possible description of positive answers to questions especially on psychosis screen. Where known, additional information that may account for symptoms (e.g. medical condition) or history of prior episodes or treatment should be indicated.
8. *If Client indicates current suicidal feelings or becomes emotionally upset or agitated during interview, please follow agency protocol for contacting your supervisor.*

Do not read or show instructions to the client.

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The CDQ is based on the PHQ which was developed by Robert L Spitzer, MD, Janet B W Williams, DSW, Kurt Kroenke, MD, et al, and is a modification of the PRIME-MD, which was developed with an unrestricted educational grant from Pfizer, Inc. Adaptation for use by SPNS/ HOPWA Program Projects by Angela Aidala, PhD and Jennifer Havens, MD with the assistance of Jeffrey Johnson, PhD, Peter Walsh, MD, Cevdet Tosyali, MD, Ezra Susser, MD, and Sally Dodds, PhD, LCSW. For information about using this instrument contact Angela Aidala, PhD, Columbia School of Public Health, 600 W 168th, New York, NY 10032. Phone: (212) 305-7023, email:aaa1@columbia.edu

Important to briefly explain the purpose of the interview.

***Client Introduction***

This questionnaire will help us better understand problems that you may have. We ask these questions of everyone so that we can get a better picture of the kind of help or support we could provide for you. Please try to answer every question. All your answers are be completely confidential.

Note the time period.

**Overview**

1. Thinking about the past six months, that is about this time in _____ (*reference date 6 mos prior to interview*), how have things been going for you in terms of your mood or feelings? Were there any periods when you were very sad or depressed? How about any times when you were very nervous, frightened, or worried about things? Were there times when you were so active or hyper that you couldnt slow down?

Pause between each question and let the client answer.

Listen carefully and write out client answers but do not probe for details at this time.

Give reference date six months before interview.

2. Did anything happened to you during that time that had anything to do with your feeling (acting) this way (sad, anxious, hyper etc... refer to symptoms)? Anything that was especially hard or stressful for you?

Let client describe in his/her own words.

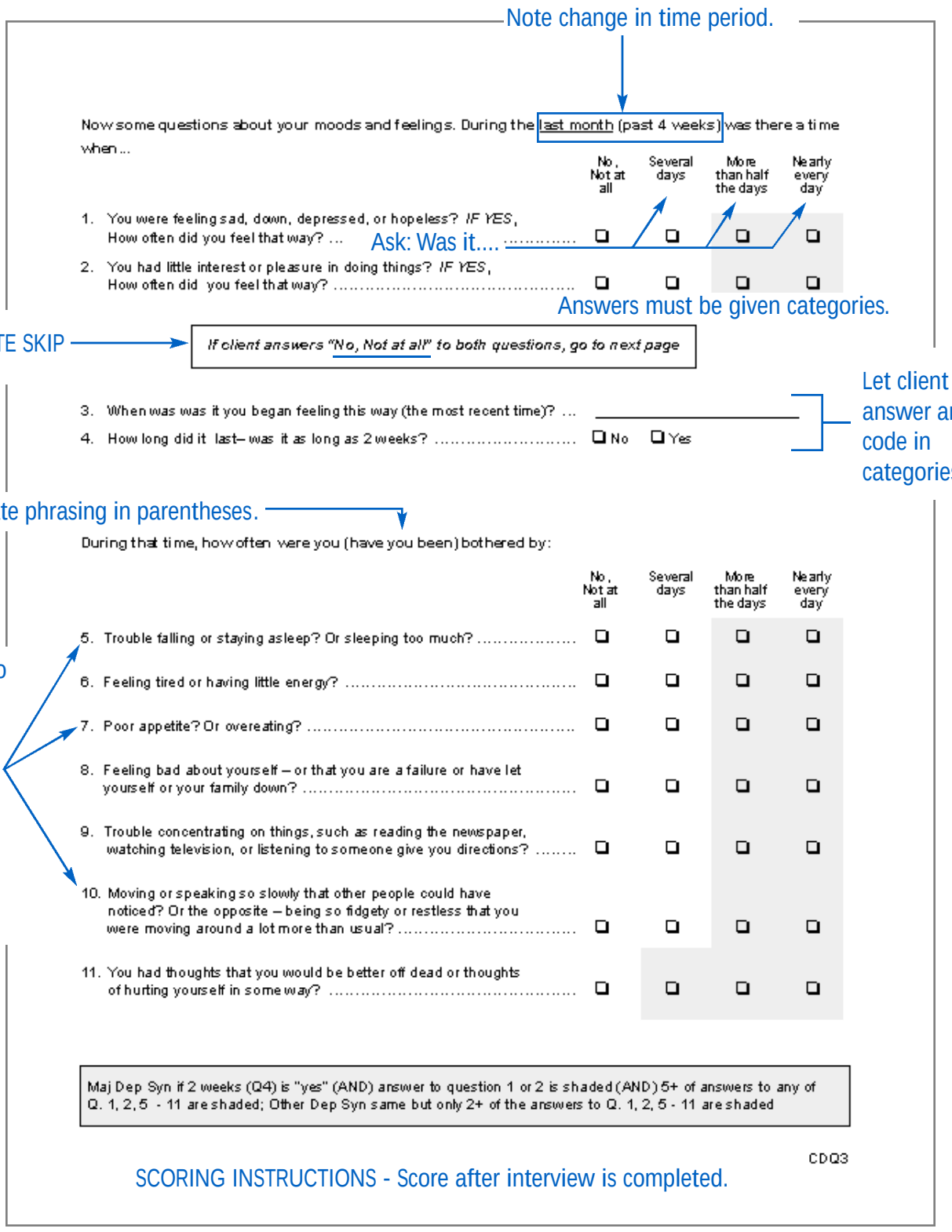
Note the time period.

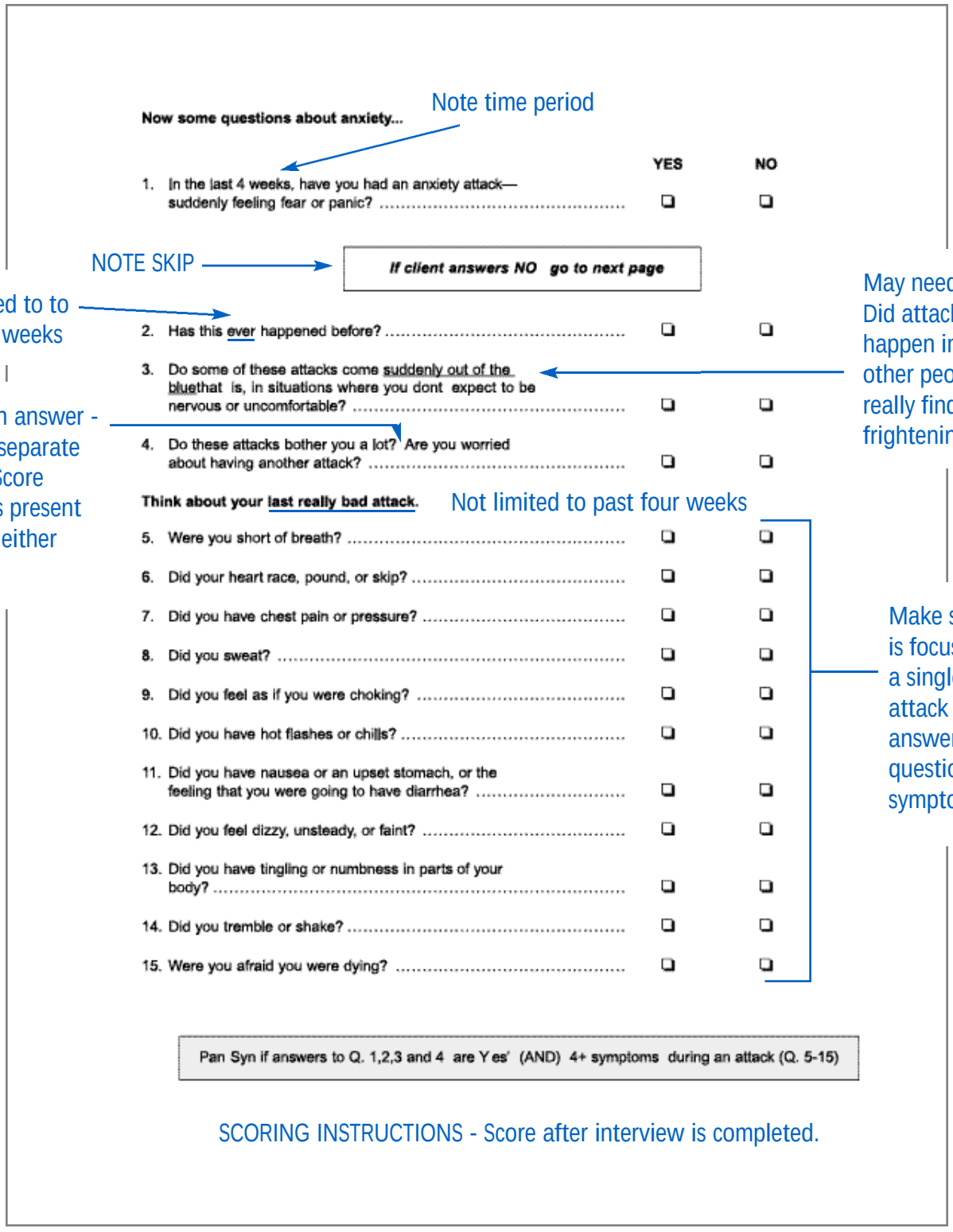
3. During the past six months did you talk to anyone about emotional problems, your nerves or the way you were feeling or acting? *If YES,* Whom did you talk to? *(Probe)* Did you talk to professional person like a doctor or counselor? What did they say about it?

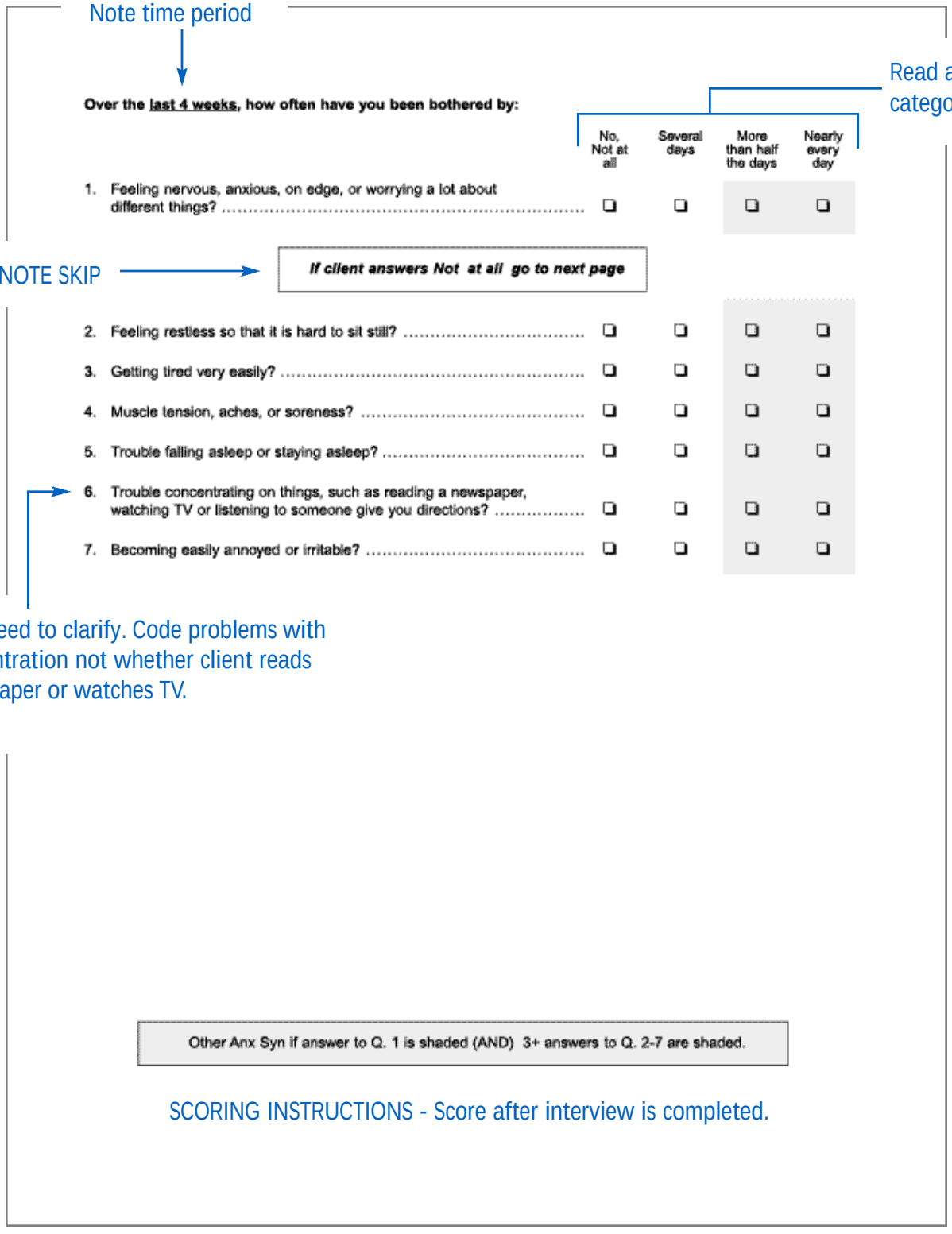
Record all help sought or received including participating in support groups or informal support from friends, family etc.

***Interviewer:*** *If client describes symptoms or treatment history, let him/her know that you will be talking about this in more detail later in the interview. All screening and appropriate symptom questions must be asked even though topic was discussed in overview. Confirm answers already known.*

IMPORTANT! Ask all questions.
Do not fill in answers you think you know.


Note change in time period.
Now some questions about your moods and feelings. During the last month (past 4 weeks) was there a time when ...
No, Not at all
Several days
More than half the days
Nearly every day
1. You were feeling sad, down, depressed, or hopeless? IF YES, How often did you feel that way? ...
Ask: Was it....
2. You had little interest or pleasure in doing things? IF YES, How often did you feel that way? ...
Answers must be given categories.
NOTE SKIP
If client answers "No, Not at all" to both questions, go to next page
3. When was was it you began feeling this way (the most recent time)? ...
4. How long did it last– was it as long as 2 weeks? ... No Yes
Let client answer and code in categories.
Alternate phrasing in parentheses.
During that time, how often were you (have you been) bothered by:
5. Trouble falling or staying asleep? Or sleeping too much? ...
6. Feeling tired or having little energy? ...
7. Poor appetite? Or overeating? ...
8. Feeling bad about yourself – or that you are a failure or have let yourself or your family down? ...
9. Trouble concentrating on things, such as reading the newspaper, watching television, or listening to someone give you directions? ...
10. 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? ...
11. You had thoughts that you would be better off dead or thoughts of hurting yourself in some way? ...
Ask as two separate questions. Pause for answer. Code frequency of either problem.
Maj Dep Syn if 2 weeks (Q4) is "yes" (AND) answer to question 1 or 2 is shaded (AND) 5+ of answers to any of Q. 1, 2, 5 - 11 are shaded; Other Dep Syn same but only 2+ of the answers to Q. 1, 2, 5 - 11 are shaded
CDQ3
SCORING INSTRUCTIONS - Score after interview is completed.


Note time period
Now some questions about anxiety...
YES
NO
1. In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic?
NOTE SKIP
If client answers NO go to next page
Not limited to to past four weeks
2. Has this ever happened before?
3. Do some of these attacks come suddenly out of the bluethat is, in situations where you dont expect to be nervous or uncomfortable?
May need to probe Did attacks ever happen in situation other people would really find frightening?
Pause for an answer - ask as two separate questions. Score symptom as present if "yes" for either question.
4. Do these attacks bother you a lot? Are you worried about having another attack?
Think about your last really bad attack.
Not limited to past four weeks
5. Were you short of breath?
6. Did your heart race, pound, or skip?
7. Did you have chest pain or pressure?
8. Did you sweat?
9. Did you feel as if you were choking?
10. Did you have hot flashes or chills?
11. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?
12. Did you feel dizzy, unsteady, or faint?
13. Did you have tingling or numbness in parts of your body?
14. Did you tremble or shake?
15. Were you afraid you were dying?
Make sure client is focusing on a single specific attack when answering questions about symptoms.
Pan Syn if answers to Q. 1,2,3 and 4 are Yes' (AND) 4+ symptoms during an attack (Q. 5-15)
SCORING INSTRUCTIONS - Score after interview is completed.


Note time period
Read answer categories
Over the last 4 weeks, how often have you been bothered by:
No, Not at all
Several days
More than half the days
Nearly every day
1. Feeling nervous, anxious, on edge, or worrying a lot about different things?
NOTE SKIP
If client answers Not at all go to next page
2. Feeling restless so that it is hard to sit still?
3. Getting tired very easily?
4. Muscle tension, aches, or soreness?
5. Trouble falling asleep or staying asleep?
6. Trouble concentrating on things, such as reading a newspaper, watching TV or listening to someone give you directions?
7. Becoming easily annoyed or irritable?
May need to clarify. Code problems with concentration not whether client reads newspaper or watches TV.
Other Anx Syn if answer to Q. 1 is shaded (AND) 3+ answers to Q. 2-7 are shaded.
SCORING INSTRUCTIONS - Score after interview is completed.

Important to give brief introduction–reason for asking and assurance of confidentiality.

**Next are some questions about drinking alcohol and use of other substances. We ask these questions as part of everyone's health profile. Everything you tell me is strictly confidential and protected.**

te time period → 1. During the past six months, how often do you drink beer, wine or liquor?

| Never | Less than 1x month | Monthly | Weekly | 3x Week | Everyday |
|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

If answer falls betwee categories code up – e 2x week = 3x week, 3 or 4 drink 4 drinks

NOTE SKIP → ***If client never drinks alcohol, go to last alcohol question - Q.13 next page***

2. How many drinks do you usually have on those days when you drink?

ne drink =
- 1 beer (12 oz)
- 1 glass wine
- 1 mxed drink

| One | Two | Three | Four | Five | More than five |
|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Have any of the following things happened to you more than one time in the last 6 months, that is from (_____) until today?
*(fill in date 6 mo prior to interview)*

ode "yes" if lient is aware of egative health onsequences ven if the client oesn't have a octor.

| | YES | NO |
|---|---|---|
| 3. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with you health? | ❑ | ❑ |
| 4. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities? | ❑ | ❑ |
| 5. You missed or were late for something important because you were drinking or hung over? | ❑ | ❑ |
| 6. You had a problem getting along with other people while you were drinking? | ❑ | ❑ |
| 7. You drove a car after having several drinks or after drinking too much? | ❑ | ❑ |

May need to probe. Code "yes" if drinking impaired taking care of any type of responsibility even if client is not work- ing or caring for children (e.g. missing medical appointments).

If client never drives a car code "no" but write "not applicable" in margin

Alc Abu if 1+ answers to Q. 3-7 are Yes (OR) 5+ drinks a day weekly or more often

SCORING INSTRUCTIONS - Score after interview is completed.

Point out change in time period

**During the PAST 30 DAYS, that is, since this time in (_____) ...**
*(month prior to interview)*

For "none" code "00"
Do not leave blank

8. How many days did you have anything alcoholic to drink? |__|__|

SKIP only if never in past 30 days

***If client never drank alcohol past 30 days, go to last alcohol question - Q.13 below***

During the past 30 days...

| | YES | NO |
|---|---|---|
| 9. Have you thought you should cut down on your drinking alcohol? ..... | ❑ | ❑ |
| 10. Has anyone complained about your drinking? ..... | ❑ | ❑ |
| 11. Have you felt guilty or upset about your drinking? ..... | ❑ | ❑ |
| 12. Was there a single day in which you had five or more drinks of beer, wine or liquor ..... | ❑ | ❑ |

All at one sitting, not throughout the day.

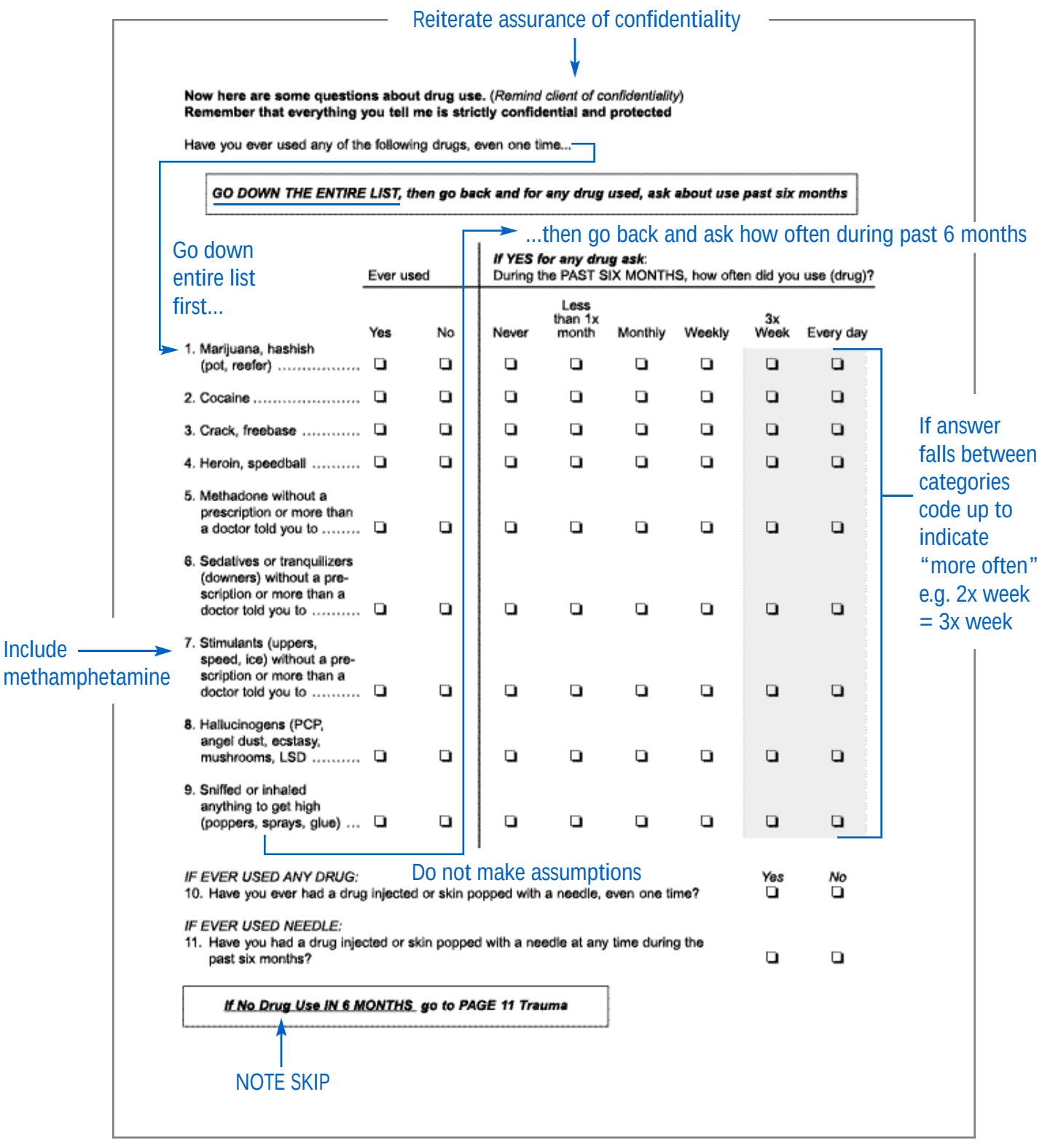
NOTE:
If client has been in controlled environment (e.g. jail, hospital) note this in margin on this page and on page 10 Drug Use

***ASK EVERYONE***
13. Did you or anyone close to you ever think you had a problem with alcohol? ..... ❑ Yes ❑ No

Ask everyone, don't make assumptions

Alc Abu 30 day if 2+ answers to questions 9-12 are YES

SCORING INSTRUCTIONS - Score after interview is completed.


Reiterate assurance of confidentiality
Now here are some questions about drug use. (Remind client of confidentiality)
Remember that everything you tell me is strictly confidential and protected
Have you ever used any of the following drugs, even one time...
GO DOWN THE ENTIRE LIST, then go back and for any drug used, ask about use past six months
Go down entire list first...
...then go back and ask how often during past 6 months
Ever used
If YES for any drug ask:
During the PAST SIX MONTHS, how often did you use (drug)?
Yes
No
Never
Less than 1x month
Monthly
Weekly
3x Week
Every day
1. Marijuana, hashish (pot, reefer)
2. Cocaine
3. Crack, freebase
4. Heroin, speedball
5. Methadone without a prescription or more than a doctor told you to
6. Sedatives or tranquilizers (downers) without a prescription or more than a doctor told you to
7. Stimulants (uppers, speed, ice) without a prescription or more than a doctor told you to
8. Hallucinogens (PCP, angel dust, ecstasy, mushrooms, LSD
9. Sniffed or inhaled anything to get high (poppers, sprays, glue)
If answer falls between categories code up to indicate "more often" e.g. 2x week = 3x week
Include methamphetamine
Do not make assumptions
IF EVER USED ANY DRUG:
10. Have you ever had a drug injected or skin popped with a needle, even one time?
IF EVER USED NEEDLE:
11. Have you had a drug injected or skin popped with a needle at any time during the past six months?
Yes
No
If No Drug Use IN 6 MONTHS go to PAGE 11 Trauma
NOTE SKIP

Note time period

***Ask all clients who have used any drug in past 6 mos***

Have any of the following things happened to you more than one time in the last 6 months, that is from (_____) until today?
fill in date 6 mo prior to interview

Code "yes" if client is that aware his/her continued drug use causes health problems even if it was not discussed with a doctor

| | YES | NO |
|---|---|---|
| 12. You used drugs even though a doctor suggested that you stop using because of a problem with your health? | ❑ | ❑ |
| 13. You used drugs, were high or hung over from drugs while you were working, going to school, taking care of children or other responsibilities? | ❑ | ❑ |
| 14. You missed or were late for something important because you were using drugs or hung over? | ❑ | ❑ |
| 15. You had a problem getting along with other people while you were using drugs | ❑ | ❑ |
| 16. You drove a car after using drugs | ❑ | ❑ |
| 17. You had legal problems because of drug use | ❑ | ❑ |

May need to probe. Code "yes" if drugs impaired taking care of any type of responsibili even if client is not working or caring for children (e.g. missing medical appointments, paying rent, etc.)

If client never drives car code "no" but write "not applicable" in margin

DRUG ABU if 1+ answers to Q 12 - Q 17 are Yes (OR) Heroin, Coke/Crack or Methamphetamine 3+ per week

SCORING INSTRUCTIONS - Score after interview is completed.

Point out change in time period

**During the PAST 30 DAYS, that is, since this time in (_____) ...**
*month prior to interview*

How many days did you use...

14. Marijuana ..... |__|__|
15. Cocaine ..... |__|__|
16. Crack ..... |__|__|
17. Heroin or speedball ..... |__|__|
18. Sedatives, Downers ..... |__|__|
19. Stimulants, Uppers ..... |__|__|
20. Hallucinogens ..... |__|__|
21. Inhalants ..... |__|__|

Use terms client uses to refer to specific drugs (e.g. weed, ice)

Ask about any drug used at all during the past 6 months

Note if a client was in a controlled environment (e.g. jail, hospital, treatment facility) during the the past 30 days. Record how many days here and on page 7 (alcohol use)

NOTE SKIP → ***If client never used any drug past 30 days, go to next page***

During the past 30 days...

| | YES | NO |
|---|---|---|
| 22. Have you thought you should cut down on your drug use? ..... | ❑ | ❑ |
| 23. Has anyone complained about your drug use? ..... | ❑ | ❑ |
| 24. Have you felt guilty or upset about your drug use? ..... | ❑ | ❑ |
| 25. Have you used any drug 3 or more times a week or more often? ..... | ❑ | ❑ |

Dru Abu 30 day if 2+ answers to questions 22-25 are Yes

SCORING INSTRUCTIONS - Score after interview is completed.

Be sure to give introduction - important to acknowledge terrible nature of these events

*ASK EVERYONE*

**Now some questions about terrible or frightening things that may have happened to you.**

People often have traumatic experiences. I mean terrible, frightening events. I am going to read a list of some possible events that sometimes happen to people. Please tell me if you ever experienced...

| | YES | NO |
|---|---|---|
| 1. A serious accident or fire at home or at your job | ❑ | ❑ |
| 2. A natural disaster such as hurricane, major earthquake, flood, or other similar disaster | ❑ | ❑ |
| 3. Direct combat experience in a war · age 18 or older | ❑ | ❑ |
| 4. Physical assault or abuse in your adult life by your partner | ❑ | ❑ |
| 5. Physical assault or abuse in your adult life by someone other than your partner | ❑ | ❑ |
| 6. Physical assault or abuse as a child · or early teen years | ❑ | ❑ |
| 7. Seeing people hitting or harming one another in your family when you were growing up | ❑ | ❑ |
| 8. Sexual assault or rape in your adult life | ❑ | ❑ |
| 9. Sexual assault or rape as a child | ❑ | ❑ |
| 10. Seeing someone physically assaulted or abused | ❑ | ❑ |
| 11. Seeing someone seriously injured or violently killed | ❑ | ❑ |
| 12. Losing a child through death | ❑ | ❑ |
| 13. Any other terrible or frightening thing that may have happened to you. Specify _____ | ❑ | ❑ |

Adult = 18+ years

Child = up to 7 years

Be warm and supportive but ask questions in a straightforward and professional manner.

If client hesitates acknowledge these experiences may be difficult to talk about but don't belabor the point as this will make the client more uncomfortable.

NOTE SKIP INSTRUCTIONS

***If client answers NO to all questions go to Page 13, PSY***
***If client answers YES to one or more questions go to the NEXT PAGE***

FOLLOW SKIP INSTRUCTIONS

If only one event

***If client answers YES to ONLY ONE event listed on the previous page, Ask Q. 1A***

1A. You have told me about the time _____ (name event).
I would like to ask you a little more about this event ..... ***skip to Q.2***

If more than one event

***If client answers YES to MORE THAN ONE event on the previous page, Ask Q. 1 B***

1B. You have told me about a number of things that have happened to you.Which of these events was the most terrible or frightening for you? _____ *(specify event or series of related events the client names)*

Use alternate wording if traumatic experience was a related series of events (e.g. ongoing sexual abuse)

**I would like to ask you a little more about this event (series of events)...**

Ask everyone

2. How frightened were you...

❑ Not at all ❑ Just a little ❑ Bad ❑ Very Bad ❑ Scared to Death

Direct client's attention to past 6 months regardless of when traumatic event occurred

**During the past six months...**

| | YES | NO |
|---|---|---|
| 3. Do you keep remembering it even when you dont want to? ..... | ❑ | ❑ |
| 4. Do you have nightmares about it? ..... | ❑ | ❑ |
| 5. Do things that remind you of it make you very upset? ..... | ❑ | ❑ |
| 6. Do you ever have flashbacks - a sudden feeling that the event was happening all over again? ..... | ❑ | ❑ |
| 7. Do you worry a lot that it might happen again? ..... | ❑ | ❑ |
| 8. Do you avoid things that remind you of it? ..... | ❑ | ❑ |
| 9. Do you sometimes have trouble remembering exactly what happened? ..... | ❑ | ❑ |
| 10. Do you feel alone even when with other people, or feel cut off from people? ..... | ❑ | ❑ |
| 11. Do you feel numb or like you no longer have strong feelings for anything? ..... | ❑ | ❑ |
| 12. Are you jumpy or on guard when there is no reason to be? ..... | ❑ | ❑ |

Q3 & Q4: Needs to be recurring. Do not code "yes" if remembering or nightmares are only now and then

Symptoms must refer to the same event/experience

Code "yes" if client avoids situations that remind her/him of event - not if client reasonably avoids person who previously vitimized her/him

PTS Syn if answer to 2 is Bad or worse (AND) 1+ answers to Q 3-6 (AND) 2+ answers to Q.8-11 are YES

SCORING INSTRUCTIONS - Score after interview is completed.

Read introcution - note time period - exclude experiences while on drugs/drinking

**Now I am going to ask you about some beliefs and feelings that some people have. Some people have these feelings and beliefs after they have been drinking alcohol or taking drugs. I would like to know if you have ever had some of these beliefs or feelings during the PAST 4 WEEKS (30 days) when you have not been drinking alcohol or taking drugs.**

Need to ask

| **During the past 4 weeks, how often . . .** | **Never** | **One Time** | **More than one time** |
|---|---|---|---|
| 1. Have you heard noises or voices that other people say they cant hear? ..... *If YES:* Tell me what was it that you heard? If a voice: What did the voice(s) say? Did the voice(s) tell you to do anything? What? Is it like the voice is inside your head or coming from the outside? _____ | ❑ | ❑ | ❑ |

FOR ALL QUESTIONS → For any answer "yes," probe to determine if experience is reasonable or possible within ordinary expeirence Code symptom present only if implausible, false or bizarre distortion of thinking

| | | | |
|---|---|---|---|
| 2. Have you felt that there were people who wanted to harm or hurt you? ..... *If YES:* Who are these people? Why do they want to hurt you? Do your fears about this make it hard for you to leave your home or where you usually sleep? _____ | ❑ | ❑ | ❑ |

Exclude reasonable concern for personal safety

_____

| | | | |
|---|---|---|---|
| 3. Have you ever felt that there was something odd or unusual going on around you? ..... *If YES:* Can you tell me something about it? Do you feel like people are plotting against you? Do things seem to have special meaning to you? Like numbers or street signs or something like that? _____ | ❑ | ❑ | ❑ |

Exclude if reasonable/understandable given certain circumstances

_____

| | | | |
|---|---|---|---|
| 4. Have you had visions or seen things that other people say they cant see? ..... *If YES:* Tell me about what you have seen. Does this hapen when you are awake? Where does it happen? Are you seeing someone who has recently died? _____ | ❑ | ❑ | ❑ |

Exclude culturally accepted religous experiences (e.g. seeing deceased loved one while in church

_____

| | | | |
|---|---|---|---|
| 5. Have you felt that you had special powers that other people dont have? ..... *If YES:* Tell me about these powers. How are they different from what other people can do? How have you used these powers? _____ | ❑ | ❑ | ❑ |

Exclude unless implausible or bizarre powers – not exceptioanl craetivity or intelligence

_____

| | | | |
|---|---|---|---|
| 6. Have you thought that you were possessed by a spirit or the devil? ..... *If YES:* Can you tell me about that? Did the spirit/devil make you do anything? What? _____ | ❑ | ❑ | ❑ |

_____

_____

_____

| During the past 4 weeks, how often . . . | Never | One Time | More than one time |
|---|---|---|---|
| 7. Have you felt that your thoughts were taken from you by some outside or external source? ..... ***If YES***: Who or what takes your thoughts? How do you think that happens? _____ | ❑ | ❑ | ❑ |
| 8. Have you had ideas or thoughts that nobody else could understand? ..... ***If YES***: Tell me about these ideas. How do you know that nobody else can understand? _____ | ❑ | ❑ | ❑ |
| 9. Have you felt that thoughts were put into your head that were not your own? ..... ***If YES***: What are some of these thoughts? How do you think they get into your head? _____ | ❑ | ❑ | ❑ |
| 10. Have you felt that your mind was taken over by forces you couldnt control? ..... ***If YES***: Who or what takes control of your mind? How do you think that happens? _____ | ❑ | ❑ | ❑ |

Not simply ideas stolen or creativity plagiarized

Exclude unless implausible or bizarre, not part of the client's cultural subgroup

Not simply being influenced by a forceful person

Exclude drugs or drinking

*Additional Comments or Observations:* _____

Interviewer observations regarding disorganized speech or behavior during interview should also be considered when screening for psychosis (See "Interviewer Observations" at end of interview)

Psy Screen Positive if 2+ answers are shaded (OR) 3+ symptoms one time only. Do not score unless experiences described are implausible and outside of ordinary or culturally supported experiences

SCORING INSTRUCTIONS - Score after interview is completed.

If treatment known go over information and record on this page

If client answers "counseling" probe to find out what type . If social worker or case manager, probe to determine if this is somene they talk to specifically for emotional or psychological issues

**These next questions are about different services you may have received** *(Confirm information if known)*

1. Have you ever talked to a mental health specialist such as a psychiatrist, psychologist, or specially trained social worker, about emotional problems, your nerves, or the way you were feeling or behaving?

❑ No ❑ Yes → ***If YES:*** What did the _____ (mental health professional) say?
Probe for diagnosis, if any

_____

_____

2. Have you ever been prescribed medications to help with emotional or psychological problems or ways you were feeling or behaving?

❑ No ❑ Yes → ***If YES:*** What medication(s)?

If client doesn't know names ask for description (e.g small, triangular pills)

3.Have you ever been in the hospital because of emotional or psychological problems or ways you were feeling or behaving?

❑ No ❑ Yes → ***If YES:*** When was that? Why were you hospitalized?

_____

_____

4. Have you ever had any type of alcohol or drug treatment?

❑ No ❑ Yes → ***If YES:*** When was that? What type of treatment did you receive?

Include AA, NA or other types of self-help or support groups

Note time switch

5. In the past six months, have you received any help for emotional or psychological difficulties like talking to a psychologist or psychiatrist, or taking medicine, or going into the hospital for a while?
***Circle all that apply***

1. Received outpatient therapy or counseling for psychological problems _____
2. Received alcohol or drug treatment _____
3. Medication (specify) _____
4. Hospitalization _____
5. Other (specify) _____

"Other "could include religious or spiritual counseling or participating in support groups

6. Is there anything else you feel is important to tell me about your moods, feelings, thoughts or ways of behaving during the past six months?

_____

_____

_____

_____

_____

It is appropriate here at close of interview to discuss referral assitance.
Follow your agency's protocol for following up with client

You may be instructed to skip this page

(Optional Demographic Questions)

**Finally, we have a few background questions.**

**1. What is your birthdate?**_____/_____/_____
Month/Day/Year

Use 2 digits for each number (e.g. 05/17/63)

**2. Client Gender** *(confirm with client )*
1. Male
2. Female
3. Transgender

**3. Which of the following best describes your racial or ethnic background...**
1. White, nonHispanic
2. Black non Hispanic
3. Hispanic, Latino
4. Asian, Pacific Islander
5. Native American, Aleutian, Eskimo

*Dont read but code if offered*
6. Other_____
7. Mixed_____ *codes for 2 ethnicities* |___| |___|

Read all answer categories do not make assumptions

**4. Where were you born?**_____ *(country or state if U.S.)*

**5. What languague do you prefer to speak?** *(choose one)*
01 English
02 Spanish
03 Creole
08 Other *(specify)*_____

**6. How far did you go in school? What was highest diploma or degree you have gotten, if any?**
01 Under 7 years of schooling
02 Junior high school (7-9th grade)
03 Partial High School (10-11 grade)
04 High School Diploma / GED
05 Some college; community college degree
06 Four year college degree (BA, BS)
07 Completed graduate or professional training
08 Other *(specify)*_____

**7. Do you consider yourself...**
01 Gay/ Lesbian
02 Bisexual, attracted to both men and women
03 Heterosexual, Straight
04 Not sure/ undecided/ in transition
05 Prefer not to say

Read all answer categories

**8. What was your most recent T-cell or CD4 count?**

*If client gives a number write it in here or else use codes below* |___|___|___|___|

Fill in only if actual CD4 count is known

01 0-100
02 101-200
03 201-300
04 301-500
05 Greater than 500
06 Dont know T-cell count but I was told it was good"
07 Dont know T-cell count but I was told it was bad"
**88** Dont know T-cell count at all/ Dont recall test result
00 Client has never had T-cell CD4 test

DO NOT LEAVE BLANK
If no positive screen check here

**SUMMARY SHEET (FILL OUT AFTER INTERVIEW)**
Review each section of the questionnaire and score the CDQ following the instructions in the shaded box on the bottom of the page at the end of each diagnostic module. Record all disorders for which the client scores positive on this sheet.

If the client does not score positive for any module, check here: ❑ **NO POSITIVE SCREEN IN ANY MODULE**

**DEPRESSIVE DISORDER**
❑ Positive for Major Depressive Syndrome — Scoring instructions page 3
❑ Positive for Other Depressive Syndrome — Scoring instructions page 3

Are client's symptoms of depression reaction to the death of a loved one? Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

**ANXIETY DISORDER**
❑ Positive for Panic Syndrome — Scoring instructions page 4
❑ Positive for Generalized Anxiety Syndrome — Scoring instructions page 5

Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

**ALCOHOL ABUSE**
❑ Positive for Alcohol Abuse, past 6 months — Scoring instructions page 6
❑ Positive for Alcohol Abuse, past 30 days — Scoring instructions page 7

Has client ever received treatment for alcohol abuse/dependence? Has client been in a controlled environment (e.g. jail, hospital)any time during the past 6 months? in the past 30 days? Other comments:

**DRUG ABUSE**
❑ Positive for Drug Abuse, past 6 months—List drug(s) of abuse: _____ — Scoring instructions page 9
❑ Positive for Drug Abuse, past 30 days—List drug(s) of abuse: _____ — Scoring instructions page 10

Has client ever received treatment for drug abuse/dependence? Has client been in controlled environment (e.g. jail, hospital) any time during the past 6 months? In the past 30 days? Other comments:

**POST TRAUMATIC STRESS DISORDER**

❑ Positive on PTSD Screen — Scoring instructions page 12

Describe traumatic events. Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

**PSYCHOSIS**

❑ Positive on Psychosis Screen — Scoring instructions page 14

Describe symptoms. Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

Report observations of delussional thinking or bizarre behavior manifest at any time during the interview

**TREATMENT EXPERIENCE**

❑ Client has had professional mental health treatment or has been prescribed psych medications in the past 6 months ← Note time period

❑ Client is currently receiving professional mental health treatment or has been prescribed psych medications

Dates of treatment? Was treatment completed? Is/was client adherent to treatment plan? Other comments:

**Interviewer Observations**

If uncertain code "DK" (don't know)

*Circle all that describe client based upon your observations during interview.*

| | | | |
|---|---|---|---|
| Manifested inappropriate affect during parts of interview | Y | N | DK |
| Unusually unkempt or bizarre in appearance | Y | N | DK |
| So withdrawn into own world that s/he found it hard to answer questions | Y | N | DK |
| Manifested unusual ways of thinking and reasoning about experiences | Y | N | DK |
| Apathetic or flat in affect during interview | Y | N | DK |
| Nervous and tense during interview | Y | N | DK |
| Intoxicated or under influence of alcohol or drugs | Y | N | DK |
| Needle track marks | Y | N | DK |
| Skin abscesses, cigarette burns, or nicotine stains | Y | N | DK |
| Tremors (shaking and twitching of hands and eyelids) | Y | N | DK |
| Unclear speech: slurred, incoherent, or too rapid | Y | N | DK |
| Unsteady gait: staggering, off balance | Y | N | DK |
| Dilated (enlarged) or constricted (pinpoint) pupils | Y | N | DK |
| Scratching | Y | N | DK |
| Swollen hands or feet | Y | N | DK |
| Smell of alcohol or marijuana on breath | Y | N | DK |
| Nodding out (dozing or falling asleep) | Y | N | DK |
| Agitation | Y | N | DK |
| Inability to focus | Y | N | DK |

These observations may be used by clinician for additional informatic regarding client's mental status

Burns on the inside of the lips ( e.g. from smoking crack) ..... Y ..... N ..... DK

**Other comments/ observations:**

Space available for interviewer or other agency staff comments or charting clinical notes

# APPENDICES A · B · C

## Guidelines for Suicide Assessment

What do you do if the client answers "yes" to the question about thoughts of suicide found in the depression module of the Client Diagnostic Questionnaire (CDQ). Or, if evidence comes up anywhere in the CDQ (or other interviews with the client) that he or she is thinking about harming him or herself? You should direct your attention and concern to discovering whether or not the person presents an immediate suicide risk. Your agency will have a protocol to follow for questioning clients and getting appropriate clinical intervention if necessary. Here are some general questions and areas to think about when further assessing suicidality:

**If the client mentions suicidal thoughts, ask additional questions including:**

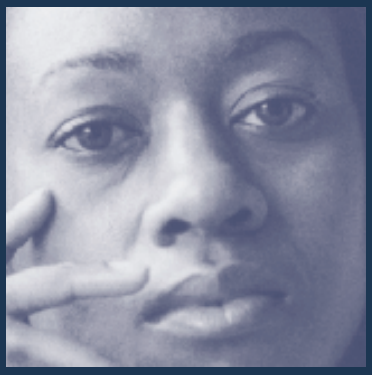
- Have you ever attempted to harm yourself? If yes, how?
- What did you do? Are you feeling like you could harm yourself now?
- When was the last time you tried to harm yourself?
- What did you do to try to take your life?
- What happened?

**If the person is not considering suicide now, then:**

- Carefully record your conversation and interaction with the client and share this information *immediately* with your supervisor.

**If the person is considering suicide now, then:**

- Ask the person if he or she has a plan.
- Get the details of what they say they are going to do.
- Stop the interview and GET HELP RIGHT AWAY.
- Do not leave the person alone.
- Contact your supervisor or whomever has been designated as clinical backup at your agency.
- If the client has no plans to hurt him or herself, then go ahead with the interview and follow instructions under "B" above.



**Risk factors for suicidal behavior include;**

1. Talking about committing suicide.
2. Having trouble eating or sleeping.
3. Feeling sad, depressed, or a lack of interest in things.
4. Withdrawing from friends and/or social activities.
5. Preparing for death by making a will and other final arrangements.
6. Giving away important possessions.
7. Having attempted suicide before.
8. Taking unnecessary risks.
9. Experiencing a severe loss, such as death of a loved one.
10. Becoming very focused on death and dying.
11. Losing interest in personal appearance.
12. Alcohol and/or drug use.

## Guidelines for Asking Sensitive Questions

**Take a professional but matter-of-fact stance.** Ask the questions in a sensitive, but clear and direct way.

**Be non-judgmental.** The interviewer should examine personal feelings about sexuality, drug use and other sensitive areas. If the interviewer feels uncomfortable talking about sensitive topics, the client will feel uncomfortable. Avoid any communication of disapproval or rejection of the client as a person no matter what they say about themselves.

**Be an active listener.** It is important that you show the client that you really want to understand what he or she is telling you. Let him/her know that you are listening by nodding your head and acknowledging the information he or she has given you. Pay close attention, as it may be useful at times to refer back to what the client said earlier in the interview.

**Be aware of feelings, attitudes and values.** Let the client know that you are able to understand how he/she feels by maintaining eye contact and occasionally shaking your head to indicate that you are listening.

**Introduce sensitive questions.** Give a brief reason why you are asking the questions. For questions about drug use and sexual behaviors, emphasize that we ask these questions of every client as part of obtaining a health profile. For questions about trauma and violence, point out that this information helps us better understand the issues that clients are dealing with and how best to assist them in getting the help they might need.

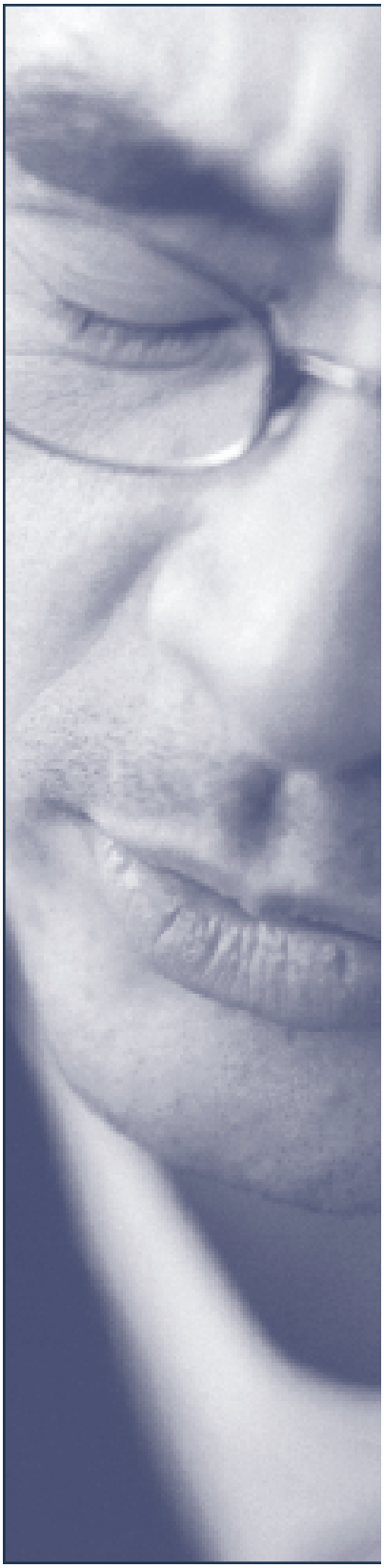
**Acknowledge difficult questions.** Some questions might be difficult to answer. The introduction to the section on trauma events introduces the topic by acknowledging that the questions are about terrible or frightening things that sometimes happen to people. This is a way of acknowledging that such questions may be difficult to answer. Do not belabor the point. A brief mention is appropriate; extensive introductions have been found to make respondents more uneasy rather than calm.

**Assure confidentiality.** Begin the interview with an assurance that all information is confidential and protected and will only be known to persons who need to know so that they can help the client. Repeat assurances of confidentiality as part of the introduction to sensitive topics. Again, don't belabor the topic. A brief, one-sentence assurance is usually sufficient.

**Get specifics.** Make sure you get specific information about the client's history, his/her current functioning, and future plans. Focusing on specifics can help the client feel more like he/she is providing you with important information.

**Deal with problems.** If there are any tensions or problems between the client and the interviewer, the interviewer should make an effort to address them as soon as possible. If the client feels disrespected or put off in any way, allow him/her to verbalize this fully. Explain why the questions are important, and that they are asked of everyone. It is important that the client feels as safe and comfortable in the context of the interview as possible.

## DSM—IV Criteria for Mental Health Disorders Screened for by the CDQ



**DSM—IV Criteria for Dysthymic Disorder**

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, *for at least two years*.

B. The presence, while depressed, of two (or more) of the following:
   (1) Poor appetite or overeating
   (2) Insomnia or hypersomnia
   (3) Low energy or fatigue
   (4) Low self-esteem
   (5) Poor concentration or difficulty making decisions
   (6) Feelings of hopelessness

C. During the two-year period of the disturbance (one-year period for children or adolescents), the person has never been without the symptoms in Criteria A and B for more than two months at a time.

D. A major depressive episode has not been present during the first two years of the disturbance; i.e., the disturbance is not better accounted for by chronic major depressive disorder, or major depressive disorder in partial remission.

E. There has never been a manic episode, a mixed episode, or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. Disturbance does not occur exclusively during the course of a chronic psychotic disorder, such as schizophrenia or delusional disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

H. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**DSM—IV Criteria for Major Depressive Disorder**

A. Five (or more) of the following symptoms have been present during the same *two-week period* and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood, such as incongruent delusions or hallucinations, depressed mood most of the day, or nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observations made by others (e.g., appears tearful).

(1) Depressed mood most of the day, nearly every day as indicated by either subjective report or observation by others. In children and adolescents, it can be an irritable mood.
(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day.
(4) Insomnia or hypersomnia nearly every day.
(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
(6) Fatigue or loss of energy nearly every day.
(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. Symptoms do not meet criteria for a mixed episode.
C. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one; the symptoms persist for longer than two-months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

**DSM—IV Criteria for Panic Disorder without Agoraphobia**

A. Both (1) and (2) from previous criteria.
B. Recurrent and unexpected panic attack.
C. At least one of the attacks has been followed by one month (or more) of one (or more) of the following:
    (1) Persistent concern about having additional attacks.
    (2) Worry about the implications for the attack and its consequences (e.g., losing control, having a heart attack, going crazy).
    (3) A significant change in behavior related to the attacks.
D. Absence of agoraphobia (see below).
E. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
F. The panic attacks are not better accounted for by another mental disorder.

**DSM—IV Criteria for Panic Disorder with Agoraphobia**

A. Both (1) and (2).
B. Recurrent and unexpected panic attack.
C. At least one of the attacks has been followed by one month (or more) of one (or more) of the following:
    (1) Persistent concern about having additional attacks.
    (2) Worry about the implications for the attack and its consequences (e.g., losing control, having a heart attack, going crazy).
    (3) A significant change in behavior related to the attacks.
D. The presence of agoraphobia.
E. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
F. The panic attacks are not better accounted for by another mental disorder.

**DSM—IV Criteria for Panic Attack**

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly, reaching a peak within ten minutes:

(1) Palpitations, pounding heart, or accelerated heart rate.
(2) Sweating.
(3) Trembling or shaking.
(4) Sensations of shortness of breath or smothering.
(5) Feeling of choking.
(6) Chest pain or discomfort.
(7) Nausea or abdominal distress.
(8) Feeling dizzy, unsteady, lightheaded, or faint.
(9) Derealization (feelings of unreality) or depersonalization (being detached from oneself).
(10) Fear of losing control or going crazy.

(11) Fear of dying.
(12) Paresthesia (numbness or tingling sensations).
(13) Chills or hot flashes.

When a panic attack happens, most people feel their heart pounding and feel sweaty, weak, faint or dizzy. Their hands may tingle or feel numb, and they might feel hot or chilled. Some people experience chest pain or smothering sensations, a sense of unreality, or fear of certain doom or loss of control. Many people feel that they are having a heart attack or a stroke, losing their mind or on the verge of death. Most attacks last for a couple of minutes but some can go on for up to 10 minutes. In rare cases they can last for an hour or more.

**DSM—IV Criteria for Agoraphobia**

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situational predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being on a bridge, and traveling in a bus, train or automobile.
B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.
C. The anxiety or phobic avoidance is not better accounted for by another mental disorder.

**DSM—IV Criteria for Generalized Anxiety Disorder**

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least *six-months*, about a number of events or activities (such as work or school performance).
B. Person finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past six-months).
   (1) Restlessness or feeling keyed up or on edge.
   (2) Being easily fatigued.
   (3) Difficulty concentrating or mind going blank.
   (4) Irritability.
   (5) Muscle tension.
   (6) Sleep disturbance (difficulty falling or staying asleep, or restless, dissatisfying sleep).
D. The focus of the anxiety and worry is not confined to features of an Axis I disorder. For example, the anxiety or worry is not about panic attacks (as in panic disorder), public embarrassment (as in social phobia), contamination (as in obsessive-compulsive disorder), separation from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), or having a serious illness (as in hypochondriasis), anxiety and worry do not occur during post-traumatic stress disorder exclusively.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

**DSM—IV Criteria for Post-Traumatic Stress Disorder**

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
   (2) The person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
   (2) Recurrent, distressing dreams of the event.
   (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
   (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
   (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
   (2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.
   (3) Inability to recall an important aspect of the trauma.
   (4) Markedly diminished interest or participation in significant activities.
   (5) Feeling of detachment or estrangement from others.
   (6) Restricted range of affect (e.g., unable to have loving feelings).
   (7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) Difficulty falling or staying asleep.
   (2) Irritability or outbursts of anger.
   (3) Difficulty concentrating.
   (4) Hypervigilance.
   (5) Exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**DSM—IV Criteria for Substance Dependence**

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring at any time within a 12-month period:

(1) Tolerance, as defined by either of the following:

(a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

(b) Markedly diminished effect with continued use of the same amount of the substance.

(2) Withdrawal, as manifested by either of the following:

(a) The characteristic withdrawal syndrome for the substance.

(b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

(3) The substance is often taken in larger amounts or over a longer period than was intended.

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.

(5) A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.

(6) Important social, occupational, or recreational activities are given up or reduced because of substance use.

(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. (For example, current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption.

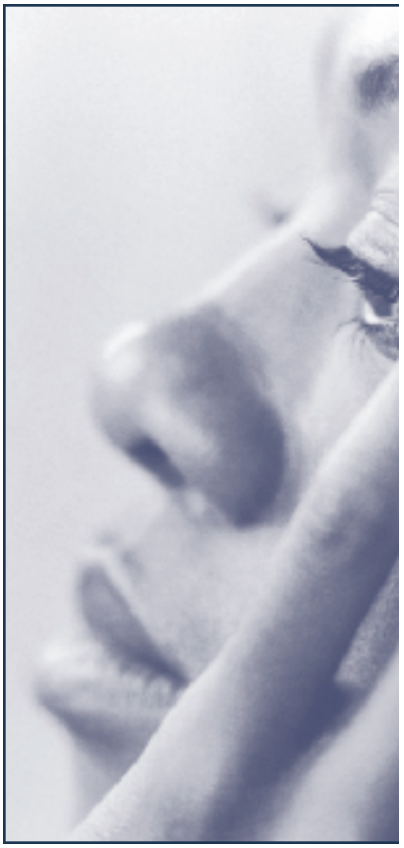
**DSM—IV Criteria for Substance Abuse**

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).

(2) Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

(3) Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).



(4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for substance sependence for this class of substance.

**Diagnostic Criteria for Schizophrenia**

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a one-month period (or less if successfully treated):
   (1) Delusions.
   (2) Hallucinations.
   (3) Disorganized speech (e.g., frequent derailment or incoherence).
   (4) Grossly disorganized or catatonic behavior.
   (5) Negative symptoms, i.e., affective flattening, alogia, or avolition.

**Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction. For a significant portion of the time, since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset. (Also, when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration. Continuous signs of the disturbance persist for at least six months. This sixmonth period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these pretrial or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and mood disorder exclusion. Schizoaffective disorder and mood disorder with psychotic features have been ruled out because of either of the following:
   (1) No major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms;
   (2) If mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a pervasive developmental disorder. If there is a history of austic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least one month (or less, if successfully treated).

## References

Aidala A, Abramson D, Lekas M. (1999). *The Unconnected Revisited: Persons Living with HIV Who Are Outside the Medical and Social Services System.* Community Health & Advisory Information Network Briefing Paper #1. Columbia School of Public Health.

Aidala A. (1997). *Continuing Need for HIV Mental Health Services and Service Utilization.* Community Health Advisory & Information Network Update Report #9. Columbia School of Public Health.

American Medical Association (2000). Journals of the AMA. *http://www.ama-assn.org/*

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition.

Frances, A & First M. (1998). *Your Mental Health: A Layman's Guide to the Psychiatrist's Bible.* New York: Scribner.

Havens, J. F; Mellins, C. A; Pilowski, D. Mental health issues in HIV-affected women and children. *International Review of Psychiatry.* Vol 8(2-3), Sep 1996, 217-225.

National Institute on Alcohol Abuse and Alcoholism. (2000). Projections of DSM-III alcohol abuse and alcohol dependence for the U.S. population aged 18 and older, 1990, 1995, 2000. *www.niaaa.nih.*

National Institute of Mental Health (2001). *Numbers Count: Mental Disorders in America.* NIH Publication No. 01-4584. Also available at: *www.nimh.nih.gov/*

National Institute of Mental Health (2000). *Anxiety Disorders*. NIH Publication NIH No.00-3879. Also available at: *www.nimh.hih.gov.*

Spitzer RL. Kroenke K. Williams JB. (1999) Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *JAMA*. 282(18):1737-44, 1999 Nov 10.

Spitzer, R. L., Williams, J. B. et al. Utility of a new procedure for diagnosing mental disorders in primary care: The PRIME-MD 1000 study. *JAMA*. 272(22):1749-56, 1994 Dec 14.

US Department of Health and Human Services (HHS), Office of Public Health & Science (1999) David Satcher, et al. *Mental Health: Report of the Surgeon General.* Washington, DC.

US Department of Health and Human Services. (1999) Mental Health Care for People Living with or Affected by HIV/AIDS: A Practical Guide. Edited by C. Acuff et al. Washington, DC.

# The Client Diagnostic Questionnaire (CDQ)

## Users' Guide

# Using the Client Diagnostic Questionnaire (CDQ)

This Implementation Manual is designed for managers and leaders within HIV service organizations, including physician's offices, hospitals, clinics and community based agencies. The manual will help you implement the CDQ within your organization, whether you currently offer mental health services or not. This document is a companion to the CDQ Training Manual: Use of the Client Diagnostic Questionnaire (CDQ). It is directed toward staff who will administer the CDQ screening tool.

Following a general introduction to the CDQ intended for all readers, we address implementation issues within the following agency settings:

**What is the CDQ?**

The CDQ is:

- A screening tool to assess client need for mental health services.
- A tool that can be used by persons with no mental health training as well as by clinicians.
- Time-sensitive. It can be completed in 10 - 15 minutes.
- Flexible. The CDQ may be modified to meet the specific needs of individual programs.
- Versatile, allowing for implementation by a range of agency personnel, in a variety of settings, for different program purposes (e.g. needs assessment, treatment planning, outcomes evaluation).
- A tool that helps to bring needed mental health services to some of our county's more vulnerable underserved individuals.

The CDQ is not:

- A barrier to care for clients or patients.
- A time-intensive assessment procedure.
- Difficult to use for non-mental health professionals.
- A tool that can be used by non-mental health professionals to determine specific psychiatric diagnoses. Definitive diagnoses require assessment by a trained mental health professional, or by having a clinician review information collected by the CDQ.

**Why use the CDQ?**

- Mental health issues or psychological problems are extremely common among persons living with HIV.
- Mental health issues are largely undiagnosed and many people with a problem do not receive any mental health services or treatment.
- The lack of appropriate mental health care is even more prevalent in already vulnerable populations, including individuals who are poor, homeless, chemically involved, or recently incarcerated.
- Untreated mental health issues can cause significant suffering, making it harder for people to function on a day-to-day basis.
- Untreated mental health issues can pose barriers to service delivery in a wide range of service areas and impair a client's ability to access medical care and adhere to treatment regimens, follow up on case management referrals, and be self-sufficient in new housing etc.
- Untreated mental health issues can pose a significant threat for relapse for those who are recovering from substance abuse.
- Research has shown that a major impediment to accessing needed mental health services is a client's lack of recognition or acknowledgement of mental health problems.
- When providers lack the tools, training, or time to adequately assess mental health needs, these needs will not be recognized and therefore cannot be met.

**How can the CDQ can improve client care?**

- The systematic use of a standardized mental health screener will increase recognition of client mental health needs, especially by staff with little or no mental health training.
- Systematic use of a screening tool is superior to assessments based on prior history of psychiatric hospitalization or other treatment experience since many people who are in need of mental health services have not had any treatment.
- The CDQ collects information in symptom clusters that can be scored to yield the likelihood of a particular diagnosis according to standard DSM-IV criteria, the standard diagnostic schema used by mental health professionals.
- A diagnostic screener such as the CDQ provides a more precise description of the mental health treatment needs of clients and can be used as a triage instrument for treatment planning and/or referral.
- The CDQ was developed specifically to facilitate rapid and accurate recognition of mental health problems commonly seen in HIV/AIDS service settings: Depressive and Anxiety Disorders including PTSD, Alcohol and Drug Abuse Disorders. There is also a Psychosis screen.
- A validation study conducted by researchers at the Mailman School of Public Health at Columbia University demonstrated that the CDQ administered by agency staff with no prior mental health training accurately identifies clients with clinically significant mental health needs.
- The study also found that clients are receptive to the screening interview.

## Implementing the CDQ

Introducing the CDQ into existing agency operations will require some changes in your agency. For example, it will be necessary to build support for the use of the tool, train staff to use the tool, alter client assessment procedures, and supervise those who conduct the screening.

The implementation process is likely to run more smoothly if you ensure that:

- There is a clear understanding of the need for the change.
- Time and energy have been given to understanding how the implementation of the CDQ will affect individual staff and the agency as a whole.
- Sufficient time has been invested in preparing to adopt the tool, including providing education and training, and facilitating paradigm or protocol shifts that need to occur.
- The desired change can be introduced incrementally into behaviors or practices that are already in place.
- Follow-up support for the change is provided.

## Preparing to use the CDQ

Before implementing the CDQ, program managers should have developed a clear rationale for the systematic screening for mental health needs and a strategic plan for implementation of the CDQ as a screening tool. Be sure you know who will administer the questionnaire and to which clients, and when in the service process the screening will take place. You must also have determined what you will do with the information generated, such as knowing who will score or review the assessments, where the information will go, and how it will be transmitted to mental health providers who will use it for individual client care or larger program purposes.

Unless screening is being done for needs assessment or research purposes only, provision must be made for on-site or linked mental health services. Managers should seek input from staff as well as leadership as this strengthens the planning process and increases buy-in. It helps managers identify resource development and training needs for proper and smooth implementation.

**Staffing**

A separate stage in the implementation process is reorganizing staff roles and responsibilities and conducting staff development training. Using the CDQ will represent a change from usual and customary behaviors at intake or client case review. While this may represent a small or a larger change from existing agency protocols, it still represents a change that must be reflected in staff job descriptions and supervision.

Staff will vary with regard to their training needs. However, all persons who use the CDQ will require some level of training to accurately administer the assessment tool. At a minimum, prior to administering the instrument, staff should be taken through the instrument item by item to ensure they understand the purpose and function of each question. It is also essential that staff practice administering the instrument by role-playing the roles of both interviewer and client. Each staff member should practice administering the instrument at least three times.

A Training Manual: Use of the Client Diagnostic Questionnaire (CDQ), which includes a copy of the actual instrument with instructions (both are included in this packet), is designed for individuals who will be using the CDQ in agency settings. Additional training resources, including a training tape and specialized staff training programs, may be obtained from Cicatelli Associates, Inc., at either 212-594-7741, or www.cti.org.

## Instructions for Agencies with an Existing Mental Health Services

**Why use the CDQ?**

- The CDQ is a benefit to your organization in its ability to access poor and vulnerable clients who may be in great need of your services, but whose ancillary issues (substance abuse, competing survival needs associated with homelessness etc.) or hesitancy to discuss mental or emotional issues create difficulties in accurately assessing their need for services.

- The CDQ can assist in standardizing assessment and intake procedures as well as decreasing time spent by clients and clinicians in completing the assessment protocol.

- There is a longer, "Clinician Version" of the CDQ that is suitable for use by mental health professionals or in situations where completed interviews are reviewed by a trained clinician. The longer version includes questions about possible rule outs, prior episodes of disorder and treatment history. This information is necessary for differential diagnosis according to DSM-IV criteria. The Clinician CDQ is similar to the SCID or other structured psychiatric interview schedules but takes less time to complete (20-30 min) and focuses on disorders most commonly seen among HIV populations.

**Steps to Implementation:**

1. Ensure that the organizational climate exists to support the introduction of the CDQ.

For some mental health providers, the process could be as simple as a change in the forms that are currently being utilized. For others, this might require the following steps:

- Educating upper management and Boards about the disproportionate number of poor and otherwise vulnerable individuals who are affected by mental health issues and have significant barriers to mental health care.
- Create buy-in through training and organizational influence.

2. Provide training and support.

- Be sure to provide sufficient training and support resources to allow for the change to occur smoothly.
- Provide ongoing support after implementation.

3. Be sure to create buy-in with line staff who will be delivering the instrument.

- Introduce the tool as an improved screener to allow for optimal utilization and increase the effectiveness of the work and the services offered to the patient/client.

- Provide the staff with sufficient training so that they feel comfortable utilizing the tool. Staff will vary with regard to their training needs. However, all persons who use the CDQ will require some level of training to accurately administer the assessment tool. At a minimum, prior to administering the instrument, staff should be taken through the instrument item by item to ensure they understand the purpose and function of each question. It is also essential that staff practice administering the instrument by role-playing the roles of both interviewer and client. Each staff member should practice administering the instrument at least three times.

- Be prepared to answer questions about the need for the change and to address resistance to the change.

- Create protocol shifts where necessary to ensure that implementation happens in an organized and systematic manner.

- Be sure that clinicians review sections of the Training Manual that address administering the CDQ and the Question-by-Question Review. Regardless of prior experience, training in the use of the CDQ as a standardized instrument is necessary

- After training is complete, begin utilizing the CDQ with all new intakes. The CDQ is versatile enough to be implemented as either a clinician-led interview or an interview by non-professional staff with clinician review.

## Instructions for Agencies Wishing to Develop Mental Health Services

**Why use the CDQ?**

- It clearly identifies clients with needs for mental health services, and will help distinguish between needs that can be met with supportive counseling or support group participation from those that require professional mental health treatment
- Increases client adherence to service plans and/or treatment regimens by addressing mental health needs
- Decreases repeated patient visits for clients better served through mental health interventions.
- Provides clients with optimal overall health related services.
- Improves services for poor and vulnerable clients who may be in great need of your services, but whose ancillary issues (substance abuse, competing survival needs associated with homelessness etc.) or hesitancy to discuss mental or emotional issues create difficulties in accurately assessing their need for services.

❁ There is a longer, "Clinician Version" of the CDQ that is suitable for in situations where completed interviews are reviewed by a trained clinician. The longer version includes questions about possible rule outs, prior episodes of disorder and treatment history. This information is necessary for differential diagnosis according to DSM-IV criteria.

**Steps to Implementation:**

1. Be sure to create the organizational climate necessary to support the introduction of the CDQ.

Addressing the need for mental health screening in relation to your services is of paramount importance. This must start at the very top of the organization and work its way throughout the staff to ensure that the CDQ is utilized to the optimal benefit of the patients/clients you serve. We suggest the following:

- Educating upper management and Boards about the disproportionate number of poor and otherwise vulnerable individuals who are both affected by mental health issues and the significant barriers to accessing care that exist for these individuals.
- Creating buy-in through training and organizational influence.
- Offering sufficient training and support resources to allow for the change to occur smoothly and ongoing support to be available after implementation.
- Making ongoing support available after implementation.

2. Be sure to create buy-in with line staff who will be delivering the instrument.

- Introduce the tool as an easy and effective screener to allow for optimal utilization and increase the effectiveness of the work and the services offered to the patient/client.

- Provide the staff with sufficient training so that they feel comfortable utilizing the tool. Staff will vary with regard to their training needs. However, all persons who use the CDQ will require some level of training to accurately administer the assessment tool. At a minimum, prior to administering the instrument, staff should be taken through the instrument item by item to ensure they understand the purpose and function of each question. It is also essential that staff practice administering the instrument by role-playing the roles of both interviewer and client. Each staff member should practice administering the instrument at least three times.

- Be prepared to answer questions about the need for the change and to address resistance to the change.

- Create protocol shifts where necessary to ensure that implementation happens in an organized and systematic manner.

3. Have on-site clinical back-up and on-site or service linkage agreements to ensure that persons who screen positive for mental health needs are referred for more complete clinical assessment and treatment as necessary

- Establish protocol for immediate response to highly distressed or possibly suicidal clients.

- If services provided by linkage agreements, establish protocol for implementing referrals and monitoring client access and outcome of off site services.

- Be prepared to address questions that your staff or clients might have about the need for mental health screening. The first section of the Training Manual provides background on mental health and mental illness that will be useful for this training.

- After training is complete, begin utilizing the CDQ with all new patients/clients.

- The CDQ is versatile enough to be implemented by a range of staff with little or no formal training in mental health assessment. Determine staff familiarity with mental health issues, and probe possible stereotypes and assumptions that may impede effective screening. These will need to be addressed as well as possible issues with asking sensitive questions.

- For existing patients/clients, case management visits, or routine clinical visits are excellent opportunities for CDQ screening.

- Review CDQ findings at general chart-review intervals as follow-up for assuring effective implementation and answering additional staff questions or ongoing issues.

**Why use the CDQ?**

- Effectively screen for mental health related issues that often exist alongside other issues of vulnerability. These may specifically include depression, anxiety disorders, stress related issues.
- Assist line staff in recognizing mental health related issues and making appropriate referrals for care.
- Increase productivity and effectiveness of staff who are not caught in attempting to address mental health issues better served through other professionals.
- Provide clients with optimal overall health related services.
- Improve services for poor and vulnerable clients who may be in great need of your services, but whose ancillary issues (substance abuse, competing survival needs associated with homelessness etc.) or hesitancy to discuss mental or emotional issues create difficulties in accurately assessing their need for services.

**Steps To Implementation:**

1. Be sure to create the organizational climate necessary to support the introduction of the CDQ.

Addressing the need for mental health screening in relation to your services is of paramount importance. This must start at the very top of the organization and work its way throughout the staff to ensure that the CDQ is utilized to the optimal benefit of the patients/clients you serve.

It is important to address, specifically, the issue of stigmatization and mental health issues as well. In many cases, CBOs are dealing directly with individuals who are already marginalized or stigmatized by societal norms Remember that the CDQ is a diagnostic screening tool and is used to classify illness, not to classify or label individuals as "mentally ill." The CDQ helps individuals access the services they might need to support healthy and ongoing change in their lives. It is an empowerment tool.

For the implementation process, we suggest the following:

- Educating upper management and Boards about the disproportionate number of poor and otherwise vulnerable individuals who are both affected by mental health issues and who have significant barriers to access that exist for these individuals.

- Creating buy-in through training and organizational influence.

- Addressing directly issues of concern around stigmatization and labeling while creating strategies to minimize this potential within your agency.

- Offering sufficient training and support resources to allow for the change to occur smoothly and on-going support to be available after implementation.

- Making on-going support available after implementation.

2. It is especially important to create understanding and buy-in with line staff who will be delivering the instrument.

- Introduce the tool as an easy and effective screener to allow for optimal utilization and increase the effectiveness of the work and the services offered to the patient/client.

- Provide the opportunity for staff ask questions and raise concerns.

- Address directly the issue of stigmatization and the plans that have been created to minimize that outcome for your clients.

- Provide the staff with sufficient training so that they feel comfortable utilizing the tool. Staff will vary with regard to their training needs. However, all persons who use the CDQ will require some level of training to accurately administer the assessment tool. At a minimum, prior to administering the instrument, staff should be taken through the instrument item by item to ensure they understand the purpose and function of each question. It is also essential that staff practice administering the instrument by role-playing the roles of both interviewer and client. Each staff member should practice administering the instrument at least three times.

- Be prepared to answer questions about the need for the change and to address resistance to the change.

- Create protocol shifts where necessary to ensure that implementation happens in an organized and systematic manner.

- Be prepared to address questions that your staff or clients might have about the need for mental health screening. The first section of the Training Manual provides background on mental health and mental illness that will be useful for this training.

- After training is complete, begin utilizing the CDQ with existing clients.

- The strategies that you use will reflect directly your organizations services, style and culture. Some things to keep in mind include:
    - The level of trust that might be necessary to access honest and reliable answers to a mental health screening tool.
    - The timing of the screening. For some organizations, intake is an appropriate and reasonable time. For others, waiting until a case review or a follow-up session might make more sense.
    - The potential that a level of disenfranchisement might already exist for the client.

- The CDQ is versatile enough that it can be used by peer counselors if appropriately trained. Determine staff familiarity with mental health issues, and probe possible stereotypes and assumptions that may impede effective screening. These will need to be addressed as well as possible issues with asking sensitive questions.

- For existing clients, case management visits, in-home assessment or home visits are excellent opportunities for CDQ screening.

- Review CDQ findings at general chart-review intervals as follow-up for assuring effective implementation and answering additional staff questions or ongoing issues.

# Additional Resources

**Materials:**

For additional copies of the CDQ instrument and the Training Manual, contact any of the following:

HRSA Information Center
2070 Chain Bridge Road, Suite 450
Vienna, Virginia 22182
888-275-4772
Attn: Carla Bustillo

Cicatelli Associates, Inc.
505 8th Ave
20th Floor
New York, New York 10018
212-594-7741

mediawise
205 North Walnut Street
Suite 200
Bloomington, Indiana 47404
812-339-9060

# ETAC/ CDQ- SHORT FORM

*Client Diagnostic Questionnaire - Short Screener 2/1/01*

***1. Agency/ Program*:**_____ ***2. Interviewer*** _____

***3. Today's Date*** **:**_____ /_____/_____ ***4. Client ID*: |**____|____|____|____|____|____|____|____|____|____|

Month/ Day/ Year

***5. Client Name or Initials*** _____

***Instructions to interviewer:***

This questionnaire is designed to facilitate the recognition of the most common mental health problems found in HIV/AIDS primary care or other service settings: mood, anxiety, alcohol and drug abuse, PTSD and thought disorder. Since the questionnaire relies on respondent self-report, definitive diagnoses must be verified by a clinician, taking into account how well the client understood the questions in the questionnaire, as well as other relevant information from family, client records, or other sources.

1. Interviewer instructions are printed in bold italics. Questions that you ask or statements that you make to the client are printed in plain type. Read questions as written. Additional probes may be used to ensure client understanding of the question or explore ambiguous answers.
2. For anything other than a "yes/no" answer, read the answer categories. The interviewer may need to assist the client in answering within the categories given. Never choose an answer category based on what you think the client means by their spoken response.
3. Be sure that the client is reporting symptoms experienced within the specified time period: past 4 weeks, past 6 months, or in some instances, past 30 days.
4. Within each module, proceed sequentially from question to question unless instructed either to skip to another question or to go to the next page.
5. At the end of each diagnostic module is a shaded area with instructions for scoring Positive Screen for each disorder. Scoring can be done by the interviewer or left for office use only.
6. A Summary Sheet is provided to record "positive screen" or "positive for syndrome" in the spaces provided for each diagnostic module. If no positive screen in any module, indicate in the space provided on the top of the summary sheet.
7. Space is also provided for interviewer observations and comments. Interviewer should write as detailed as possible description of positive answers to questions especially on psychosis screen. Where known, additional information that may account for symptoms (e.g. medical condition) or history of prior episodes or treatment should be indicated.
8. ***If Client indicates current suicidal feelings or becomes emotionally upset or agitated during interview, please follow agency protocol for contacting your supervisor.***

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The CDQ is based on the PHQ which was developed by Robert L Spitzer, MD, Janet B W Williams, DSW, Kurt Kroenke, MD, et al, and is a modification of the PRIME-MD, which was developed with an unrestricted educational grant from Pfizer, Inc. Adaptation for use by SPNS/ HOPWAProgram Projects by Angela Aidala, PhD and Jennifer Havens, MD with the assistance of Jeffrey Johnson, PhD, Peter Walsh, MD, Cevdet Tosyali, MD, Ezra Susser, MD, and Sally Dodds, PhD, LCSW. For information about using this instrument contact Angela Aidala, PhD, Columbia School of Public Health, 600 W 168th, New York, NY 10032. Phone: (212) 305-7023, email:aaa1@columbia.edu

***Client Introduction***

This questionnaire will help us better understand problems that you may have. We ask these questions of everyone so that we can get a better picture of the kind of help or support we could provide for you. Please try to answer every question. All your answers are be completely confidential.

**Overview**

1. Thinking about the past six months, that is about this time in _____ (***reference date 6 mos prior to interview***), how have things been going for you in terms of your mood or feelings? Were there any periods when you were very sad or depressed? How about any times when you were very nervous, frightened, or worried about things? Were there times when you were so active or hyper that you couldn't slow down?

2. Did anything happened to you during that time that had anything to do with your feeling (acting) this way (sad, anxious, hyper etc... refer to symptoms)? Anything that was especially hard or stressful for you?

3. During the past six months did you talk to anyone about emotional problems, your nerves or the way you were feeling or acting? ***If YES***, Whom did you talk to? ***(Probe)*** Did you talk to professional person like a doctor or counselor? What did they say about it?

***Interviewer: If client describes symptoms or treatment history, let him/her know that you will be talking about this in more detail later in the interview. All screening and appropriate symptom questions must be asked even though topic was discussed in overview. Confirm answers already known.***

**Now some questions about your moods and feelings. During the last month (past 4 weeks) was there a time when...**

| | No, Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. You were feeling sad, down, depressed, or hopeless? ***IF YES***, How often did you feel that way? ..... | ❑ | ❑ | ❑ | ❑ |
| 2. You had little interest or pleasure in doing things? ***IF YES***, How often did you feel that way? ..... | ❑ | ❑ | ❑ | ❑ |

***If client answers "No, Not at all" to both questions, go to next page***

3. When was was it you began feeling this way (the most recent time)? ... _____
4. How long did it last– was it as long as 2 weeks? ..... ❑ No ❑ Yes

**During that time, how often were you (have you been) bothered by:**

| | No, Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 5. Trouble falling or staying asleep? Or sleeping too much? ..... | ❑ | ❑ | ❑ | ❑ |
| 6. Feeling tired or having little energy? ..... | ❑ | ❑ | ❑ | ❑ |
| 7. Poor appetite? Or overeating? ..... | ❑ | ❑ | ❑ | ❑ |
| 8. Feeling bad about yourself – or that you are a failure or have let yourself or your family down? ..... | ❑ | ❑ | ❑ | ❑ |
| 9. Trouble concentrating on things, such as reading the newspaper, watching television, or listening to someone give you directions? ..... | ❑ | ❑ | ❑ | ❑ |
| 10. 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? ..... | ❑ | ❑ | ❑ | ❑ |
| 11. You had thoughts that you would be better off dead or thoughts of hurting yourself in some way? ..... | ❑ | ❑ | ❑ | ❑ |

Maj Dep Syn if 2 weeks (Q4) is "yes" (AND) answer to question 1 or 2 is shaded (AND) 5+ of answers to any of Q. 1, 2, 5 - 11 are shaded; Other Dep Syn same but only 2+ of the answers to Q. 1, 2, 5 - 11 are shaded

**Now some questions about anxiety...**

| | YES | NO |
|---|---|---|
| 1. In the last 4 weeks, have you had an anxiety attack– suddenly feeling fear or panic? ..... | ❑ | ❑ |

***If client answers "NO" go to next page***

| | | |
|---|---|---|
| 2. Has this ever happened before? ..... | ❑ | ❑ |
| 3. Do some of these attacks come <u>suddenly out of the blue</u>—that is, in situations where you don't expect to be nervous or uncomfortable? ..... | ❑ | ❑ |
| 4. Do these attacks bother you a lot? Are you worried about having another attack? ..... | ❑ | ❑ |

**Think about your last really bad attack.**

| | | |
|---|---|---|
| 5. Were you short of breath? ..... | ❑ | ❑ |
| 6. Did your heart race, pound, or skip? ..... | ❑ | ❑ |
| 7. Did you have chest pain or pressure? ..... | ❑ | ❑ |
| 8. Did you sweat? ..... | ❑ | ❑ |
| 9. Did you feel as if you were choking? ..... | ❑ | ❑ |
| 10. Did you have hot flashes or chills? ..... | ❑ | ❑ |
| 11. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? ..... | ❑ | ❑ |
| 12. Did you feel dizzy, unsteady, or faint? ..... | ❑ | ❑ |
| 13. Did you have tingling or numbness in parts of your body? ..... | ❑ | ❑ |
| 14. Did you tremble or shake? ..... | ❑ | ❑ |
| 15. Were you afraid you were dying? ..... | ❑ | ❑ |

Pan Syn if answers to Q. 1,2,3 and 4 are 'Yes' (AND) 4+ symptoms during an attack (Q. 5-15)

**Over the <u>last 4 weeks</u>, how often have you been bothered by:**

| | No, Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, on edge, or worrying a lot about different things? | ❑ | ❑ | ❑ | ❑ |

***If client answers "Not at all" go to next page***

| | | | | |
|---|---|---|---|---|
| 2. Feeling restless so that it is hard to sit still? | ❑ | ❑ | ❑ | ❑ |
| 3. Getting tired very easily? | ❑ | ❑ | ❑ | ❑ |
| 4. Muscle tension, aches, or soreness? | ❑ | ❑ | ❑ | ❑ |
| 5. Trouble falling asleep or staying asleep? | ❑ | ❑ | ❑ | ❑ |
| 6. Trouble concentrating on things, such as reading a newspaper, watching TV or listening to someone give you directions? | ❑ | ❑ | ❑ | ❑ |
| 7. Becoming easily annoyed or irritable? | ❑ | ❑ | ❑ | ❑ |

Other Anx Syn if answer to Q. 1 is shaded (AND) 3+ answers to Q. 2-7 are shaded.

**Next are some questions about drinking alcohol and use of other substances. We ask these questions as part of everyone's health profile. Everything you tell me is strictly confidential and protected**.

1. During the past six months, how often do you drink beer, wine or liquor?

| Never | Less than 1x month | Monthly | Weekly | 3x Week | Everyday |
|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

***If client <u>never</u> drinks alcohol, go to last alcohol question - Q.13 next page***

2. How many drinks do you usually have on those days when you drink?

| One | Two | Three | Four | Five | More than five |
|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

Have any of the following things happened to you <u>more than one time in the last 6 months</u>, that is from (_____) until today?
***(fill in date 6 mo prior to interview)***

| | YES | NO |
|---|---|---|
| 3. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with you health? ..... | ❑ | ❑ |
| 4. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities? ..... | ❑ | ❑ |
| 5. You missed or were late for something important because you were drinking or hung over? ..... | ❑ | ❑ |
| 6. You had a problem getting along with other people while you were drinking? ..... | ❑ | ❑ |
| 7. You drove a car after having several drinks or after drinking too much? ..... | ❑ | ❑ |

Alc Abu if 1+ answers to Q. 3-7 are Yes (OR) 5+ drinks a day weekly or more often

**During the PAST 30 DAYS, that is, since this time in (_____) ...**
***(month prior to interview)***

8. How many days did you have anything alcoholic to drink? |__|__|

***If client <u>never</u> drank alcohol past 30 days, go to last alcohol question - Q.13 below***

During the past 30 days...

| | YES | NO |
|---|---|---|
| 9. Have you thought you should cut down on your drinking alcohol? ..... | ❑ | ❑ |
| 10. Has anyone complained about your drinking? ..... | ❑ | ❑ |
| 11. Have you felt guilty or upset about your drinking? ..... | ❑ | ❑ |
| 12. Was there a single day in which you had five or more drinks of beer, wine or liquor ..... | ❑ | ❑ |

***ASK EVERYONE***

13. Did you or anyone close to you ever think you had a problem with alcohol? ..... ❑ Yes ❑ No

Alc Abu 30 day if 2+ answers to questions 9-12 are YES

**Now here are some questions about drug use.** (***Remind client of confidentiality***)
**Remember that everything you tell me is strictly confidential and protected**

Have you ever used any of the following drugs, even one time...

***GO DOWN THE ENTIRE LIST, then go back and for any drug used, ask about use past six months***

| | Ever used | | ***If YES for any drug ask***: During the PAST SIX MONTHS, how often did you use (drug)? | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Never | Less than 1x month | Monthly | Weekly | 3x Week | Every day |
| 1. Marijuana, hashish (pot, reefer) …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 2. Cocaine …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 3. Crack, freebase …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 4. Heroin, speedball …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 5. Methadone without a prescription or more than a doctor told you to …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 6. Sedatives or tranquilizers (downers) without a pre-scription or more than a doctor told you to …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 7. Stimulants (uppers, speed, ice) without a pre-scription or more than a doctor told you to …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 8. Hallucinogens (PCP, angel dust, ecstasy, mushrooms, LSD …… | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 9. Sniffed or inhaled anything to get high (poppers, sprays, glue) … | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

| | ***Yes*** | ***No*** |
|---|---|---|
| ***IF EVER USED ANY DRUG:*** | | |
| 10. Have you ever had a drug injected or skin popped with a needle, even one time? | ❑ | ❑ |
| ***IF EVER USED NEEDLE:*** | | |
| 11. Have you had a drug injected or skin popped with a needle at any time during the past six months? | ❑ | ❑ |

***<u>If No Drug Use IN 6 MONTHS</u> go to PAGE 11 Trauma***

***Ask all clients who have <u>used any drug</u> in past 6 mos***

Have any of the following things happened to you <u>more than one time in the last 6 months</u>, that is from (_____) until today?

fill in date 6 mo prior to interview

| | YES | NO |
|---|---|---|
| 12. You used drugs even though a doctor suggested that you stop using because of a problem with your health? ..... | ❑ | ❑ |
| 13. You used drugs, were high or hung over from drugs while you were working, going to school, taking care of children or other responsibilities? ..... | ❑ | ❑ |
| 14. You missed or were late for something important because you were using drugs or hung over? ..... | ❑ | ❑ |
| 15. You had a problem getting along with other people while you were using drugs ..... | ❑ | ❑ |
| 16. You drove a car after using drugs ..... | ❑ | ❑ |
| 17. You had legal problems because of drug use ..... | ❑ | ❑ |

DRUG ABU if 1+ answers to Q 12 - Q 17 are Yes (OR) Heroin, Coke/Crack or Methamphetamine 3+ per week

**During the PAST 30 DAYS, that is, since this time in (_____) ...**
***month prior to interview***

How many days did you use...

14. Marijuana …… |___|___|
15. Cocaine …… |___|___|
16. Crack …… |___|___|
17. Heroin or speedball …… |___|___|
18. Sedatives, Downers …… |___|___|
19. Stimulants, Uppers …… |___|___|
20. Hallucinogens …… |___|___|
21. Inhalants …… |___|___|

***If client <u>never</u> used any drug past 30 days, go to next page***

During the past 30 days...

| | YES | NO |
|---|---|---|
| 22. Have you thought you should cut down on your drug use? …… | ❑ | ❑ |
| 23. Has anyone complained about your drug use? …… | ❑ | ❑ |
| 24. Have you felt guilty or upset about your drug use? …… | ❑ | ❑ |
| 25. Have you used any drug 3 or more times a week or more often? …… | ❑ | ❑ |

Dru Abu 30 day if 2+ answers to questions 22-25 are Yes

***ASK EVERYONE***

**Now some questions about terrible or frightening things that may have happened to you.**

People often have traumatic experiences. I mean terrible, frightening events. I am going to read a list of some possible events that sometimes happen to people. Please tell me if you ever experienced...

| | YES | NO |
|---|---|---|
| 1. A serious accident or fire at home or at your job ..... | ❑ | ❑ |
| 2. A natural disaster such as hurricane, major earthquake, flood, or other similar disaster ..... | ❑ | ❑ |
| 3. Direct combat experience in a war ..... | ❑ | ❑ |
| 4. Physical assault or abuse in your adult life by your partner ..... | ❑ | ❑ |
| 5. Physical assault or abuse in your adult life by someone other than your partner ..... | ❑ | ❑ |
| 6. Physical assault or abuse as a child ..... | ❑ | ❑ |
| 7. Seeing people hitting or harming one another in your family when you were growing up ..... | ❑ | ❑ |
| 8. Sexual assault or rape in your adult life ..... | ❑ | ❑ |
| 9. Sexual assault or rape as a child ..... | ❑ | ❑ |
| 10. Seeing someone physically assaulted or abused ..... | ❑ | ❑ |
| 11. Seeing someone seriously injured or violently killed ..... | ❑ | ❑ |
| 12. Losing a child through death ..... | ❑ | ❑ |
| 13. Any other terrible or frightening thing that may have happened to you. Specify _____ | ❑ | ❑ |

***If client answers "NO" to all questions go to Page 13, PSY***
***If client answers "YES" to one or more questions go to the NEXT PAGE***

***If client answers "YES" to <u>ONLY ONE</u> event listed on the previous page, Ask Q. 1A***

1A. You have told me about the time _____ (name event).
I would like to ask you a little more about this event …… ***skip to Q.2***

***If client answers "YES" to <u>MORE THAN ONE</u> event on the previous page, Ask Q. 1 B***

1B. You have told me about a number of things that have happened to you.Which of these events was the most terrible or frightening for you? _____ ***(specify event or series of related events the client names)***

**I would like to ask you a little more about this event (series of events)...**

2. How frightened were you...

| ❑ | ❑ | ❑ | ❑ | ❑ |
|---|---|---|---|---|
| Not at all | Just a little | Bad | Very Bad | Scared to Death |

**During the past six months...**

| | | **YES** | **NO** |
|---|---|---|---|
| 3. | Do you keep remembering it even when you don't want to? …… | ❑ | ❑ |
| 4. | Do you have nightmares about it? …… | ❑ | ❑ |
| 5. | Do things that remind you of it make you very upset? …… | ❑ | ❑ |
| 6. | Do you ever have flashbacks - a sudden feeling that the event was happening all over again? …… | ❑ | ❑ |
| 7. | Do you worry a lot that it might happen again? …… | ❑ | ❑ |
| 8. | Do you avoid things that remind you of it? …… | ❑ | ❑ |
| 9. | Do you sometimes have trouble remembering exactly what happened? …… | ❑ | ❑ |
| 10. | Do you feel alone even when with other people, or feel cut off from people? …… | ❑ | ❑ |
| 11. | Do you feel numb or like you no longer have strong feelings for anything? …… | ❑ | ❑ |
| 12. | Are you jumpy or on guard when there is no reason to be? …… | ❑ | ❑ |

PTS Syn if answer to 2 is "Bad" or worse (AND) 1+ answers to Q 3-6 (AND) 2+ answers to Q.8-11 are YES

**Now I am going to ask you about some beliefs and feelings that some people have. Some people have these feelings and beliefs after they have been drinking alcohol or taking drugs. I would like to know if you have ever had some of these beliefs or feelings during the PAST 4 WEEKS (30 days) when you <u>have not</u> been drinking alcohol or taking drugs.**

| **During the past 4 weeks, how often . . .** | **Never** | **One Time** | **More than one time** |
|---|---|---|---|
| 1. Have you heard noises or voices that other people say they can't hear? ..... ***If YES:*** Tell me what was it that you heard? If a voice: What did the voice(s) say? Did the voice(s) tell you to do anything? What? Is it like the voice is inside your head or coming from the outside? _____ | ❑ | ❑ | ❑ |
| 2. Have you felt that there were people who wanted to harm or hurt you? ..... ***If YES:*** Who are these people? Why do they want to hurt you? Do your fears about this make it hard for you to leave your home or where you usually sleep? _____ | ❑ | ❑ | ❑ |
| 3. Have you ever felt that there was something odd or unusual going on around you? ..... ***If YES:*** Can you tell me something about it? Do you feel like people are plotting against you? Do things seem to have special meaning to you? Like numbers or street signs or something like that? _____ | ❑ | ❑ | ❑ |
| 4. Have you had visions or seen things that other people say they can't see? ..... ***If YES:*** Tell me about what you have seen. Does this hapen when you are awake? Where does it happen? Are you seeing someone who has recently died? _____ | ❑ | ❑ | ❑ |
| 5. Have you felt that you had special powers that other people don't have? ..... ***If YES:*** Tell me about these powers. How are they different from what other people can do? How have you used these powers? _____ | ❑ | ❑ | ❑ |
| 6. Have you thought that you were possessed by a spirit or the devil? ..... ***If YES:*** Can you tell me about that? Did the spirit/devil make you do anything? What? _____ | ❑ | ❑ | ❑ |

| During the past 4 weeks, how often . . . | Never | One Time | More than one time |
|---|---|---|---|
| 7. Have you felt that your thoughts were taken from you by some outside or external source? ……<br>***If YES***: Who or what takes your thoughts? How do you think that happens? _____ | ❑ | ❑ | ❑ |
| 8. Have you had ideas or thoughts that nobody else could understand? ……<br>***If YES***: Tell me about these ideas. How do you know that nobody else can understand? _____ | ❑ | ❑ | ❑ |
| 9. Have you felt that thoughts were put into your head that were not your own? ……<br>***If YES***: What are some of these thoughts? How do you think they get into your head? _____ | ❑ | ❑ | ❑ |
| 10. Have you felt that your mind was taken over by forces you couldn't control? ……<br>***If YES***: Who or what takes control of your mind? How do you think that happens? _____ | ❑ | ❑ | ❑ |

***Additional Comments or Observations:*** _____

Psy Screen Positive if 2+ answers are shaded (OR) 3+ symptoms one time only. Do not score unless experiences described are implausible and outside of ordinary or culturally supported experiences

**These next questions are about different services you may have received *(Confirm information if known)***

1. Have you ever talked to a mental health specialist such as a psychiatrist, psychologist, or specially trained social worker, about emotional problems, your nerves, or the way you were feeling or behaving?

❑ No ❑ Yes → ***If YES:*** What did the _____ (mental health professional) say? Probe for diagnosis, if any

_____

_____

2. Have you ever been prescribed medications to help with emotional or psychological problems or ways you were feeling or behaving?

❑ No ❑ Yes → ***If YES:*** What medication(s)?

_____

_____

3.Have you ever been in the hospital because of emotional or psychological problems or ways you were feeling or behaving?

❑ No ❑ Yes → ***If YES:*** When was that? Why were you hospitalized?

_____

_____

4. Have you ever had any type of alcohol or drug treatment?

❑ No ❑ Yes → ***If YES:*** When was that? What type of treatment did you receive?

_____

_____

5. In the past six months, have you received any help for emotional or psychological difficulties like talking to a psychologist or psychiatrist, or taking medicine, or going into the hospital for a while?
***Circle all that apply***

1. Received outpatient therapy or counseling for psychological problems _____
2. Received alcohol or drug treatment _____
3. Medication (specify) _____
4. Hospitalization _____
5. Other (specify) _____

6. Is there anything else you feel is important to tell me about your moods, feelings, thoughts or ways of behaving during the past six months?

_____

_____

_____

_____

_____

(Optional Demographic Questions)

**Finally, we have a few background questions.**

**1. What is your birthdate?**_____/_____/_____
Month/Day/Year

**2. Client Gender** ***(confirm with client*** )
1. Male
2. Female
3. Transgender

**3. Which of the following best describes your racial or ethnic background...**
1. White, nonHispanic
2. Black non Hispanic
3. Hispanic, Latino
4. Asian, Pacific Islander
5. Native American, Aleutian, Eskimo

***Don't read but code if offered***
6. Other_____
7. Mixed_____ ***codes for 2 ethnicities*** |___| |___|

**4. Where were you born?**_____ (***country or state if U.S.)***

**5. What languague do you prefer to speak?** ***(choose one)***
01 English
02 Spanish
03 Creole
08 Other ***(specify)***_____

**6. How far did you go in school? What was highest diploma or degree you have gotten, if any?**
01 Under 7 years of schooling
02 Junior high school (7-9th grade)
03 Partial High School (10-11 grade)
04 High School Diploma / GED
05 Some college; community college degree
06 Four year college degree (BA, BS)
07 Completed graduate or professional training
08 Other ***(specify)***_____

**7. Do you consider yourself...**
01 Gay/ Lesbian
02 Bisexual, attracted to both men and women
03 Heterosexual, Straight
04 Not sure/ undecided/ in transition
05 Prefer not to say

**8. What was your most recent T-cell or CD4 count?**

***If client gives a number write it in here*** |___|___|___|
***or else use codes below***

| | | | |
|---|---|---|---|
| 01 | 0-100 | 06 | Don't know T-cell count but I was told it was "good" |
| 02 | 101-200 | 07 | Don't know T-cell count but I was told it was "bad" |
| 03 | 201-300 | 88 | Don't know T-cell count at all/ Don't recall test result |
| 04 | 301-500 | | |
| 05 | Greater than 500 | 00 | Client has never had T-cell CD4 test |

**SUMMARY SHEET (FILL OUT AFTER INTERVIEW)**
Review each section of the questionnaire and score the CDQ following the instructions in the shaded box on the bottom of the page at the end of each diagnostic module. Record all disorders for which the client scores positive on this sheet.

If the client does not score positive for any module, check here: ❑ **NO POSITIVE SCREEN IN ANY MODULE**

**DEPRESSIVE DISORDER**

❑ Positive for Major Depressive Syndrome

❑ Positive for Other Depressive Syndrome

Are client's symptoms of depression reaction to the death of a loved one? Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

**ANXIETY DISORDER**

❑ Positive for Panic Syndrome

❑ Positive for Generalized Anxiety Syndrome

Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

**ALCOHOL ABUSE**

❑ Positive for Alcohol Abuse, past 6 months

❑ Positive for Alcohol Abuse, past 30 days

Has client ever received treatment for alcohol abuse/dependence? Has client been in a controlled environment (e.g. jail, hospital)any time during the past 6 months? in the past 30 days? Other comments:

**DRUG ABUSE**

❑ Positive for Drug Abuse, past 6 months–List drug(s) of abuse:

❑ Positive for Drug Abuse, past 30 days–List drug(s) of abuse:

Has client ever received treatment for drug abuse/dependence? Has client been in controlled environment (e.g. jail, hospital) any time during the past 6 months? In the past 30 days? Other comments:

**POST TRAUMATIC STRESS DISORDER**

❑ Positive on PTSD Screen

Describe traumatic events. Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

**PSYCHOSIS**

❑ Positive on Psychosis Screen

Describe symptoms. Could symptoms be caused by medical condition, medication, or drug use? Has client ever received treatment for disorder? Other comments:

**TREATMENT EXPERIENCE**

❑ Client has had professional mental health treatment or has been prescribed psych medications in the past 6 months

❑ Client is <u>currently</u> receiving professional mental health treatment or has been prescribed psych medications

Dates of treatment? Was treatment completed? Is/was client adherent to treatment plan? Other comments:

**Interviewer Observations**

***Circle all that describe client based upon your observations during interview.***

Manifested inappropriate affect during parts of interview ..... Y..... N..... DK
Unusually unkempt or bizarre in appearance ..... Y..... N..... DK
So withdrawn into own world that s/he found it hard to answer questions ..... Y..... N..... DK
Manifested unusual ways of thinking and reasoning about experiences ..... Y..... N..... DK
Apathetic or flat in affect during interview ..... Y..... N..... DK
Nervous and tense during interview ..... Y..... N..... DK
Intoxicated or under influence of alcohol or drugs ..... Y..... N..... DK
Needle track marks ..... Y..... N..... DK
Skin abscesses, cigarette burns, or nicotine stains ..... Y..... N..... DK
Tremors (shaking and twitching of hands and eyelids) ..... Y..... N..... DK
Unclear speech: slurred, incoherent, or too rapid ..... Y..... N..... DK
Unsteady gait: staggering, off balance ..... Y..... N..... DK
Dilated (enlarged) or constricted (pinpoint) pupils ..... Y..... N..... DK
Scratching ..... Y..... N..... DK
Swollen hands or feet ..... Y..... N..... DK
Smell of alcohol or marijuana on breath ..... Y ..... N..... DK
"Nodding out" (dozing or falling asleep) ..... Y ..... N..... DK
Agitation ..... Y..... N..... DK
Inability to focus ..... Y..... N..... DK

Burns on the inside of the lips ( e.g. from smoking crack) ..... Y..... N..... DK

**Other comments/ observations:**