

Brief Mental Health (BMH) Screening Tool









KWAZULU-NATAL PROVINCE







HEALTH
REPUBLIC OF SOUTH AFRICA

Chart for Standard Alcohol Drinks

1 serving = ONE standard drink

<p>1 glass wine (125ml)</p>  <p>1 serving</p>	<p>1 single measure spirits (25ml)</p>  <p>1 serving</p>	<p>1 bottle beer/cider (330ml)</p>  <p>1 serving</p>	<p>1 can beer/cider (330ml)</p>  <p>1 serving</p>	<p>1 carton tlokwe (1L)</p>  <p>1 serving</p>	<p>Jar punch/skelm gemmer/umqombothi</p>  <p>1 serving</p>
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The number of standard drinks in commonly purchased quantities of alcohol

<p>1 bottle spirits (750ml)</p>  <p>30 servings</p>	<p>1 bottle wine (750ml)</p>  <p>6 servings</p>	<p>1/2 bottle spirits (375ml)</p>  <p>16 servings</p>	<p>1 quart beer/cider (947ml)</p>  <p>2 servings</p>	<p>Double measure spirits (50ml)</p>  <p>2 servings</p>	<p>punch/skelm gemmer/umqombothi</p> <p>Jar Jar Jar</p>  <p>2 servings 1 serving 1/2 serving</p>
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Source: Schoeman JH, Parry CD, Lombard CJ, Klopper HJ. Assessment of alcohol-screening instruments in tuberculosis patients. *Tuber Lung Dis.* 1994;75(5):371-376. doi:10.1016/0962-8479(94)90084-1

Graphics: South Africa - HIV Addiction Technology Transfer Centre (<https://atcnetwork.org/centers/south-africa-hiv-atcc/home>)

How to score

Depression		Anxiety		Alcohol	
Score	What and how to record	Score	What and how to record	Score	What and how to record
2 or less	NAD (No Abnormality Detected) in the Mental Health section of the Clinical Management Page in the patient file	2 or less	NAD (No Abnormality Detected) in the Mental Health section of the Clinical Management Page in the patient file	3 or less	NAD (No Abnormality Detected) in the Mental Health section of the Clinical Management Page in the patient file
3 or more	Write as a fraction i.e. 3/6, 4/6, 5/6 or 6/6 so that the CNP can use their Adult Primary Care Guideline to conduct further assessment	3 or more	Write as a fraction i.e. 3/6, 4/6, 5/6 or 6/6 so that the CNP can use their Adult Primary Care Guideline to conduct further assessment	4 or more	Write as a fraction i.e. 4/12, 5/12, 6/12, 7/12, 8/12, 9/12, 10/12, 11/12 or 12/12 so that the CNP can use their Adult Primary Care Guideline to conduct further assessment

Patient name and surname:				
Date of screening:				

1. DEPRESSION: Patient Health Questionnaire - 2

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

Kulamasonto amabili edlule, kukangaki ube nalezizinkinga ezilandelayo?

Little interest or pleasure in doing things	0 days	0	0	0	0
	1-7 days	1	1	1	1
Uzizwa engathi awufuni ukwenza lutho futhi ayikho nento ekujabulisayo	8-11 days	2	2	2	2
	12-14 days	3	3	3	3
Feeling down, depressed or hopeless	0 days	0	0	0	0
	1-7 days	1	1	1	1
Uzizwa sengathi umoya wakho uphansi, unengcindezi noma ulahlekelwe ithemba	8-11 days	2	2	2	2
	12-14 days	3	3	3	3
A score of 3 or more is screen positive for depression:	TOTAL	/6	/6	/6	/6

2. ANXIETY: Generalized Anxiety Disorder - 2

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

Kulamasonto amabili edlule, kukangaki ube nalezizinkinga ezilandelayo?

Feeling nervous, anxious or on edge	0 days	0	0	0	0
	1-7 days	1	1	1	1
Uzizwa engathi ushaywa uvalo noma uzizwa wethukile ngaphandle kwesizathu	8-11 days	2	2	2	2
	12-14 days	3	3	3	3
Not being able to stop or control worrying	0 days	0	0	0	0
	1-7 days	1	1	1	1
Uzizwa ukhathazekile ngaso sonke isikhathi futhi awukwazi nokuyeka ukukhathazeka	8-11 days	2	2	2	2
	12-14 days	3	3	3	3
A score of 3 or more is screen positive for anxiety:	TOTAL	/6	/6	/6	/6

3. ALCOHOL: Alcohol Use Disorders Identification Test (AUD-C)

I am going to ask you some questions about your use of alcoholic beverages

Ngizokubuzwa imibuzo mayelana nokusebenzisa iziphuzo ezidakayo

How often do you have a drink containing alcohol?	Never	0	0	0	0
	Monthly or less	1	1	1	1
	2-4 times a month	2	2	2	2
Ujwayele kangakanani ukuphuza amanzi amonjwana?	2-3 times a week	3	3	3	3
	4 or more times per week	4	4	4	4
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	0	0	0	0
	3 or 4	1	1	1	1
	5 or 6	2	2	2	2
Uma uphuza, ujwayele uphuza iziphuzo ezingaki?	7 to 9	3	3	3	3
	10 or more	4	4	4	4
How often do you have six or more drinks in one session?	Never	0	0	0	0
	Less than monthly	1	1	1	1
	Monthly	2	2	2	2
Kwenzeka kangaki ukuthi uphuze iziphuzo eziwu-6 kuyaphezulu ngesikhathi esisodwa?	Weekly	3	3	3	3
	Daily or almost daily	4	4	4	4
A score of 4 or more is screen positive for harmful substance use:	TOTAL	/12	/12	/12	/12

Administered by:				
Signature:				