

## SCORING GUIDE

## In the past 7 days:

1. I have been able to laugh and see the funny side of things
  - 0 As much as I always could
  - 1 Not quite so much now
  - 2 Definitely not so much now
  - 3 Not at all
2. I have looked forward with enjoyment to things
  - 0 As much as I ever did
  - 1 Rather less than I used to
  - 2 Definitely less than I used to
  - 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong
  - 3 Yes, most of the time
  - 2 Yes, some of the time
  - 1 Not very often
  - 0 No, never
4. I have been anxious or worried for no good reason
  - 0 No, not at all
  - 1 Hardly ever
  - 2 Yes, sometimes
  - 3 Yes, very often
5. I have felt scared or panicky for no very good reason
  - 3 Yes, quite a lot
  - 2 Yes, sometimes
  - 1 No, not much
  - 0 No, not at all
6. Things have been getting on top of me
  - 3 Yes, most of the time I haven't been able to cope
  - 2 Yes, sometimes I haven't been coping as well as usual
  - 1 No, most of the time I have coped quite well
  - 0 No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
  - 3 Yes, most of the time
  - 2 Yes, sometimes
  - 1 Not very often
  - 0 No, not at all
8. I have felt sad or miserable
  - 3 Yes, most of the time
  - 2 Yes, quite often
  - 1 Not very often
  - 0 No, not at all
9. I have been so unhappy that I have been crying
  - 3 Yes, most of the time
  - 2 Yes, quite often
  - 1 Only occasionally
  - 0 No, never
10. The thought of harming myself has occurred to me
  - 3 Yes, quite often
  - 2 Sometimes
  - 1 Hardly ever
  - 0 Never

**A score of 1 - 3 to item 10 indicating a risk of self-harm, requires immediate mental health assessment and intervention as appropriate.**

*Scoring of 11 - 13 range, monitor, support, and offer education.*

*Scoring of 14 or higher, follow up with comprehensive bio-psychosocial diagnostic assessment for depression.*

Source: Cox, JL, Holden, JM, Sagovsky, R (1987).  
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<b>T</b>	<b>Tolerance:</b> "How many drinks does it take to make you feel high?" (Or this can be modified to "How many drinks can you hold?") <i>Record number of drinks.</i>	3 or more drinks = 2 points
<b>W</b>	<b>Worry:</b> "Have close friends or relatives worried or complained about your drinking in the past year?"	Yes = 2 points
<b>E</b>	<b>Eye-Opener:</b> "Do you sometimes have a drink in the morning when you first get up?"	Yes = 1 point
<b>A</b>	<b>Amnesia (Blackout):</b> "Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?"	Yes = 1 point
<b>K (C)</b>	<b>Cut Down:</b> "Do you sometimes feel the need to cut down on your drinking?"	Yes = 1 point

**A score of 2 or more points indicates a risk of a drinking problem.**

*Source: Russell, M (1994). New Assessment tools for risk drinking during pregnancy: T-ACE, TWEAK and others. Alcohol Health and Research World.*