| Date: (yy/mm/dd) | Name of Individual: Last, First | CID:       |
| --- | --- | --- |
| DOB: (yy/mm/dd) | Address:   |
| Phone Number:       | Name of Person Completing Screener:       |
|  |  |
| **Pre-Screening** |
| Has the client previously graduated from the CMHA DBT program? |  [ ]  Yes [ ]  No |
| *If no, please continue with the screener. If yes, the client is ineligible, as clients can only complete the program once.* |
| Has the client previously attended and dropped out of the program? |  [ ]  Yes [ ]  No |
| *If no, please continue with the screener. If yes, please contact DBT Team to confirm eligibility.* |
| **General information -** *Please share the following information with the client:* |
| **Summary of the DBT program** |
| The DBT program at CMHA is based on the standard 24 week DBT curriculum. Some places do a shortened version (13 or 20 weeks); we do the full curriculum as developed and researched by Dr. Marsha Linehan. When clients join our DBT program, they are committing to attending our DBT group for a minimum of 6 months. The DBT program is cognitively based, involving reading, reflection, and homework. |
| Description of BPD |
| In DBT, we understand BPD as an experience of emotion dysregulation. That means that clients who join our program may have emotions that go up and down really fast and get really overwhelming, and behaviours that go along with that: those may be things like suicidal and self-harming behaviours, anger behaviours, and impulsive behaviours. The CMHAWW DBT program is designed to treat a primary diagnosis (or traits) of Borderline Personality Disorder.  |
| Does this sound like the kind of program that might be a fit with what you're looking for? | [ ]  Yes [ ]  No |
| *If yes, please continue with the screener. If no, please refer to another program.* |
| **Introductory Questions** |
| **REASON FOR DBT -** *Client may have been told they "should" do DBT. DBT is an entirely voluntary program; we're interested to know more about in why THEY are interested to do DBT* |
| Why do you want to do DBT?  |
|       |
| Notes: |       |
| **MENTAL HEALTH SUPPORT PERSON** |
| Clients joining our DBT groups need to have an individual Mental Health Support Person. This person needs to be professional or semi-professional; not a friend or family member. This person could be: * Therapist
* Counsellor
* AA sponsor
* Pastor
* Mental health nurse
* Support coordinator
* Anyone else in a designated mental health support role
 |
| Do you currently have a mental health support person that you meet with regularly? *(Therapist, counsellor, support coordinator, etc.)* | [ ]  Yes [ ]  No |
| Name: |       | Role: |       | How often do you meet? |       |
| ***WHY WE ASK THIS****:* Clients who join our DBT program need to have an individual mental health support person for the duration of their involvement in our group. This is true of DBT groups everywhere, not just our program. The reason for this is that the DBT group is like a class; it is not a process group. As such we are required to ensure that any client who joins our group has an individual mental health support person who can support them with emotional material that may be beyond the scope of the group. |
| **COGNITIVE CAPACITY** |
| DBT is a cognitively based therapy, based on reading, reflection, and homework. This section is intended to assess if this learning style may be a fit with the client's cognitive capacity and learning style.For this reason, if the client has had experiences of psychosis, we ask that they have had a least 6 months without a psychotic episode and a plan for managing psychotic symptoms before they will be considered to join the DBT program***SHARE WITH CLIENT:*** DBT is cognitively based program; it involves a lot of reading, reflection, and homework. This may be a fit with where some brains are at, and not so much for others |
| Does this learning style sound like it may be a fit for you? | [ ]  Yes [ ]  No |
| Have you had an experience of psychosis in the last 6 months? | [ ]  Yes [ ]  No |
| What was the reason? *(diagnosis of psychotic disorder, stress induced, drug-induced, other)*:  |
|       |
| How is it currently managed?  |
|       |
| Do you experience a significant learning disability and/or developmental disability? | [ ]  Yes [ ]  No |
| If you answered yes to any of the questions above, do you think that would that impact your participation in group?  | [ ]  Yes [ ]  No |
| Have you ever had a concussion in your life?  | [ ]  Yes [ ]  No |
| If yes, how many have you had?  |       |
| NOTES: *(If psychological assessment has been completed, please note when and by whom)* |
|       |
| ***If cognitive capacity looks like it may be a barrier to benefitting from the DBT program, please discontinue the screener.*** |
| **Assessment Questions to be Scored** |
| **DIAGNOSIS**  |
| The DBT program at CMHA is mandated to support clients with moderate to severe presentations of Borderline Personality Disorder (either diagnosis or traits) |
| Have you been diagnosed with BPD? - *Check only 1 response* |
| Person has diagnosis of BPD | 3 [ ]  | Person has been told they may be BPD | 2 [ ]  | Person has no diagnosis or indication of BPD | 0 [ ]  |
| If yes, when, and by whom?  |       |
| Other diagnoses: |       |
| ***SAY TO CLIENT:*** Clients who join the DBT program may have multiple diagnoses, however, DBT is designed to treat a primary diagnosis of BPD.  |
| Is focusing on BPD a fit with what you're looking to treat? | [ ]  Yes [ ]  No |
| NOTES:  |       |
| **THE FOLLOWING SECTIONS (1-9) ARE ABOUT BPD SYMPTOMS** |
| 1. **SELF-HARM**
 |
| *When asking questions about difficult experiences use matter-of-fact tone, don't ask for more details than are necessary for the screener so as not to reopen traumatic experiences, and normalize that we ask about these experiences because they are common to folks who may be interested in DBT.****SAY TO CLIENT*:** The next questions are about things that are commonly experienced by clients have who may be interested in DBT. If this is an experience you have, we'll ask about the most recent time. |
| Do you have experiences of self-harm? | [ ]  Yes [ ]  No |
| If yes, when most recently? - *Check only 1 response* |
| Current, ongoing | 4 [ ]  | One or more times in the past 6 months | 3 [ ]  | One or more times in the past 1 year | 2 [ ]  |
| One or more times in the past 2 years | 2 [ ]  | One or more times in the past 5 years | 1 [ ]  | No self-harm in the past 5 years, or never | 0 [ ]  |
| What forms of self-harm? *(cutting, burning, head-banging, other behaviours deliberately causing harm to your physical self)*  |
| Please specify: |       |
| NOTES:  |       |
| **2. SUICIDAL BEHAVIOURS**  |
| *When asking questions about difficult experiences use matter-of-fact tone, don't ask for more details than are necessary for the screener so as not to reopen traumatic experiences, and normalize that we ask about these experiences because they are common to folks who may be interested in DBT.* |
| Have you had any recent or historical suicide attempts? | [ ]  Yes [ ]  No |
| If yes, when most recently? - *Check only 1 response* |
| One or more times in the past 6 months | 3 [ ]  | One or more times in the past 1 year | 2 [ ]  | One or more times in the past 2 years | 2 [ ]  |
| One or more times in the past 5 years | 1 [ ]  | No attempts in the past 5 years, or never | 0 [ ]  |  |  |
| How many attempts in lifetime? |       |
| NOTES:  |       |
| ***MOTIVATION*** *- if client has identified suicidal and self-harming behaviours above*This question is intended to gauge client's motivation to stop suicidal and self-harming behaviours; if client says they intend to continue these behaviours and don't want to stop, this may not be the program for them.***SAY TO CLIENT*:** DBT is a program that supports clients to stop suicidal and self-harming behaviours. There may be people who feel that these are necessary coping mechanisms for themselves and don't want to stop; we don't tell anyone what to do, but the whole purpose of DBT is to support people in changing these behaviours |
| Is it your goal to stop? | [ ]  Yes [ ]  No |
| NOTES:  |       |
| **3. SUICIDAL IDEATION**  |
| May be active suicidal ideation (with intent and/or plan), or passive suicidal ideation (thoughts like "It would be easier if I just didn't wake up") |
| Do you experience thoughts of wanting to end your life by suicide? | [ ]  Yes [ ]  No |
| If yes, when most recently? - *Check only 1 response* |
| One or more times in the past week | 2 [ ]  | One or more times in the past month | 1 [ ]  |
| One or more times in the past year | 1 [ ]  | Less than one time in the past year, or never | 0 [ ]  |
| Do these thoughts include a plan? *Yes/No answer is sufficient; don't need to enquire re: details of plan* | Yes | 1 [ ]  | No | 0 [ ]  |
| Do you tell other people you're going to kill yourself? When you’re really upset, do you ever make suicidal threats? *Again, when asking this question, use matter of fact, non-judgmental tone. We're asking about behaviours that are common to clients with dysregulated emotions* | [ ]  Yes [ ]  No |
| If yes, when most recently – *Check only 1 response* |
| One or more times in the past month | 2 [ ]  | One or more times in the past year | 1 [ ]  | Less than one time in the past year, or never | 0 [ ]  |
| NOTES:  |       |
| **4. IMPUSLSIVITY** |
| Examples of impulsive behaviours: * eating binges
* spending sprees
* impulsive sexual behaviours
* shoplifting
* internet/gaming use
* substance misuse
 |
| Do you experience impulsive behaviours? - *An impulsive behaviour would be something you do without thinking, and then regret later.* | [ ]  Yes [ ]  No |
| If yes, when most recently? - *Check only 1 response* |
| Current and ongoing impulsive behaviours | 3 [ ]  | One or more times in the past 6 months | 3 [ ]  | One or more times in the past 1 year | 2 [ ]  |
| One or more times in the past 2 years | 1 [ ]  | One or more times in the past 5 years | 0 [ ]  | No impulsive behaviours in the past 5 years, or never | 0 [ ]  |
| Specify impulsive behaviours |       |
| NOTES:  |       |
| **5. HOSPITALIZATION -** *Please specify visits to ER or hospital admissions* |
| Have you visited or been admitted to hospital for mental health related reasons? | [ ]  Yes [ ]  No |
| If yes, when most recently? - *Check only 1 response* |
| One or more times in the past 6 months | 3 [ ]  | One or more times in the past 1 year | 3 [ ]  | One or more times in the past 2 years | 2 [ ]  |
| One or more times in the past 5 years | 1 [ ]  | No attempts in the past 5 years, or never | 0 [ ]  |  |  |
| How frequently are you currently going to hospital? |       |
| NOTES:  |       |
| **6. EMOTIONAL DYSREGULATION** |
| *Make the choices YES or NO. If the client answers 'yes' to one or more question(s) in this section, please score 1 for the entire section* |
| Do you have emotions that go up and down really fast, or get really overwhelming? | [ ]  Yes [ ]  No |
| Do you have temper outbursts or get so angry that you lose control?  | [ ]  Yes [ ]  No |
| If yes, do you think you could be a danger to other people's safety at such times? | [ ]  Yes [ ]  No |
| Answered "yes" to at least one question | 1 [ ]  | Answered "no" to all questions | 0 [ ]  |
| NOTES:  |       |
| **7. INTERPERSONAL DYSREGULATION** |
| *Make the choices YES or NO. If the client answers 'yes' to one or more question(s) in this section, please score 1 for the entire section* |
| Have you ever become frantic when you thought someone you really cared about was going to leave you? *(Called or texted repeatedly, cling to them, stood in front of the door so they couldn't leave)* | [ ]  Yes [ ]  No |
| Do you experience extreme ups and downs in relationships with people you care about? | [ ]  Yes [ ]  No |
| Answered "yes" to at least one question | 1 [ ]  | Answered "no" to all questions | 0 [ ]  |
| NOTES:  |       |
| **8. STRESS-RELATED SYMPTOMS** |
| *Make the choices YES or NO. If the client answers 'yes' to one or more question(s) in this section, please score 1 for the entire section* |
| Do you ever feel paranoid? | [ ]  Yes [ ]  No |
| If yes, please give examples: |       |
| Do you ever hear voices/have auditory hallucinations? | [ ]  Yes [ ]  No |
| If yes, please give examples: |       |
| Do you have experience of dissociation? *(Feeling like you or the world around you isn't real, lose track of time, find yourself somewhere without remembering how you got there)* | [ ]  Yes [ ]  No |
| If yes, please give examples: |       |
| Answered "yes" to at least one question | 1 [ ]  | Answered "no" to all questions | 0 [ ]  |
| NOTES:  |       |
| **ASSESSMENT SCORING** |
| Score of 16-23: Add to the DBT Waitlist | Score of 0-15: refer to other programs | TOTAL SCORE:  |       |
| *\*Clients with a score below 15 may still benefit from DBT, however our program is mandated to support clients with moderate to severe BPD symptoms. Clients with a score of 15 or below may be referred to ERG, SFSL, private DBT, etc.* |
| **Fax your referral to Here24/7 at 1-844-437-3329 for processing during regular business hours** |
| Completed by: (Worker, Designation) |       |
| CC: Client Family:       Date:       Referral Source/GP:       Date:       Other:       Date:        |