**Baby Pediatric Symptom Checklist (BPSC)**

**Scoring Directions, 12/14/15**

1. The BPSC is divided into three subscales, each with 4 items. Determine the BPSC subscale scores by assigning a “0” for each “Not at All” response, a “1” for each “Somewhat” response, and a “2” for each “Very Much” response, and then sum the results.

   a. In the event that parents have selected multiple responses for a single question and are unavailable for further questioning, then choose the more concerning answer (i.e. "Somewhat" or "Very Much") farthest to the right.

   b. In the event that there is a missing response, that item counts as zero.

2. Any summed score of 3 or more on any of the three subscales indicates that a child is “at risk” and needs further evaluation or investigation.
**Preschool Pediatric Symptom Checklist (PPSC)**

**Scoring Directions, 12/14/15**

1. Determine the PPSC total score by assigning a “0” for each “Not at All” response, a “1” for each “Somewhat” response, and a “2” for each “Very Much” response, and then sum the results.
   
   a. In the event that parents have selected multiple responses for a single question and are unavailable for further questioning, then choose the more concerning answer (i.e. "Somewhat" or "Very Much") farthest to the right.
   
   b. In the event that there is a missing response, that item counts as zero.

2. A PPSC total score of 9 or greater indicates that a child is "at risk" and needs further evaluation.
**SWYC Milestones**

**Scoring Directions, 3/22/16**

*SWYC Milestones* scoring can be done electronically. Please the downloadable Milestones Excel calculator available on our website, [www.theSWYC.org](http://www.theSWYC.org). For manual scoring, see below:

1. Each form includes 10 items. Score each item using these values: “Not Yet” corresponds to “0”; “Somewhat” to “1”; and “Very Much” to “2.” Missing items count as zero.

2. Add up all 10 item scores to calculate the total score.

3. On the *Milestones* scoring chart (see right), the child’s age in months is indicated in the “age” column. Check to be sure that the parent completed the correct form for the child’s age (far left column labeled “form”). If not, the score will be misleading. **Please Note:** Cut scores are not available for the 2- and 60-month forms. The individual questions are valid and reliable and may be useful for surveillance, but our initial research did not support the validity of the overall scores for detecting developmental delays.\(^1\)

4. Following along the appropriate age row, determine whether the child’s total score falls into the “Needs Review” or “Appears to Meet Age Expectations” category.

5. If a child scores in the “Needs Review” range, further evaluation or investigation is indicated.

To track *Milestones* scores longitudinally, download the Comprehensive SWYC Scoring Chart from our website, [www.theSWYC.org](http://www.theSWYC.org).

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\(^1\) We will attempt to correct this difficulty in future revisions of the *Milestones*. Please see section 5D of the manual on “Future Research” for more detail.
**Parent’s Observations of Social Interactions (POSI)**

**Scoring Directions, 12/14/15**

1. Score each of the seven questions. Each question is assigned either a “1” or a “0”. If the parent selects one or more responses that fall in the last three columns, the question is scored as “1”; otherwise, it is scored as “0” (see image below).

2. For items where parents have selected multiple responses for a single question (i.e., multiple responses in each row):
   a. Choose the more concerning answer (i.e., lower-functioning behavior) farthest to the right.
   b. If the parent has selected multiple answers in the last three columns for one item, assign only one point for the item.
   c. Missing items count as zero.

3. Since there are seven questions total, there is a maximum of seven potential points.

4. A result of three or more points in the last three columns indicates that a child is “at risk” and needs further evaluation or investigation.¹

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¹ Based on recent data, we are actively working to revise the POSI scoring system. Our goal is to maintain sensitivity while increasing positive predictive value.
### Example of a Positive POSI

#### SWYC:
18 months, 0 days to 34 months, 31 days

<table>
<thead>
<tr>
<th>PARENT’S OBSERVATIONS OF SOCIAL INTERACTIONS (POS)</th>
<th>Many times a day</th>
<th>A few times a day</th>
<th>A few times a week</th>
<th>Less than once a week</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child bring things to you to show them to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your child interested in playing with other children?</td>
<td>Always</td>
<td>Usually</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
</tr>
<tr>
<td>When you say a word or wave your hand, will your child try to copy you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child look at you when you call his or her name?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child look if you point to something across the room?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does your child usually show you something he or she wants?</td>
<td>Sways a word for what he or she wants</td>
<td>Points to it with one finger</td>
<td>Reaches for it</td>
<td>Pulls me over or puts my hand on it</td>
<td>Grunts, cries or screams</td>
</tr>
<tr>
<td>What are your child’s favorite play activities?</td>
<td>Playing with dolls or stuffed animals</td>
<td>Reading books with you</td>
<td>Climbing, running and being active</td>
<td>Lining up toys or other things</td>
<td>Watching things go round and round like fans or wheels</td>
</tr>
</tbody>
</table>

**Total Score: 3**

*Note: Omitted questions receive a score of 0.*

*Note: Each question has a maximum score of 1. Even though these two “check all that apply” questions have two checks in the three right columns, they only count for one point each.*

### Example of a Negative POSI

#### SWYC:
18 months, 0 days to 34 months, 31 days

<table>
<thead>
<tr>
<th>PARENT’S OBSERVATIONS OF SOCIAL INTERACTIONS (POS)</th>
<th>Many times a day</th>
<th>A few times a day</th>
<th>A few times a week</th>
<th>Less than once a week</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child bring things to you to show them to you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your child interested in playing with other children?</td>
<td>Always</td>
<td>Usually</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
</tr>
<tr>
<td>When you say a word or wave your hand, will your child try to copy you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child look at you when you call his or her name?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child look if you point to something across the room?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does your child usually show you something he or she wants?</td>
<td>Sways a word for what he or she wants</td>
<td>Points to it with one finger</td>
<td>Reaches for it</td>
<td>Pulls me over or puts my hand on it</td>
<td>Grunts, cries or screams</td>
</tr>
<tr>
<td>What are your child’s favorite play activities?</td>
<td>Playing with dolls or stuffed animals</td>
<td>Reading books with you</td>
<td>Climbing, running and being active</td>
<td>Lining up toys or other things</td>
<td>Watching things go round and round like fans or wheels</td>
</tr>
</tbody>
</table>

**Total Score: 2**

*Note: Omitted questions receive a score of 0.*

*Note: Each question has a maximum score of 1. Even though these two “check all that apply” questions have two checks in the three right columns, they only count for one point each.*
Family Questions

Scoring Directions 12/14/15

Positive endorsement of items on this list indicates that a child should be monitored further. If after reviewing the Family Questions, a PPCP believes a child or family member may be at immediate risk of harm, appropriate steps should be taken to refer the child and/or family to the appropriate child protection agency for help as soon as possible.

1. **Question 1: Tobacco Use** We incorporated a single-item screen for tobacco use. A "yes" response is positive.

2. **Questions 2, 3, and 4: TICS** At least one positive response on the Two-item Conjoint Screener (TICS) has been found to detect substance abuse disorders with adequate sensitivity and specificity (nearly 80% or higher). In addition, we have included an additional question: “Has a family member's drinking or drug use ever had a negative effect on your child?”

3. **Question 5: Food Insecurity** We have incorporated one question food insecurity screen. A response of "often" or "sometimes" true should be further discussed.

4. **Questions 6 and 7 on 9-60 month forms: Patient Health Questionnaire-2 (PHQ-2)** Parental depression is assessed by the Patient Health Questionnaire-2 (PHQ-2). Answers are scored such that "Not at All" is given a "0", "Several Days" is given a "1", "More than Half the Days" is given a "2", and "Nearly Every Day" is given a "3." If the total score on both questions sums to 3 or greater, the remaining questions of the Patient Health Questionnaire-9 (PHQ-9), a well-validated criterion-based measure for diagnosing depression and evaluating symptom severity, could be administered where available resources exist.

5. **Questions 8 and 9 on 9-60 month forms, 6 and 7 on 2-6 month forms: Woman Abuse Screening Tool (WAST)** These questions deal with domestic violence. The short version of the Woman Abuse Screening Tool (WAST-Short) is considered positive if the most extreme choices, "A Lot of Tension" and/or "Great Difficulty" are endorsed on one or both of the items.

6. **Question 10 on 9-60 month forms, 8 on 2-6 month forms: Reading frequency** There is no formal scoring for this item. Parents should be encouraged to read to their child as much as possible.
Edinburgh Postnatal Depression Scale Scoring

The EPDS appears on the 2, 4, and 6 month SWYC forms.

Postpartum depression is the most common complication of childbearing. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for postpartum depression. The EPDS is easy to administer and has proven to be an effective screening tool. Parents who score 10 or greater may be suffering from a depressive illness. Those who score 13 or greater are likely to be suffering from a depressive illness. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the parent has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

| QUESTIONS 1, 2, & 4 (without an *) are scored 0, 1, 2 or 3 with the far left response bubble scored as 0 and the far right response bubble scored as 3. |
| QUESTIONS 3, 5, 6, 7, 8, 9, 10 (marked with an *) are reverse scored, with the far left response bubble scored as a 3 and the far right response bubble scored as 0. |

Maximum score: 30
Possible Depression: 10-12
Probable Depression: 13 or greater
Always look at item 10 (thoughts of self harm)

INSTRUCTIONS FOR USING THE EPDS

1. The parent is asked to check the response that comes closest to how s/he has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the parent discussing his/her answers with others. (Answers come from the parent)
4. The parent should complete the scale him/herself, unless s/he has limited English or has difficulty with reading.