Behavioral Health Provider Toolkit

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Ohio

Behavioral Health Provider Toolkit:

Behavioral Health Education and Support for Our Network Providers

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Chapter One:

Anxiety Disorders

Overview

Anxiety disorders in children and adults

Anxiety disorders are the most common behavioral health condition that affects many people throughout the United States. An estimated 18 percent of adults have an anxiety disorder. The American Academy of Pediatrics indicates approximately 8 percent of children and adolescents experience some type of anxiety disorder that has a negative impact at school and home.[1]

One in three women met criteria for an anxiety disorder during her lifetime, compared to 22% of men. Overall, the lifetime and past year rates were approximately one-and-a-half to twice times as common among women, with the greatest differences in post-traumatic stress disorder (PTSD). This overview intends to provide information on anxiety disorder diagnosis, types, symptoms, age of onset, treatment, Healthcare Effectiveness Data and Information Set (HEDIS®) measure, and clinical practice guidelines.[2]

If you have questions about HEDIS or need more information, please contact your Provider Network Account Executive or Provider Services at **1-833-644-6001**.

Diagnosis

The provider should consult the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, to ensure the criteria for an anxiety disorder have been met. It is also advised that a thorough examination be completed to rule out any underlying medical and/or psychiatric conditions.

- Excessive anxiety and worry about many life events and activities, such as work or school performance, that is present more days than not for a minimum of six months.
- The individual has problems controlling the worry.
- The anxiety and worry are associated with three or more of the following six symptoms. Some symptoms must be present for more days than not for at least six months.
  - Restlessness or feeling keyed up or on edge.
  - Being easily fatigued.
  - Difficulty concentrating or mind going blank.
  - Irritability.
  - Muscle tension.
  - Sleep disturbance (difficulty falling or staying asleep).
- The anxiety or physical symptoms cause clinically significant distress in functional areas of social, occupational, or other important areas.
- The disturbance is not attributable to physiological effects of a substance or another medical condition.
- The disturbance is not due to another mental illness.

Types

There are different types of anxiety disorders that have various symptoms and require individualized treatment plans for effective treatment.

- **Generalized anxiety disorder (GAD):** A common anxiety disorder in which an individual is almost continuously predicting, anticipating, or imagining "dangerous" (unpleasant) events.
- **Separation anxiety disorder:** The individual is fearful or anxious about separation from attachment figures to an extent that is developmentally inappropriate.
- **Selective mutism:** The individual consistently fails to speak in a social situation in which there is an expectation to speak, such as at school or work, even though the individual speaks in other situations.
- **Specific phobia:** The individual is fearful of, anxious about, or avoidant of certain objects or situations.
- **Social anxiety disorder:** The individual is fearful or anxious about one or more social situations in which the individual is exposed to possible scrutiny by others.
- **Panic disorder (PD):** The individual experiences recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or discomfort accompanied by specific physical symptoms.
- **Agoraphobia:** The individual is fearful and anxious about two or more situations, such as using public transportation, being in open or enclosed spaces, standing in line or being in a crowd, or being outside of the home alone or in other situations.
- **Substance or medication-induced anxiety disorder:** Anxiety that occurs during or soon after substance intoxication or withdrawal or after exposure to a medication.

[1] "American Academy of Pediatrics Anxiety Fact Sheet. Retrieved 2020. **www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Anxiety-Fact-Sheet.aspx**"

[2] "Dorte M. Christiansen Institute of Psychology, Aarhus University, Denmark National Center for Psychotraumatology, University of Southern Denmark, Denmark

From the Edited Volume: A Fresh Look at Anxiety Disorders, IntechOpen, A Fresh Look at Anxiety Disorders
Edited by Federico Durbano: Retrieved: 2.1.2021: **www.intechopen.com/predownload/48416**

Symptoms

Anxiety disorders last at least six months and can become worse if they are not appropriately treated.

Symptoms vary for each individual and generally include:

- Excessive fears and worries.
- Continual nervousness or restlessness.
- Sleep disturbance.
- Extreme stress.
- Feelings of uneasiness.
- Extreme caution or hypervigilance.
- Withdrawal in social settings.
- Feeling keyed up or on edge.
- Difficulty concentrating or mind going blank.
- Irritability.
- Physical complaints (muscle aches or cramps, stomachaches, headaches, or other pain or discomfort).

Age of onset

Many anxiety disorders develop in childhood and persist to adulthood. The The Centers for Disease Control and Prevention (CDC) statistics updated in 2020 reveal that in U.S. children.

- 7.1% of children ages 3 – 17 years (approximately 4.4 million) have diagnosed anxiety.[3]

Some of these conditions commonly occur together.

For example:

- About three in four children ages 3 – 17 years with depression also have anxiety (73.8%) and almost one in two have behavior problems (47.2%).[3]
- For children ages 3 – 17 years with anxiety, more than one in three also have behavior problems (37.9%) and about one in three also have depression (32.3%).[3]
- For children ages 3 – 17 years with behavior problems, more than one in three also have anxiety (36.6%) and about one in five also have depression (20.3%).[3]

Depression and anxiety have increased over time

- "Ever having been diagnosed with either anxiety or depression" among children ages 6 – 17 years increased from 5.4% in 2003 to 8% in 2007 and to 8.4% in 2011 – 2012.[4]
- "Ever having been diagnosed with anxiety" increased from 5.5% in 2007 to 6.4% in 2011 – 2012.[4]

Treatment rates vary among different mental disorders

- Six in 10 children (59.3%) ages 3 – 17 years with anxiety received treatment.[5]

  www.cdc.gov/childrensmentalhealth/data.html

Treatment

- Medication: Antidepressants, anti-anxiety drugs, or beta blockers can be effective in treating these symptoms.
- Psychotherapy (talk therapy).
  - Cognitive behavioral therapy (CBT) is an effective approach to help people address their fears by changing the way they think and respond to stressful events.
  - Exposure therapy uses a method to gradually expose a person to fearful situations that can lead to decreased anxiety.
- A combination of medication and psychotherapy has been an effective treatment for many people.
- Exercise and relaxation techniques, such as meditation, can help reduce overall stress and worry.

HEDIS measure

The HEDIS standards, the most widely used set of performance measures in the managed care industry, are a system for establishing accountability in health care.

AmeriHealth Caritas Ohio collects data on the following HEDIS measure for anxiety disorders:

- Follow-up after hospitalization for mental illness (FUH): Members ages 6 years old and older who had an inpatient psychiatric hospitalization are required to have a follow-up outpatient appointment after discharge.

  Two rates are reported:
  - Discharges for which a member received a follow-up within seven days of discharge.
  - Discharges for which a member received a follow-up within 30 days of discharge.

[3] Ghandour RM, Sherman LJ, Vladutiu CJ, Ali MM, Lynch SE, Bitsko RH, Blumberg SJ. "Prevalence and Conduct Problems in US Children." *J Pediatr*. 2019 Vol. 206, 2019, pp. 256-267.

[4] Bitsko RH, Holbrook JR, Ghandour RM, Blumberg SJ, Visser SN, Perou R, Walkup JT. "Epidemiology and Impact of Health Care Provider-Diagnosed Anxiety and Depression Among US Children." *J Dev Behav Pediatr*. Vol. 39, No. 5, pp. 395 – 403.

[5] Data and Statistics on Children's Mental Health," National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, March 21, 2021, **www.cdc.gov/childrensmentalhealth/data.html**.

Clinical practice guidelines

The clinical practice guidelines for treatment of patients with anxiety disorders are developed for use in a primary care setting.

Here are the major recommendations for adults with GAD, PD with or without agoraphobia, and panic attacks:

- CBT is recommended as a treatment option due to its effectiveness in decreasing symptoms of anxiety, worry, and sadness. It also improves panic symptoms and quality of life.
- CBT should include techniques such as cognitive restructuring, exposure, relaxation, breathing exercise, psycho-education, and systematic desensitization.
- Antidepressants are recommended as a medication option if:
  - Symptoms are severe or are not improving apart from medication. If optimal dosages are ineffective or medication is not well tolerated, consider switching to another selective serotonin reuptake inhibitor (SSRI).
  - There is no improvement after 8 – 12 weeks. In such cases, consider using another medication with a different mechanism of action, such as an a serotonin-norepinephrine reuptake inhibitor (SNRI).A combination of CBT and antidepressants is an effective treatment approach.
- Information about the symptoms of, treatment options for, and resources about anxiety disorders should be provided to the member and family as indicated to foster self-management of the condition.

Additional information can be found at **www.guideline.gov/browse/by-topic.aspx**.

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.DSM5.org

National Alliance on Mental Illness
www.nami.org

National Committee for Quality Assurance (NCQA): HEDIS® 2018 Technical Specifications for Health Plans, Volume 2 **http://store.ncqa.org/index.php/catalog/product/view/id/2871/s/hedis-2018-volume-2-epub/**

National Guideline Clearinghouse
www.guideline.gov/browse/by-topic.aspx

National Institute of Mental Health
www.nimh.nih.gov/index.shtml

Medication management for anxiety disorders

The most common types of medications for managing anxiety symptoms are antidepressants, anti-anxiety drugs, and beta blockers.

Antidepressants	Anti-anxiety drugs**	Beta blockers
Generic: citalopram Brand: Celexa®	Generic: diazepam** Brand: Valium®	Generic: propranolol Brand: Inderal®
Generic: venlafaxine Brand: Effexor®/Effexor XR®	Generic: clonazepam** Brand: Klonopin®	
Generic: escitalopram Brand: Lexapro®	Generic: lorazepam** Brand: Ativan®	
Generic: paroxetine Brand: Paxil®/Paxil CR®		
Generic: fluoxetine Brand: Prozac®	Generic: buspirone Brand: Buspar®	
Generic: sertraline Brand: Zoloft®		

Note: Not an exhaustive list. Formulary restrictions may apply. Please check the website for formulary status and prior authorization criteria.

- The Food and Drug Administration (FDA) issued a "black box" warning label emphasizing that all individuals taking antidepressants should be closely monitored for possible side effects, such as worsening depression or suicidal ideation.
- Potential side effects should always be discussed with the individual.
- Antidepressants usually take four – six weeks before symptoms start to decrease.
- Antidepressants should be continued for at least six – 12 months to obtain the maximum benefits.
- Antidepressants should not be discontinued suddenly. Instead, gradually decrease over several weeks.
- Benzodiazepines are very safe and effective in short-term treatment for anxiety if other measures have been ineffective or if anxiety is severe. However, prolonged use (over six months) may lead to tolerance or dependence. Benzodiazepines should not be prescribed to individuals with substance use disorders.**
- Beta blockers can help reduce the physical symptoms associated with anxiety, such as sweating or trembling.

Assessment, screening tools and follow-up for anxiety disorders

Assessment

The health care provider should complete a comprehensive examination to include a medical, developmental, school history, and psychiatric history to rule out any underlying medical conditions and identify any other coexisting mental health conditions. It is important to address these coexisting conditions that may affect one another. Anxiety disorders can coexist with other mental health conditions that may include:

- Depression.
- Substance use disorders.
- Attention-deficit/hyperactivity disorder (ADHD).
- Eating disorders.
- Problems with sleeping.

Screening tools

There are several reliable screening tools to assess for anxiety disorders. These scales can be used to obtain baseline data on the severity of the symptoms and can also be re-administered to monitor progress, which will guide the treatment plan.

- Generalized Anxiety Disorder 7-Item (GAD-7) Scale.
- Screen for Child Anxiety Related Disorders (SCARED) Parent Version, to be completed by the parent.
- Spence Children's Anxiety Scale (SCAS).
- Hamilton Anxiety Rating Scale (HAM-A).
- American Society for Addiction Medicine (ASAM) for substance abuse services (used for medical necessity reviews in all member ages).
- Early Childhood Services Intensity Instrument (ECSII).
- Children and Adolescents Needs and Strengths (CANS).

Follow-up interventions

The following interventions are based on the individual's needs and their agreement on the next steps. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool for an anxiety disorder should be told the results of the screening.
- Individuals with positive results will need some type of intervention, which will vary depending on the severity of the anxiety, such as:
  - Education on anxiety disorders.
  - Resource information on anxiety disorders.
  - Encouraging participation in a support group.
  - Discussing medication options if applicable.
  - Scheduling a follow-up appointment.
  - Referring to a behavioral health provider for therapy.
  - Referring to the health plan Integrated Health Care Management program.
  - For severe symptoms: Initiate a referral to a behavioral health care provider who can further assess and provide a treatment plan.
- If the individual is in a crisis, call **911** and refer them to the closest emergency room.

Confidentiality

It is essential for health care providers to respect an individual's autonomy and right to confidentiality if they are to be effective in developing a trusting relationship that will impact the quality of screening and proper follow-up interventions.

Health care providers need to be familiar with and abide by all applicable state and federal laws pertaining to the privacy of patient health information. Although state laws vary by state, the relevant federal laws include:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 42 CFR Part 2 (governs the confidentiality of alcohol and drug treatment information).

Resources for anxiety disorders

Member resources

Anxiety and Depression Association of America
www.adaa.org
Provides education to individuals and their families with anxiety disorders and helps them find treatment, resources, and support.

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention
www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll free at **1-800-QUIT-NOW (1-800-784-8669)**.

Job Corps
https://www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, and earn a high school diploma or a GED.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Trained counselors to help individuals with suicidal crisis and/or emotional distress.

Parent to Parent USA
www.p2pusa.org
Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration
www.ssa.gov/disability
May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

Anxiety and Depression Association of America
www.adaa.org/resources-professionals

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/understanding-suicide

American Psychiatric Association
www.psychiatry.org/mental-health

Centers for Disease Control and Prevention
www.cdc.gov/mentalhealth

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml

Appendix A: Screeners for anxiety disorders

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T____ = ____ + ____ + ____*)

GAD-7

Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un " " para indicar su respuesta)*	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	0	1	2	3
2. No ha sido capaz de parar o controlar su preocupación	0	1	2	3
3. Se ha preocupado demasiado por motivos diferentes	0	1	2	3
4. Ha tenido dificultad para relajarse	0	1	2	3
5. Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	0	1	2	3
6. Se ha molestado o irritado fácilmente	0	1	2	3
7. Ha tenido miedo de que algo terrible fuera a pasar	0	1	2	3

(*For office coding: Total Score T____ = ____ + ____ + ____)*

Elaborado por los doctores Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke y colegas, mediante una subvención educativa otorgada por Pfizer Inc. No se requiere permiso para reproducir, traducir, presentar o distribuir.

Hamilton Anxiety Rating Scale (HAM-A)

Reference: **Hamilton M. The assessment of anxiety states by rating. Br J Med Psychol 1959; 32:50–55.**

Rating Clinician-rated

Administration time 10–15 minutes

Main purpose To assess the severity of symptoms of anxiety

Population Adults, adolescents and children

Commentary

The HAM-A was one of the first rating scales developed to measure the severity of anxiety symptoms, and is still widely used today in both clinical and research settings. The scale consists of 14 items, each defined by a series of symptoms, and measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). Although the HAM-A remains widely used as an outcome measure in clinical trials, it has been criticized for its sometimes poor ability to discriminate between anxiolytic and antidepressant effects, and somatic anxiety versus somatic side effects. The HAM-A does not provide any standardized probe questions. Despite this, the reported levels of inter-rater reliability for the scale appear to be acceptable.

Scoring

Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity and 25–30 moderate to severe.

Versions

The scale has been translated into: Cantonese for China, French and Spanish. An IVR version of the scale is available from Healthcare Technology Systems.

Additional references

Maier W, Buller R, Philipp M, Heuser I. The Hamilton Anxiety Scale: reliability, validity and sensitivity to change in anxiety and depressive disorders. J Affect Disord 1988;14(1):61–8.

Borkovec T and Costello E. Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. J Clin Consult Psychol 1993; 61(4):611–19

Address for correspondence

The HAM-A is in the public domain.

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.

1 Anxious mood [0] [1] [2] [3] [4]

Worries, anticipation of the worst, fearful anticipation, irritability.

2 Tension [0] [1] [2] [3] [4]

Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

3 Fears [0] [1] [2] [3] [4]

Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

4 Insomnia [0] [1] [2] [3] [4]

Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

5 Intellectual [0] [1] [2] [3] [4]

Difficulty in concentration, poor memory.

6 Depressed mood [0] [1] [2] [3] [4]

Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

7 Somatic (muscular) [0] [1] [2] [3] [4]

Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.

8 Somatic (sensory) [0] [1] [2] [3] [4]

Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

9 Cardiovascular symptoms [0] [1] [2] [3] [4]

Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

10 Respiratory symptoms [0] [1] [2] [3] [4]

Pressure or constriction in chest, choking feelings, sighing, dyspnea.

11 Gastrointestinal symptoms [0] [1] [2] [3] [4]

Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.

12 Genitourinary symptoms [0] [1] [2] [3] [4]

Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

13 Autonomic symptoms [0] [1] [2] [3] [4]

Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

14 Behavior at interview [0] [1] [2] [3] [4]

Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	O	O	O	PN
2. My child gets headaches when he/she am at school.	O	O	O	SH
3. My child doesn't like to be with people he/she does't know well.	O	O	O	SC
4. My child gets scared if he/she sleeps away from home.	O	O	O	SP
5. My child worries about other people liking him/her.	O	O	O	GD
6. When my child gets frightened, he/she fells like passing out.	O	O	O	PN
7. My child is nervous.	O	O	O	GD
8. My child follows me wherever I go.	O	O	O	SP
9. People tell me that my child looks nervous.	O	O	O	PN
10. My child feels nervous with people he/she doesn't know well.	O	O	O	SC
11. My child gets stomachaches at school.	O	O	O	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	PN
13. My child worries about sleeping alone.	O	O	O	SP
14. My child worries about being as good as other kids.	O	O	O	GD
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	PN
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	SP
17. My child worries about going to school.	O	O	O	SH
18. When my child gets frightened, his/her heart beats fast.	O	O	O	PN
19. He/she child gets shaky.	O	O	O	PN
20. My child has nightmares about something bad happening to him/her.	O	O	O	SP

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.	O	O	O	**GD**
22. When my child gets frightened, he/she sweats a lot.	O	O	O	**PN**
23. My child is a worrier.	O	O	O	**GD**
24. My child gets really frightened for no reason at all.	O	O	O	**PN**
25. My child is afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	**SC**
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	**PN**
28. People tell me that my child worries too much.	O	O	O	**GD**
29. My child doesn't like to be away from his/her family.	O	O	O	**SP**
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. My child worries that something bad might happen to his/her parents.	O	O	O	**SP**
32. My child feels shy with people he/she doesn't know well.	O	O	O	**SC**
33. My child worries about what is going to happen in the future.	O	O	O	**GD**
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	**PN**
35. My child worries about how well he/she does things.	O	O	O	**GD**
36. My child is scared to go to school.	O	O	O	**SH**
37. My child worries about things that have already happened.	O	O	O	**GD**
38. When my child gets frightened, he/she feels dizzy.	O	O	O	**PN**
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	O	O	O	**SC**
41. My child is shy.	O	O	O	**SC**

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

March 27, 2012

SPENCE CHILDREN'S ANXIETY SCALE

Your Name: _____ **Date:** _____

PLEASE PUT A CIRCLE AROUND THE WORD THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU. THERE ARE NO RIGHT OR WRONG ANSWERS.

1.	I worry about things.....	Never	Sometimes	Often	Always
2.	I am scared of the dark.....	Never	Sometimes	Often	Always
3.	When I have a problem, I get a funny feeling in my stomach.....	Never	Sometimes	Often	Always
4.	I feel afraid.....	Never	Sometimes	Often	Always
5.	I would feel afraid of being on my own at home.....	Never	Sometimes	Often	Always
6.	I feel scared when I have to take a test.....	Never	Sometimes	Often	Always
7.	I feel afraid if I have to use public toilets or bathrooms.....	Never	Sometimes	Often	Always
8.	I worry about being away from my parents.....	Never	Sometimes	Often	Always
9.	I feel afraid that I will make a fool of myself in front of people.....	Never	Sometimes	Often	Always
10.	I worry that I will do badly at my school work.....	Never	Sometimes	Often	Always
11.	I am popular amongst other kids my own age.....	Never	Sometimes	Often	Always
12.	I worry that something awful will happen to someone in my family.....	Never	Sometimes	Often	Always
13.	I suddenly feel as if I can't breathe when there is no reason for this.....	Never	Sometimes	Often	Always
14.	I have to keep checking that I have done things right (like the switch is off, or the door is locked).....	Never	Sometimes	Often	Always
15.	I feel scared if I have to sleep on my own.....	Never	Sometimes	Often	Always
16.	I have trouble going to school in the mornings because I feel nervous or afraid.....	Never	Sometimes	Often	Always
17.	I am good at sports.....	Never	Sometimes	Often	Always
18.	I am scared of dogs.....	Never	Sometimes	Often	Always
19.	I can't seem to get bad or silly thoughts out of my head.....	Never	Sometimes	Often	Always
20.	When I have a problem, my heart beats really fast.....	Never	Sometimes	Often	Always
21.	I suddenly start to tremble or shake when there is no reason for this...	Never	Sometimes	Often	Always
22.	I worry that something bad will happen to me.....	Never	Sometimes	Often	Always
23.	I am scared of going to the doctors or dentists.....	Never	Sometimes	Often	Always
24.	When I have a problem, I feel shaky.....	Never	Sometimes	Often	Always
25.	I am scared of being in high places or lifts (elevators).....	Never	Sometimes	Often	Always

26.	I am a good person.....	Never	Sometimes	Often	Always
27.	I have to think of special thoughts to stop bad things from happening (like numbers or words).....	Never	Sometimes	Often	Always
28	I feel scared if I have to travel in the car, or on a Bus or a train.....	Never	Sometimes	Often	Always
29.	I worry what other people think of me.....	Never	Sometimes	Often	Always
30.	I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds).....	Never	Sometimes	Often	Always
31.	I feel happy.....	Never	Sometimes	Often	Always
32.	All of a sudden I feel really scared for no reason at all.....	Never	Sometimes	Often	Always
33.	I am scared of insects or spiders.....	Never	Sometimes	Often	Always
34.	I suddenly become dizzy or faint when there is no reason for this.....	Never	Sometimes	Often	Always
35.	I feel afraid if I have to talk in front of my class.....	Never	Sometimes	Often	Always
36.	My heart suddenly starts to beat too quickly for no reason.....	Never	Sometimes	Often	Always
37.	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of.....	Never	Sometimes	Often	Always
38.	I like myself.....	Never	Sometimes	Often	Always
39.	I am afraid of being in small closed places, like tunnels or small rooms.	Never	Sometimes	Often	Always
40.	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order).....	Never	Sometimes	Often	Always
41.	I get bothered by bad or silly thoughts or pictures in my mind.....	Never	Sometimes	Often	Always
42.	I have to do some things in just the right way to stop bad things happening.....	Never	Sometimes	Often	Always
43.	I am proud of my school work.....	Never	Sometimes	Often	Always
44.	I would feel scared if I had to stay away from home overnight.....	Never	Sometimes	Often	Always
45.	Is there something else that you are really afraid of?.....	YES	NO		
	Please write down what it is_____				
	_____				
	_____				
	How often are you afraid of this thing?.....	Never	Sometimes	Often	Always

Chapter Two:

Attention-Deficit/Hyperactivity Disorder (ADHD)

Overview

Attention-deficit/hyperactivity disorder (ADHD) is a common neurobehavioral condition in children and adolescents that interferes with their performance in school, ability to maintain social relationships, and ability to complete tasks at home. Adults can also have ADHD, which can lead to problems at work, problems with relationships, and the inability to get organized with everyday activities. Both adults and adolescents with ADHD are at increased risk for school failure, multiple car accidents, cigarette smoking, and other substance use.

This overview intends to provide information and consideration about ADHD diagnosis, symptoms, age of onset, treatment, HEDIS measures, and clinical practice guidelines.

If you have questions about HEDIS or need more information, please contact your Provider Network Account Executive or Provider Services at **1-833-644-6001**.

Diagnosis

To diagnose ADHD for any child 4 through 18 years old, the primary care provider (PCP) should determine that Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for ADHD have been met (including documentation of impairment in more than one major setting). It is also advised that a thorough examination be completed to rule out any underlying medical and/or psychiatric conditions.

Symptoms

Symptoms of ADHD interfere with an individual's routine activities, such as school, work, relationships, and household activities. Children with ADHD have symptoms that decrease their ability to function compared with other children the same age. Symptoms must be present in more than one setting and persist for at least six months.

- **Inattentiveness:** easily distracted, trouble focusing, problems completing a task, trouble completing or turning in homework assignments, often losing things, not listening when spoken to, daydreaming, difficulty processing information, and struggling to follow instructions.
- **Hyperactivity or impulsivity:** excessive restlessness, fidgety, talks nonstop, trouble sitting still, constantly in motion, difficulty doing quiet activities, impatient, talks out of turn, blurts out inappropriate comments, difficulty taking turns or waiting for things, often interrupts conversations.
- **Combined type:** Some individuals with significant symptoms have both inattentive and hyperactive/impulsive symptoms.

Age of onset

The American Academy of Pediatrics has expanded its guidelines to recommend that any child 4 – 18 years old who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity and may need evaluation for ADHD.

The average age of onset is 7 years old. Boys are more frequently diagnosed than girls with ADHD by about three to one.

Treatment

For preschool-age children (4 – 5 years old), the PCP may prescribe parent/teacher evidence-based behavior management training as the first-line treatment. Methylphenidate may be prescribed if the behavior interventions do not provide significant improvement and there is moderate to severe continuing disturbance in the child's function.

For elementary school-aged children (6 – 11 years old), the PCP may prescribe FDA-approved medications for ADHD or follow parent/teacher evidence-based behavior management training as treatment for ADHD, preferably both.

For adolescents (12 – 18 years old), the PCP may prescribe FDA-approved medications for ADHD with the assent of the adolescent and/or recommend behavioral therapy for ADHD, preferably both.

For adults (18 years old and older), the PCP may prescribe FDA-approved medications for ADHD and/or recommend counseling services, preferably both.

School-based services

Special education services: Children with ADHD may be eligible for special education services. They may qualify under the "Other Health Impairment" disability category for an individual education plan (IEP). If they do not qualify for special education services, they still might be eligible for a 504 plan. Parents and caregivers can request for the public school to provide testing at no cost to the family to further evaluate the child's needs. The request must be submitted in writing to the school before testing can occur.

There are two main laws that ensure a child's rights to an appropriate public education. The Individuals with Disability Education Improvement Act (IDEA) is the nation's federal special education law. This law requires states to provide a free age-appropriate education in the least restrictive environment to meet the needs of children (ages 3 – 21) who have disabilities with varying degrees of severity.

- **The IEP:** This is the key document developed by the parent or caregiver and the child's teachers in a collaborative approach. The IEP serves as a road map that includes the child's academic achievement, annual goals, progress toward goals, and accommodations to help meet those goals Conferences with the parent or caregiver, child, and school teachers and officials are required at least annually.
- **Section 504 of the Rehabilitation Act of 1973:** This is the civil rights law that protects individuals with disabilities in any agency, school, or institution to eliminate barriers and provide the appropriate accommodations to allow the child to participate in the general curriculum. An individualized document (504 plan) is created that outlines the child's needs and accommodations, but not to the extent of an IEP. Conferences with the parent or caregiver, child, and school teachers and officials are required at least annually.

HEDIS measures

AmeriHealth Caritas Ohio collects data on the following HEDIS measures for ADHD:

- **Follow-up care for children prescribed ADHD medication:** Members ages 6 years old and older who have been newly prescribed an ADHD medication need to have at least three follow-up care visits within a 10-month period.

  Two rates are reported:

  – Initiation phase: The percentage of members who had a follow-up visit with a provider with prescribing authority within 30 days of when the medication was dispensed.

  – Continuation and maintenance phase: The percentage of members who remained on the medication for at least 210 days and who had at least two additional follow-up visits with a provider within 270 days (nine months) after the initiation.

- **Follow-up after hospitalization for mental illness (FUH):** Members ages 6 years old and older who had an inpatient psychiatric hospitalization are required to have a follow-up outpatient appointment with a licensed behavioral health care provider after discharge.

  Two rates are reported:

  – Discharges for which a member received a follow-up within seven days of discharge.

  – Discharges for which a member received a follow-up within 30 days of discharge.

Clinical practice guidelines

The following clinical practice guidelines include the major recommendations for the diagnosis and management of ADHD in children, young people, and adults.

Individuals with ADHD require integrated care that addresses a broad range of personal, social, educational, and occupational needs, and treatment by health care professionals who have adequate expertise in the diagnosis and management of ADHD.

Health care professionals should:

- Develop a trusting relationship with individuals with ADHD and their families by:
  - Respecting their knowledge and experience of ADHD.
  - Being sensitive to stigma in relation to mental illness.
- Provide individuals with ADHD and their families age-appropriate information about ADHD in regard to diagnosis, assessment, support options, treatment, and the use and potential side effects of medication.
- Allow individuals to provide their own explanations of their feelings, symptoms, and how ADHD is impacting the different domains of their lives.
- Involve the individual and family in treatment decisions.
- Become familiar with local and national resources pertaining to ADHD.
- Provide adults with ADHD written information about local and national support groups and voluntary organizations.
- Inquire about the impact of ADHD on patients and their families.
- Encourage participation in self-help and support groups when relevant.
- Discuss parent training and education programs to optimize parenting skills, and provide referrals.
- Determine the severity of the problems, how these affect the individual and family, and the impact on the different domains and settings.

Additional clinical practice guidelines:

- Parent training and education is the first line of treatment for parents of preschool-age children.
- Following a diagnosis of ADHD, the health care provider, with parent or caregiver consent, should contact the child's preschool or teacher to explain the diagnosis and severity of symptoms, the care plan, and any special education needs.
- Drug treatment should be provided for school-age children with moderate to severe impairments.
- For older adolescents with ADHD and moderate impairment, CBT or social skills training may be considered.
- Prior to starting a medication, it is important to document baseline measures on height and weight plotted on a growth chart, heart rate and blood pressure, mental health and social assessment, family history of cardiac disease, and risk for substance misuse.
- Antipsychotics are not recommended for the treatment of ADHD in children and young people.
- When starting medications, monitor side effects.

Additional information can be found at **www.guideline.gov/content.aspx?id=36881&search=adhd.**

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.DSM5.org

National Alliance on Mental Illness
www.nami.org

National Committee for Quality Assurance (NCQA): HEDIS® 2015 Technical Specifications for Health Plans, Volume 2 **https://store.ncqa.org/hedis-my-2020-my-2021-volume-2-epub.html**

National Guideline Clearinghouse
www.guideline.gov/browse/by-topic.aspx

National Institute of Mental Health
www.nimh.nih.gov/index.shtml

Medication management for ADHD

There are two main categories of ADHD medications: stimulant and non-stimulant. The most common type of medication used to treat ADHD is stimulants. The research evidence supporting the effectiveness of stimulant medications is particularly strong and sufficient, but it is less strong for non-stimulant medications.

Amphetamines (stimulants): short-acting (4 – 5 hours)	Amphetamines (stimulants): long-acting (7 – 12 hours)	Non-stimulants
Generic: amphetamine Brand: Adderall®	Generic: dextroamphetamine Brand: Adderall XR®	Generic: atomoxetine Brand: Strattera®
Generic: dextroamphetamine Brand: Dexedrine®	Generic: dextroamphetamine sulfate Brand: Dexedrine Spansule®	Generic: bupropion Brand: Wellbutrin
Generic: dexmethylphenidate Brand: Focalin®	Generic: methylphenidate Brand: Concerta®	Generic: clonidine ER Brand: Kapvay
Generic: methylphenidate Brand: Ritalin®	Generic: methylphenidate Brand: Daytrana® (patch)	Generic: guanfacine ER Brand: Intuniv
	Generic: dexmethylphenidate HCL Brand: Focalin XR®	
	Generic: methylphenidate Brand: Ritalin LA	
	Generic: lisdexamfetamine Brand: Vyvanse®	

Note: Not an exhaustive list. Formulary restrictions may apply. Please check the website for formulary status and prior authorization criteria.

- **Some common sides effects of stimulants:**
  - Decreased appetite.
  - Sleep problems.
  - Transient headache.
  - Transient stomachache.
  - Behavioral rebound.

  These side effects usually diminish within the first couple of months of treatment. The child's height and weight should be routinely monitored by the health care provider and parents or caregivers when medication management is used.

- **Helpful strategies to relieve side effects for the prescribing provider to consider:**
  - Sustained-release stimulant.
  - Decreased dose.
  - Frequent healthy snacks.
  - Drug holidays.
  - Adding reduced dose in late afternoon.
  - Reduced or eliminated afternoon dose.
  - Strict bedtime routine.
  - Moving dosing regimen to earlier time.

  Side effects will vary for each individual. The above strategies are options for the health care provider to consider and discuss with the individual and/or family to achieve maximum benefit and minimize side effects.

Assessment, screening tools and follow-up for ADHD

Assessment

The PCP should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders), developmental (e.g., learning and language disorders), or other neurodevelopmental disorders, and physical (e.g., tics and sleep apnea) conditions.

Screening tools

Screening tools and checklists help providers obtain information from parents, teachers, and others about the individual's symptoms and functioning level in various settings. Symptoms must be present in more than one setting (e.g., home and school) to meet the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for the diagnosis of ADHD.

The following rating scales are often used to screen and evaluate children and adolescents for ADHD:

- SNAP IV Scale (created by Swanson, Nolan, and Pelham).
- Strengths and weaknesses of ADHD symptoms (SWAN) rating scale.
- Vanderbilt ADHD Parent Rating Scale.
- Vanderbilt Teacher Rating Scale.

For adults, the 18-question Adult ADHD Self-Report Scale (ASRS v1.1) can be utilized. There is an online version that can provide a quick score and indicate whether further testing by a health care provider is warranted.

Follow-up interventions

The following interventions are based on the individual's needs and their agreement on the next steps. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool for ADHD should be told the results of the screening.
- Individuals with positive results will need some type of intervention, which will vary depending on the severity of the condition, such as:
  - Provide education on ADHD.
  - Provide resource information on ADHD.
  - Encourage participation in a support group.
  - Discuss medication options if applicable.
  - Assess the concern for possible medication misuse before initiation of stimulant therapy.
  - Prepare the individual and family for the initial medication process to include beginning with a low dose and incrementally increasing to the optimal dose to achieve maximum benefit and minimal side effects.
  - Schedule a face-to-face follow-up appointment that is recommended within the first two to three weeks of initiation of the medication.
  - For the first year of treatment, face-to-face visits are recommended every three months and then at least twice a year.
  - Initiate a referral to a behavioral health care provider for therapy if appropriate.
  - Refer to the health plan Integrated Health Care Management program.
  - For severe symptoms: Initiate a referral to a behavioral health care provider who can further assess and provide a treatment plan.
  - If the individual is in a crisis, call **911** and refer them to the closest emergency room.

Confidentiality

It is essential for health care providers to respect an individual's autonomy and right to confidentiality if they are to be effective in developing a trusting relationship that will impact the quality of screening and proper follow-up interventions.

Health care providers need to be familiar with and abide by all applicable state and federal laws pertaining to the privacy of patient health information. Although state laws vary by state, the relevant federal laws include:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 42 CFR Part 2 (governs the confidentiality of alcohol and drug treatment information).

Resources for ADHD

Member resources

ADHD Directory and Resources
www.addresources.org
Provides education, support, resources, and networking opportunities for individuals with ADHD.

Attention-Deficit Disorder Association (ADDA)
www.add.org
Provides information, resources, and networking opportunities to assist adults with attention deficit disorder lead more productive lives.

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention
www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll free at **1-800-QUIT-NOW** (**1-800-784-8669**).

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
www.chadd.org
Provides education, advocacy, and support for individuals with ADHD.

Job Corps
https://www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, and earn a high school diploma or a GED.

Kids Health
www.kidshealth.org/teen
Provides education and resources regarding children and teens' health and development.

Mental Health America
www.mentalhealthamerica.net
Promotes mental health as a critical part of overall wellness, which includes prevention, early identification, and intervention for individuals.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Center for Learning Disabilities (NCLD)
www.ncld.org
Works to ensure that children, adolescents, and adults with learning disabilities have every opportunity to succeed in school, work, and life.

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Provides trained counselors to help individuals with suicidal crisis and/or emotional distress.

PACER Center: Champions for Children with Disabilities
www.pacer.org
A parent training and information center on education, bullying, vocational training, and employment for youth and young adults with disabilities.

Parent to Parent USA
www.p2pusa.org
Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration
www.ssa.gov/disability
May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/understanding-suicide

Attention-Deficit Disorder Association
www.add.org

American Psychiatric Association
www.psychiatry.org/mental-health

Attention Research Update newsletter
www.helpforadd.com

Bright Futures
www.brightfutures.org

Centers for Disease Control and Prevention
www.cdc.gov/ncbddd/adhd

Center for Mental Health Services Knowledge Exchange Network
www.mentalhealth.org

Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD)
www.chadd.org

Comprehensive Treatment for Attention-Deficit Disorder
www.ctadd.com

National Institute of Mental Health
https://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml

Appendix B: Screeners for attention-deficit/hyperactivity disorder

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

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NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance ***Academic Performance***	Excellent	Average	Above Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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Chapter Three:

Depressive Disorders

Overview

An estimated 17.3 million adults in the United States had at least one major depressive episode. This number represented 7.1% of all U.S. adults. The prevalence of major depressive episode was higher among adult females (8.7%) compared to males (5.3%). The prevalence of adults with a major depressive episode was highest among individuals aged 18-25 (13.1%). The prevalence of major depressive episode was highest among adults reporting two or races (11.3%). Depression is a potentially life-threatening disorder that affects approximately 14.8 million Americans 18 years old or older in a given year. Depression also affects many people younger than age 18.[6]

Depression is associated with substantial morbidity and disability for individuals. Yet depression is a highly treatable condition. PCPs should be equipped to screen for depression and provide immediate treatment either in their own practices or by referring members to mental health professionals for more severe depressive episodes.

This overview intends to provide information on depression diagnosis, types, symptoms, age of onset, treatment, HEDIS measures, and clinical practice guidelines.

If you have questions about HEDIS or need more information, please contact your Provider Network Account Executive or Provider Services at **1-833-644-6001**.

Diagnosis

The provider should consult the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, to ensure the criteria for a depressive disorder have been met. It is also advised that a thorough examination be completed to rule out any underlying medical and/or psychiatric conditions.

- Members diagnosed with one or more chronic conditions are at increased risk for depression.
- Members may self-identify, or provider may observe signs of depression during the interview or examination.
- Multiple somatic complaints may suggest underlying depression.
- Past history, substance use disorder, family history, history of abuse, presence of anxiety, and acute or chronic psychosocial stressors are all risk factors for depression.

Types

There are several forms of depressive disorders that have various symptoms and require individualized treatment plans for effective treatment.

- Major depressive disorder or major depression: The individual has a mixture of symptoms that interfere with the individual's ability to work, sleep, study, eat, and enjoy once-enjoyable activities. Major depression can be disabling if not treated and stops an individual from doing their usual activities. Some individuals may have only a single episode within their lifetimes, but more often an individual may have multiple episodes.
- Dysthymic disorder, or dysthymia: The individual has a long-term (two years or longer) depression, but it may not be severe enough to disable an individual. Still, it can stop the individual from doing usual activities or from feeling well. Individuals with dysthymia may also experience one or more episodes of major depression during their lifetimes.
- Postpartum depression: The individual experiences symptoms more serious than the "baby blues" that many women have after giving birth, when hormonal and physical changes occur and the new duties of caring for a newborn can be overwhelming. It is estimated that 10 percent to 15 percent of women have postpartum depression after giving birth.
- Seasonal affective disorder (SAD): The individual will experience depression during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be treated with light therapy.

[6] Major Depression," National Institute of Mental Health, **www.nimh.nih.gov/health/statistics/major-depression.shtml**.

Symptoms

For major depressive disorders, at least five of the following symptoms must be present most of the day for at least two weeks. Also, at least one of the first two symptoms must be present:

- Depressed mood.
- Marked diminished interest in usual activities.
- Significant increase or loss in appetite or weight.
- Insomnia or hypersomnia.
- Psychomotor agitation or retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or guilt.
- Difficulty with thinking, concentrating, or making decisions.
- Recurrent thoughts of death or suicide.

Depression in teens can look very different from depression in adults. The following symptoms of depression are more common in teenagers than in their adult counterparts.

- **Irritable or angry mood:** Irritability, rather than sadness, is often the predominant mood in teens with depression. A teenager with depression may be grumpy, hostile, easily frustrated, or prone to angry outbursts.
- **Unexplained aches and pains:** Teens with depression frequently complain about physical ailments such as headaches or stomachaches. If a thorough physical exam does not reveal a medical cause, these aches and pains may indicate depression.
- **Extreme sensitivity to criticism:** Teens with depression are plagued by feelings of worthlessness, making them extremely vulnerable to criticism, rejection, and failure. This is a particular problem for "overachievers."
- **Withdrawing from some people, but not all:** While adults tend to isolate themselves when depressed, teenagers usually keep up at least some friendships. However, teens with depression may socialize less than before, pull away from their parents, or start hanging out with a different crowd.

Age of onset

Although the average age of an individual with depression is 32, the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study found that nearly 40 percent of youth had their first depressive episode before age 18.

Treatment

- The Texas Medication Algorithm Project is a diagnostic tool that may be helpful for medication management of depression.
- Antidepressants from several subcategories have been found to be effective: SSRIs, SNRIs, atypical antidepressants, tricyclic antidepressants (TCAs), and nonselective monoamine oxidase inhibitors (MAOIs).
- The most widely prescribed antidepressants are SSRIs.
- Psychotherapy (talk therapy) has been found to be effective.
- Combination of medication and psychotherapy has been an effective treatment for many people.
- Some simple things can lift mood, such as exercise, healthy eating, and getting a healthy amount of sleep.
- Depression is a disease of isolation, so finding ways to spend time with family and friends can be helpful.

HEDIS measures

AmeriHealth Caritas Ohio collects data on the following HEDIS measures for depressive disorders:

- **Antidepressant medication management (AMM):** Members ages 18 years old and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment.

  Two rates are reported:

  – Effective acute phase treatment: members who remained on an antidepressant medication for at least 84 days (12 weeks).

  – Effective continuation phase treatment: members who remained on an antidepressant medication for at least 180 days (six months).

- **Follow-up after hospitalization for mental illness (FUH):** Members ages 6 years old and older who had an inpatient psychiatric hospitalization are required to have a follow-up outpatient appointment with a licensed behavioral health care provider after discharge.

  Two rates are reported:

  – Discharges for which a member received a follow-up within seven days of discharge.

  – Discharges for which a member received a follow-up within 30 days of discharge.

Clinical practice guidelines

The following clinical practice guidelines include the major recommendations for the treatment of individuals with major depressive disorder.

- **Evaluation and management:**
  - Complete a comprehensive assessment that will rule out any underlying medical and/or psychiatric conditions.
  - Complete a safety evaluation that includes a suicide risk level and risk of harm to others.
  - Coordinate care with other providers when appropriate.
  - Assess and acknowledge potential barriers to treatment.
  - Provide patient and family education.
- **Treatment:**
  - Common medications to consider:
    - SSRIs.
    - SNRIs.
    - Mirtazapine.
    - Bupropion.
    - MAOIs.
  - Refer to psychotherapy:
    - CBT.
    - Interpersonal psychotherapy.
    - Psychodynamic therapy.
    - Marital and family therapy.
    - Problem-solving therapy in individual and group sessions.
  - Combination of medications and psychotherapy is an effective approach.

Additional information can be found at **www.guideline.gov/browse/by-topic.aspx**.

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

American College of Preventive Medicine (2009, October 6): Primary Care Urged to Have Systems in Place for Screening and Treating Depression. ScienceDaily.

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.DSM5.org

National Alliance on Mental Illness
www.nami.org

National Committee for Quality Assurance (NCQA):

HEDIS Measurement Year 2020 & Measurement Year 2021, Volume 2 **https://store.ncqa.org/hedis-my-2020-my-2021-volume-2-epub.html**

National Institute of Mental Health
www.nimh.nih.gov/index.shtml

Medication management for depressive disorders

There are different types of medication for the treatment of depression, such as SSRIs, SNRIs, TCAs, and MAOIs. The most widely prescribed antidepressants are the SSRIs. TCAs and older antidepressants are effective, but are usually not a first-choice treatment for depression because of numerous side effects. Similarly, MAOIs are used as a last resort because of numerous bothersome and potentially dangerous side effects and the need for a special diet.

SSRIs	SNRIs	Atypical antidepressants	TCAs	MAOIs
Generic: citalopram Brand: Celexa	Generic: duloxetine Brand: Cymbalta®		Generic: clomipramine hydrochloride Brand: Anafranil®	Generic: phenelzine Brand: Nardil®
Generic: fluvoxamine Brand: Luvox®/ Luvox CR	Generic: desvenlafaxine Brand: Pristiq®	Generic: vortioxetine Brand: Trintellix®	Generic: imipramine Brand: Tofranil®	Generic: tranylcypromine Brand: Parnate®
Generic: escitalopram Brand: Lexapro		Generic: mitrazapine Brand: Remeron®/ Remeron SolTab	Generic: amitriptyline Brand: Elavil®	Generic: iscarboxacid Brand: Marplan®
	Generic: venlafaxine Brand: Effexor/ Effexor XR	Generic: nefazadone HCL Brand: Serzone®	Generic: nortriptyline HCL Brand: Pamelor®	
Generic: paroxetine Brand: Paxil/ Paxil CR	Generic: levomlinacipran Brand: Fetzima	Generic: bupropion Brand: Wellbutrin XL, Wellbutrin SR, Aplenzin, Forfivo XL	Generic: desipramine Brand: Norpramin®	
Generic: fluoxetine Brand: Prozac		Generic: vilazodone Brand: Viibryd®		
Generic: sertraline Brand: Zoloft				

Note: Not an exhaustive list. Formulary restrictions may apply. Please check the website for formulary status and prior authorization criteria.

Mayo Clinic. Retrieved 2020.
www.mayoclinic.org/diseases-conditions/depression/diagnosis-treatment/drc-20356013

- **The most common side effects associated with SSRIs and SNRIs include:**
  - Headache, which usually goes away within a few days.
  - Nausea, which also usually goes away within a few days.
  - Sleeplessness or drowsiness, which may go away, but not for some individuals. Sometimes the dose may need reduction or the time of day to take the medication may need adjustment.
  - Agitation, a feeling of jitteriness.
  - Sexual dysfunction, reducing sex drive and possibly enjoyment of sex.
- **Tricyclic medications can also cause side effects, including:**
  - Dry mouth.
  - Constipation.
  - Bladder issues, such as difficulty with emptyingor the stream not being as strong.
  - Sexual dysfunction, reducing sex drive and potentially enjoyment of sex.
- **General recommendations:**
  - FDA issued a "black box" warning label emphasizing that all individuals taking antidepressants should be closely monitored for possible side effects, such as worsening depression and/or suicidal ideation.
  - Assess an individual for mania prior to prescribing an antidepressant medication, as antidepressants can lead to increased manic episodes.
  - Potential side effects should always be discussed with the individual.
  - Antidepressants usually take four to six weeks before symptoms start to decrease.
  - Antidepressants should be continued for at least 6 – 12 months to obtain the maximum benefits.
  - Antidepressants should not be discontinued suddenly. Instead, gradually decrease over several weeks.

Assessment, screening tools, and follow-up for depressive disorders

Assessment

When initially assessing the member, the provider should consider other conditions that may appear with depressive-like symptoms:

- Medication side effects.
- Antihypertensive drugs, cardiovascular drugs, sedatives.
- Analgesics, narcotics, anti-inflammatory agents.
- Hormones, which can influence mood.
- Use of alcohol and street drugs, which can influence presentation.
- Adolescents with depression are often excessively critical of themselves and feel they are a failure, yet do not recognize their feelings and symptoms as depression.

Screening tools

The screening process starts with the Patient Health Questionnaire (PHQ-9), a well-known and valid tool.

- The PHQ-9 and the PHQ-9A for adolescents are part of most electronic health records systems.
- The PHQ-9 can be self-administered before or during the office visit.
- Translations into other languages are available by going to **www.phqscreeners.com**.
- Scoring of the PHQ-9 is done by the provider.

Follow-up interventions

PHQ-9 proposed treatment actions:

PHQ-9	Depression severity	Proposed treatment actions
0 – 4	None to minimal	None
5 – 9	Mild	Watchful waiting. Repeat PHQ-9 at follow-up.*
10 – 14	Moderate	Treatment plan, consider counseling, follow-up, and/or pharmacotherapy.
15 – 19	Moderately severe	Active treatment with pharmacotherapy and/or psychotherapy.
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management. Verified 2/1/2021 source: INSTRUCTION MANUAL Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures Retrieved: **www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf**

Confidentiality

It is essential for health care providers to respect an individual's autonomy and right to confidentiality if they are to be effective in developing a trusting relationship that will impact the quality of screening and proper follow-up interventions.

Health care providers need to be familiar with and abide by all applicable state and federal laws pertaining to the privacy of patient health information. Although state laws vary by state, the relevant federal laws include:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 42 CFR Part 2 (governs the confidentiality of alcohol and drug treatment information).

Resources for depressive disorders

Member resources

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention
www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll free at **1-800-QUIT-NOW** (**1-800-784-8669**).

Depression and Bipolar Support Alliance
www.dbsalliance.org/site/PageServer?pagename=home
National organization that provides peer support groups and training, education, and support for parents and guardians of individuals who have mood disorders.

Job Corps
https://www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, and earn a high school diploma and a GED.

Kids Health
www.kidshealth.org/teen
Provides education and resources regarding children and teens' health and development.

Mental Health America
www.mentalhealthamerica.net
Promotes mental health as a critical part of overall wellness that includes prevention, early identification, and intervention for individuals.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Trained counselors help individuals with suicidal crisis and/or emotional distress.

Parent to Parent USA
www.p2pusa.org
Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration
www.ssa.gov/disability
May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/understanding-suicide

American Psychiatric Association
www.psychiatry.org/mental-health

Centers for Disease Control and Prevention
www.cdc.gov/mentalhealth

Depression and Bipolar Support Alliance
www.dbsalliance.org

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml

Appendix C: Screeners for depressive disorder

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un "□" para indicar su respuesta)*	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3
3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado	0	1	2	3
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3
5. Sin apetito o ha comido en exceso	0	1	2	3
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	0	1	2	3
8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	0	1	2	3
9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

Si marcó <u>cualquiera</u> de los problemas, ¿qué tanta <u>dificultad</u> le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

No ha sido difícil	**Un poco difícil**	**Muy difícil**	**Extremadamente difícil**
☐	☐	☐	☐

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PHQ-9 Modified for Teens. Image: **www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf**

American Academy of Child and Adolescent Psychiatry. Retrieved 2020: **www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf**

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	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?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Instructions to Clinicians

The Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

$$\frac{(\text{Raw sum} \times 9)}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

Chapter Four:

Substance Use Disorders

Overview

Since substance use disorders are frequently a chronic condition that can progress slowly, the PCP is in an optimal position to screen for alcohol and drug problems. Research has shown that PCPs can help individuals reduce alcohol consumption through office-based interventions that only take 10 – 15 minutes.

Alcohol-related disorders are present in up to 26 percent of PCPs, which is a prevalence rate similar to those for other chronic conditions, such as hypertension and diabetes.

This overview intends to provide information on substance use disorder diagnosis, types, symptoms, age of onset, treatment, and clinical practice guidelines.

Diagnosis

Substance use disorders are present when an individual has a recurrent use of alcohol and/or drugs that results in problems with overall health and significant functional impairment in regard to school, work, and responsibilities. Many mental health experts no longer refer to this condition as substance abuse or dependence. "Substance use disorders" is the most recent term used, and the condition can be further described as mild, moderate, or severe.

The provider should consult the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, to ensure the criteria for a substance use disorder have been met. It is also advised that a thorough examination be completed to rule out any underlying medical conditions and/or psychiatric conditions. Each specific substance is addressed as a separate disorder, but most substances are diagnosed based on the same primary criteria.

Types

The most common types of substance use disorders include:

- **Alcohol use disorder (AUD):** Characterized by problems controlling alcohol intake, continued use of alcohol despite serious consequences, involvement in risky situations, development of substance tolerance, and the occurrence of withdrawal symptoms.
- **Tobacco use disorder (TUD):** Often leads to significant health conditions, such as lung cancer, respiratory disorders, heart disease, stroke, and in many instances death.
- **Cannabis use disorder (CUD):** Marijuana use can lead to distorted perception, problems with thinking and problem solving, impaired motor coordination, respiratory infection, decreased memory, and exposure to cancer-causing compounds.
- **Stimulant use disorder (SUD):** Often leads to increased alertness, attention, energy, blood pressure, and heart rate; amphetamines are the most abused type of stimulant.
- **Hallucinogen use disorder (HUD):** The use of these drugs can result in hallucinations, feelings of detachment from one's body and environment, and discrepancies with time and perception.
- **Opioid use disorder (OUD):** The use of these drugs reduces the perception of pain; there are illegal opioids such as heroin and legal opioids such as prescription pain killers. Both types can lead to misuse, which often results in an overdose.

Symptoms

It is important for PCPs to be aware of the signs and symptoms of an individual's substance use to be able to intervene effectively.

Physical signs:

- Dental cavities.
- Swollen hands or feet.
- Swollen parotid glands.
- Leukoplakia in mouth.
- Gingivitis.
- Perforated septum.
- Needle track marks.
- Skin abscesses, burns on insides of lips.
- Disrupted menstrual cycle.
- Dilated or constricted pupils.
- Slurred, incoherent, or too-rapid speech.
- Inability to concentrate.
- Unsteady gait.
- Nodding off.
- Blackouts or memory loss.
- Insomnia or other sleep disturbances.
- Withdrawal symptoms.
- Agitation.

Psychiatric or behavioral signs:

- Depression.
- Anxiety.
- Low self-esteem.
- Feelings of desperation and/or loss of control.
- Impulsive and risk-taking behavior.
- Alienation and rebellious behavior.
- Academic and behavioral problems at school.
- Involvement with the criminal justice system.
- Poor interpersonal relationships.

Age of onset

Substance use disorders can occur in children age 12 years and up; young people with substance use disorders mainly engage in alcohol, tobacco, cannabis, and stimulant misuse. The use and misuse of alcohol and drugs is a common occurrence in teens and can lead to serious consequences.

Treatment

The treatment for substance use disorders will vary depending on the individual's age, severity, and type of substance use. There are several components that can be a part of the treatment plan for a successful recovery based on the member's needs, which may include:

- **Individual and group counseling:** The goal is to reduce or stop substance use, build skills, develop a recovery plan, and provide social support and mentors (e.g., CBT).
- **Intensive outpatient program:** This program offers intensive and regular treatment sessions three times a week for several hours per day.
- **Partial hospital program:** This program offers intensive and regular treatment sessions four times a week for several hours per day.
- **Inpatient hospitalization:** This involves a brief hospitalization to address withdrawal symptoms, medication adjustment, and individual and/or group sessions, as well as facilitate a recovery plan.
- **Residential treatment facility:** These facilities offer a highly structured setting with the goal of intensive treatment and preparation for the return to community outpatient programs.
- **Medication-assisted treatment (MAT):** Is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. It is also important to address other health conditions during treatment (SAMHSA, 2020.) SAMHSA. Retrieved 202. **www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions**
- **Case management services:** The goal is to provide community-based supports, resources, and referrals.
- **Recovery support services:** These services provide individuals with additional supports to help them be successful in their treatments, such as transportation services; support groups (e.g., Alcoholics Anonymous); employment or educational supports; peer-to-peer mentoring, coaching, or sponsors; faith-based supports; and education about wellness and recovery.

Clinical practice guidelines

Individuals with substance use disorders vary in regard to many clinically important features and areas of functioning. Therefore, health care providers will need to use a multimodal approach to treatment for the most effective outcomes. The main interventions in assisting individuals with substance use disorders are the following:

- Conduct a thorough assessment.
- Treat intoxication and withdrawal symptoms when needed.
- Address coexisting psychiatric and medical conditions.
- Develop and implement an overall treatment plan.
- Refer to specialists when needed.

SAMHSA. Retrieved 2020. **www.samhsa.gov/medication-assis ed-treatment/medications-counseling-related-conditions**

(SAMHSA, 2020.) SAMHSA. Retrieved 202. **www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions**

The goals of treatment include:

- Achievement of abstinence from or a decrease in the use and effects of substances.
- Reduction in the frequency and severity of relapse to substance use.
- Improvement in psychological and social functioning.

References

American Psychiatry Association
www.psychiatry.org

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Psychiatric Association:
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.DSM5.org

Substance Abuse and Mental Health Services Administration: **www.SAMHSA.gov**

Medication-assisted treatment for substance use disorders

In addition to utilizing behavioral health services such as individual and family counseling, specific medications can be used to treat opioid use disorder — referred to as medication-assisted treatment (MAT). Medications used to treat opioid use disorder include buprenorphine products, methadone and Suboxone.

In order to prescribe MAT medications, providers are required to complete additional training and oversight. After completing training, providers receive a DEA-X license number and are then approved to treat up to 100 patients with MAT products, which may be increased after one year. After this, providers can apply for increase in patient limits to a maximum of 275.

www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver

To learn how to apply for a DEA-X license: **www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver**.

MAT addition information and training webinars are also available through SC MAT ECHO: **www.scmataccess.org/**

Medication is often used in combination with therapy to address the many issues that arise from substance use disorders. The most common types of medications for managing certain types of substance use disorders include:

Alcohol use disorder	Tobacco use disorder	Opioid use disorder
Generic: naltrexone hydrochloride Brand: Revia® Generic: naltrexone (injection) Brand: Vivitrol®	Generic: bupropion Brand: Wellbutrin, Zyban®	Generic: methadone Brand: Dolophine®, Methadose™, Methadose Sugar-Free, Diskets®
Generic: disulfiram Brand: Antabuse®	Generic: varenicline Brand: Chantix®	Generic: buprenorphine and naloxone Brand: Bunavail™, Suboxone®, Zubsolv®
Generic: acamprosate calcium Brand: Campral®	Nicotine replacement: • Chewing gum • Patch • Lozenges • Nasal and oral inhalers (Nicotrol®)	Generic: naltrexone hydrochloride Brand: Revia Generic: naltrexone (injection) Brand: Vivitrol

Note: Not an exhaustive list. Formulary restrictions may apply. Please check the website for formulary status and prior authorization criteria.

Potential side effects should always be discussed with the individual.

Assessment, screening tools, and follow-up for substance use disorders

Assessment

Discussing sensitive questions about substance use in the context of other behavioral lifestyle questions may be less threatening than just asking individuals about substance use. There are a variety of screening instruments that assess for substance use in adolescents and adults that can become part of your overall screening protocols and tools.

Screening tools

There are several reliable screening instruments to assess for substance use disorders.

- CAGE-AID (**www.integration.samhsa.gov/clinical-practice/screening-tools**): a brief screening tool to use for individuals ages 18 and older. Asking the following questions of every adult routinely is an efficient way of screening and identifying substance use problems at an early stage in the individual's development.
  - Have you ever felt you ought to cut down on your drinking or drug use?
  - Have people annoyed you by criticizing your drinking or drug use?
  - Have you felt bad or guilty about your drinking or drug use?
  - Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

  Scoring: Responses to questions are scored 0 for "no" and 1 for "yes" answers.
- **AUDIT (Alcohol Use Disorders Identification Test) Questionnaire:** a brief instrument that can be incorporated into a general health interview, lifestyle questionnaire, or medical history.
- CRAFFT (**www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_SA_English.pdf**): identifies adolescent alcohol and drug use and associated behaviors and is incorporated into the American Academy of Pediatrics Policy Statement on Substance Use Screening, Brief Intervention, and Referral to Treatment for pediatricians.
  - **C:** Have you ever ridden in a **car** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
  - **R:** Do you ever use alcohol or drugs to **relax**, feel better about yourself, or fit in?
  - **A:** Do you ever use alcohol or drugs while you are by yourself, **alone?**
  - **F:** Do you ever **forget** things you did while using alcohol or drugs?
  - **F:** Do your family or **friends** ever tell you that you should cut down on your drinking or drug use?
  - **T:** Have you ever gotten into **trouble** while you were using alcohol or drugs?

Trauma and Substance Use

Exposure to traumatic experiences, especially those occurring in childhood, has been linked to substance use disorders (SUDs), including abuse and dependence. SUDs are also highly comorbid with Posttraumatic Stress Disorder (PTSD) and other mood-related psychopathology. Enhanced awareness of PTSD and substance abuse comorbidity in high-risk, impoverished populations is critical to understanding the mechanisms of substance addiction as well as in improving prevention and treatment.[7]

Follow-up interventions

The following interventions are based on the individual's needs and agreement on the next steps. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool for alcohol or drug use should be told the results of the screening.
- For individuals who do not appear to have any substance use problems, no further intervention is required.
- Individuals with positive results will need some type of intervention, which will vary depending on the severity of the use, such as:
  - Provide education on the hazards of alcohol and drug use.
  - Provide resource information on substance use disorders.
  - Encourage participation in AA and Al-Anon support groups.
  - Discuss medication options if applicable.
  - Schedule a follow-up appointment.

[7] Khoury L, Tang YL, Bradley B, Cubells JF, Ressler KJ. "Substance Use, Childhood Traumatic Experience, and Posttraumatic Stress Disorder in an Urban Civilian Population." Vol. 27, No. 12, 2010, pp. 1077 – 86.

- Initiate a referral to a behavioral health and/or substance use care provider for therapy.
- Refer to the health plan Integrated Health Care Management program.
- For severe symptoms: Initiate a referral to a behavioral health and/or substance use care provider who can further assess and provide a treatment plan.
- If the individual is showing signs of withdrawal and/or is in a crisis, call **911** and refer them to the closest emergency room.

Confidentiality

It is essential for health care providers to respect an individual's autonomy and right to confidentiality if they are to be effective in developing a trusting relationship that will impact the quality of screening and proper follow-up interventions.

Health care providers need to be familiar with and abide by all applicable state and federal laws pertaining to the privacy of patient health information. Although state laws vary by state, the relevant federal laws include:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 42 CFR Part 2 (governs the confidentiality of alcohol and drug treatment information).

Resources for substance use disorders

Member resources

Alcoholics Anonymous
www.aa.org
Mutual support group dedicated to individuals with substance use disorders.

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention
www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll free at **1-800-QUIT-NOW** (**1-800-784-8669**).

Job Corps
https://www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, and earn a high school diploma or a GED.

Kids Health
www.kidshealth.org/teen
Provides education and resources regarding children and teens' health and development.

Mental Health America
www.mentalhealthamerica.net
Promotes mental health as a critical part of overall wellness, which includes prevention, early identification, and intervention for individuals.

Narcotics Anonymous
www.na.org
Provides support groups that provide each member with the opportunity to share and hear the experiences of others who are learning to live without the use of drugs.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Council on Alcoholism and Drug Dependence Inc.
www.ncadd.org
Provides a resource for individuals who are struggling with alcoholism and addiction.

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Provides trained counselors to help individuals with suicidal crisis and/or emotional distress.

Parent to Parent USA
www.p2pusa.org
Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration
www.ssa.gov/disability
May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

Alcoholics Anonymous
www.aa.org

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/understanding-suicide

American Psychiatric Association
www.psychiatry.org/mental-health

Centers for Disease Control and Prevention
www.cdc.gov/mentalhealth

Narcotics Anonymous
www.na.org

National Council on Alcoholism and Drug Dependence Inc.
www.ncadd.org

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml

Substance Abuse and Mental Health Services Administration
https://www.samhsa.gov

Appendix D: Screeners for substance use disorders

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

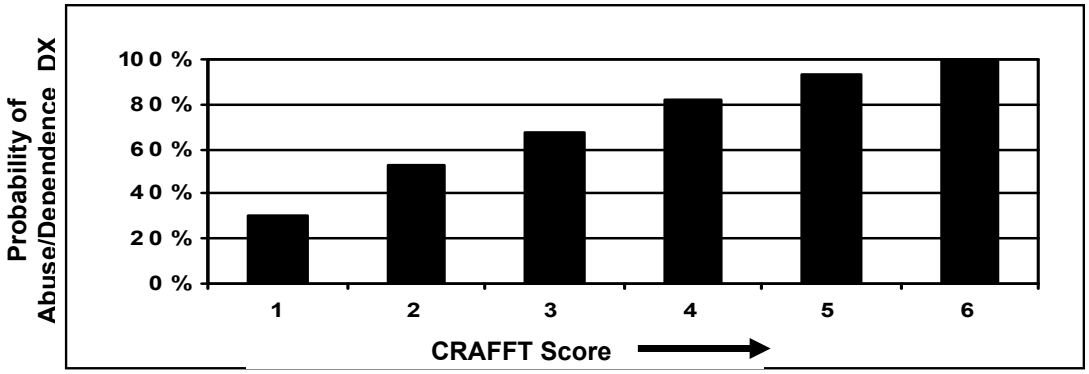
Part B

	No	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each "yes" response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



DSM-IV Diagnostic Criteria[3] (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

References:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagostic and Statistical Manual of Mental Disorders, fourth edition, text revision. Washington DC, American Psychiatric Association, 2000.

La entrevista de diagnóstico CARLOS (CRAFFT)

Inicio: "Le voy a hacer algunas preguntas que le hago a todos mis pacientes. Le agradezco que responda con la mayor sinceridad posible. Trataré sus respuestas de manera confidencial."

Parte A

Durante los ÚLTIMOS 12 MESES:	**No**	**Sí**
1. ¿Ha consumido bebidas alcohólicas (más de unos pocos sorbos)? (Sin tomar en cuenta sorbos de bebidas alcohólicas consumidas durante reuniones familiares o religiosas)	☐	☐
2. ¿Ha fumado marihuana o probado hachís?	☐	☐
3. ¿Ha usado algún otro tipo de sustancias que alteren su estado de ánimo o de conciencia?	☐	☐

(El término "algún otro tipo" se refiere a drogas ilícitas, medicamentos de venta libre o de venta con receta médica, así como a sustancias inhalables que alteren su estado mental.)

Para uso exclusivo del personal médico: ¿Respondió el paciente "sí" a cualquiera de las preguntas de la Parte A?

No ☐	**Sí** ☐
↓	↓
Pasar a la pregunta B1 solamente	**Pasar a las 6 preguntas CARLOS**

Parte B

	No	**Sí**
1. ¿Ha viajado, alguna vez, en un **CARRO** o vehículo conducido por una persona (o usted mismo/a) que haya consumido alcohol, drogas o sustancias psicoactivas?	☐	☐
2. ¿Le han sugerido, alguna vez, sus **AMIGOS o su familia** que disminuya el consumo de alcohol, drogas o sustancias psicoactivas?	☐	☐
3. ¿Ha usado, alguna vez, bebidas alcohólicas, drogas o sustancias psicoactivas para **RELAJARSE**, para sentirse mejor consigo mismo o para integrarse a un grupo?	☐	☐
4. ¿Se ha metido, alguna vez, en **LÍOS** o problemas al tomar alcohol, drogas o sustancias psicoactivas?	☐	☐
5. ¿Se le ha **OLVIDADO,** alguna vez, lo que hizo mientras consumía alcohol, drogas o sustancias psicoactivas?	☐	☐
6. ¿Alguna vez ha consumido, alcohol, drogas o alguna sustancia psicoactiva mientras estaba **SOLO** o SOLA, sin compañía?	☐	☐

CAGE-AID – Overview

The CAGE-AID is a conjoint questionnaire where the focus of each item of the CAGE questionnaire was expanded from alcohol alone to include alcohol and other drugs.

Clinical Utility
Potential advantage is to screen for alcohol and drug problems conjointly rather than separately.

Scoring
Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE- AID exhibited	**Sensitivity**	**Specificity**
One or more **Yes** responses	0.79	0.77
Two or more **Yes** responses	0.70	0.85

1. *Brown RL, Rounds, LA. Conjoint screening questionnaires for alcohol and other drug abuse; criterion validity in a primary care practice. Wisconsin Medical Journal. 1995:94(3) 135-140.*

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	**YES**	**NO**
1. Have you ever felt you ought to cut down on your drinking or drug use?	___	___
2. Have people annoyed you by criticizing your drinking or drug use?	___	___
3. Have you ever felt bad or guilty about your drinking or drug use?	___	___
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	___	___

Permission for use granted by Richard Brown, MD.

Chapter Five:

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Overview

SBIRT is a comprehensive, integrated public health approach that leads to the early identification of and intervention for individuals with one or more substance use disorders and those who are at risk for developing these types of disorders.

The SBIRT process can help PCPs and other health care providers detect the severity of substance use disorders, depression, and other behavioral issues and identify the appropriate level of treatment. Early intervention and treatment are vital to achieve positive outcomes and an improved quality of life for individuals with both substance use disorders and mental illness.

Importance of SBIRT

Recent studies have shown that individuals with serious mental illness die as much as 25 years earlier than the general population due to medical causes rather than suicides. They also show many of these deaths may have been avoidable with routine preventive services and proper follow-up care for chronic medical diseases. Individuals with a serious mental illness are highly likely to also have a comorbid substance use disorder.

Untreated chronic disease is a major reason for the overall higher cost of care for individuals with mental illness and/or substance use disorders. Many individuals with these disorders are seeking treatment from their PCPs rather than behavioral health care providers.

Core components

There are three main components to the SBIRT process:

- Screening: a brief process that effectively assesses the severity of substance use and/or mental illness and identifies the appropriate level of treatment.
- Brief intervention: focuses on raising awareness and increasing motivation toward behavioral change that supports overall health.
- Referral to treatment: critical component that facilitates a clear pathway to follow up with individuals who have been identified as having substance use disorder and/or mental illness and who need specialized treatment.

Referral to treatment

Referral to treatment is a vital component of the SBIRT process. This involves following up with individuals who need more intensive and specialized treatment services. This can be a complex process, and many individuals will need assistance in several areas:

- Obtaining access to specialized treatment.
- Selecting treatment facilities.
- Resolving barriers such as transportation.
- Understanding the cost and insurance reimbursement.
- Making the initial appointment.
- Completing forms.

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

National Institute on Alcohol Abuse and Alcoholism
www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/YouthGuide.aspx

Substance Abuse and Mental Health Services Administration
www.samhsa.gov/health-care-health-systems-integration/screening-referral

Assessment, screening tools and follow-up for SBIRT

Assessment

Many individuals continue to be under diagnosed for mental health and substance use disorder conditions and as a result do not receive treatment. Routine screenings in primary care and other health care settings facilitate the early identification of mental health conditions and substance use disorders, which leads to earlier care. Screenings should be provided to individuals of all ages.

Screening tools

There are several reliable screening tools to assess for both substance use disorders and mental health conditions. Here are some examples of brief screening tools that provide valuable clinical information:

- Alcohol Use Disorders Identification Test (AUDIT) is a 10-item questionnaire that assesses for dangerous alcohol consumption. This was developed by the World Health Organization and has been used with various populations and cultural groups. The questionnaire was primarily designed to be administered in primary care settings.
- AUDIT-C is a three-item questionnaire that assesses for dangerous alcohol consumption. This can be a separate screener or included as part of a general health history questionnaire.
- Drug Abuse Screen Test (DAST-10) is a 10-item self-report scale to provide a brief assessment of drug abuse. It can be used with adults and older youth for screening and treatment purposes.

These tools can be found at **www.integration.samhsa.gov/clinical-practice/screening-tools.**

(See other chapters for further screening assessments.)

Follow-up interventions

The following interventions are based on the individual's needs and willingness to take the next steps in intervention. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool for alcohol or drug use should be told the results of the screening.
- Individuals who do not appear to have any substance use disorder problems require no further intervention.
- Individuals with positive results will need some type of intervention, which will vary depending on the severity of the use and symptoms, such as:
  - Providing education on the hazards of alcohol and drug use or other mental health comorbidities.
  - Providing resource information on substance use disorders or other mental health comorbidities.
  - Encouraging participation in Alcoholics Anonymous and/or other mental health support groups.
  - Discussing medication options if applicable.
  - Scheduling a follow-up appointment.
  - Initiating a referral to a behavioral health and/or substance use care provider for therapy.
  - Referring to the health plan Integrated Health Care Management program.
  - For severe symptoms: initiating a referral to a behavioral health and/or substance use care provider who can further assess and provide a treatment plan.
  - Calling **911** and referring to the closest emergency room if the individual is showing signs of withdrawal and/or is in a crisis.

Confidentiality

It is essential for health care providers to respect an individual's autonomy and right to confidentiality if they are to be effective in developing a trusting relationship that will impact the quality of screening and proper follow-up interventions.

Health care providers need to be familiar with and abide by all applicable state and federal laws pertaining to the privacy of patient health information. Although state laws vary by state, the relevant federal laws include:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 42 CFR Part 2 (governs the confidentiality of alcohol and drug treatment information).

Motivational interviewing

Evidence-based practice

Motivational interviewing (MI) is a clinical approach that engages individuals with mental health conditions; substance use disorders; and other chronic conditions such as diabetes, asthma, and cardiovascular disease to make positive behavioral changes to support better health.

MI techniques are an effective way to engage individuals when assessing for any conditions and stressors that impact an individual's functioning.

Core components

The approach consists of four components:

- Expressing empathy and avoiding arguing.
- Developing discrepancy.
- Rolling with resistance.
- Supporting self-efficacy (an individual's belief that they can successfully make a change).

Techniques

MI is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach to help individuals express their own desires for change, plan for and begin the process of change, and increase their confidence and commitment to change. There are many effective techniques. Here are a few examples:

Ask permission

- Rationale: shows respect for individuals, which may lead to better results when discussing change.
- Example: "I appreciate you answering the screening questions. Could we take a minute to discuss your results?"

Use open-ended questions

- Rationale: When individuals are asked open-ended questions, it allows for a collaborative dialogue.
- Example: "Tell me what you like about your risky behavior."

Elicit change talk

- Rationale: Change talk is more prone to successful outcomes. This technique elicits reasons for changing that are a priority to the individual.
- Example: "What would you like to see different about your current situation?"

Reflective listening

- Rationale: This is the primary way of responding to individuals and building empathy; it involves carefully listening to individuals and responding to what they are saying.
- Example: "It sounds like you recently became concerned about your drinking."

References

SAMHSA-HRSA Center for Integrated Health Solutions
www.samhsa.gov/health-care-health-systems-integration/screening-referral

Motivational Interviewing Strategies and Techniques
www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

Motivational Interviewing from the Center for Evidence-Based Practice
www.centerforebp.case.edu/practices/mi

Appendix E: Screeners for SBIRT

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

NAME: _____ **DATE:** _____

DRUG USE QUESTIONNAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Adult Version

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
7. Do you every feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19. Have you gone to anyone for help for drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

Adolescent Version

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
7. Do you every feel bad or guilty about your drug use?	Yes	No
8. Do your parents ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at school because of drug abuse?	Yes	No
13. Have you missed school assignments because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19. Have you gone to anyone for help for drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

NAME: _____ DATE: _____

DRUG USE QUESTIONNAIRE (DAST – 10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
5. Do you every feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

GUIDE FOR USING THE DRUG ABUSE SCREENING TEST (DAST)

Harvey A. Skinner, Ph.D.
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Why assess Drug Use?

Systematic assessment of drug use and abuse is necessary for ensuring good clinical care. Measures, which are both reliable and valid, provide information to the practitioner, which can be used for identifying problems (early if possible) and for evaluating the effectiveness of treatment. As well, this information is useful for matching patient needs with tailored intervention.

The Drug Abuse Screening Test (DAST) was designed to provide a brief, self-report instrument for population screening, clinical case finding and treatment evaluation research. The DAST yields a *quantitative* index of the degree of consequences related to drug abuse. This instrument takes approximately 5 minutes to administer and may be given in either a self-report or interview format. The DAST may be used in a variety of settings to provide a quick index of drug abuse problems.

DAST-20 and DAST-10 Version

The original DAST contained 28 items that were modeled after the widely used Michigan Alcoholism Screening Test (Selzer, American Journal of Psychiatry, 1971, 127, 1653-1658). Two shortened versions of the DAST were devised using 20-items and 10-items that were good discriminators. The 20-item DAST correlated almost perfectly r = .99) with the original 28-item DAST is measuring the same construct as the longer scale. Moreover, the internal consistency reliability (alpha) was extremely high (.95 for the total sample, and .86 for a subsample that excluded clients with only alcohol problems). Good discrimination is evident among clients classified by their reason for seeking treatment. Most clients with alcohol related problems scored 5 or below, whereas the majority of clients with drug problems scored 6 or above on the 20-item DAST. The DAST-10 correlated very high (r = .98) with the DAST-20 and has excellent internal consistency reliability for such a brief scale (.92 total sample and .74 drug abuse).

Measurement properties of the DAST were initially evaluated using a clinical sample of 256 drug/alcohol abuse clients (Skinner …Addictive Behaviors, 1982). The internal consistency reliability estimate was substantial at .92. and a factor analysis of item intercorrelations suggested an unidimensional scale. With respect to response style biases, the DAST was only moderately correlated with social desirability and denial. Concurrent validity was examined by correlating the DAST with background variables, frequency of drug use, and psychopathology. A greater range of problems associated with drug abuse (DAST) was related to the more frequent use of cannabis, barbiturates and opiates other then heroin. With respect to psychopathology, the largest correlations were with the sociopathic scales of Impulse Expression and Social Deviation. High scorers on the DAST tended to engage in reckless actions and express attitudes that are markedly different from common social codes.

Furthermore, the DAST was positively related to interpersonal problems, suspiciousness, depressive symptoms and a preoccupation with bodily dysfunction. Thus, drug abuse tended to be manifests in, or covary with, other psychopathological characteristics. Finally, the DAST total score clearly differentiated among clients with (1) drug problems only versus (2) mixed drug/alcohol problems versus (3) alcohol problems only.

Advantages

1. The DAST is brief and inexpensive to administer.
2. It provides a quantitative index of the extent of problems related to drug abuse. Thus, one may move beyond the identification of a drug problem and obtain a reliable estimate of the degree of problem severity.
3. DAST scores could be used to corroborate information gained by other assessment sources (e.g. clinical interview or laboratory tests).
4. The routine administration of the DAST would provide a convenient device of recording the extent of problems associated with drug abuse. It would ensure that relevant questions regarding consequences of drug abuse are asked of all clients.
5. The DAST could provide a reference standard for monitoring changes in client population over time, as well as for comparing clients at different assessment centres.

Limitations

1. Since the content of the DAST items is obvious, clients may fake results.
2. Since any given assessment approach provides an incomplete picture of the client's status, there is a danger that DAST scores may be given too much emphasis. Because the DAST yields a numerical score, this score may be misinterpreted.

Administration and Scoring

The DAST may be administered in either an interview or self-report format. The self-report version is generally preferred since it allows the efficient assessment of large groups. In many circumstances one would expect the interview and self-report formats to give identical results. However, the assessment approaches may differ (1) when a client is particularly defensive or high on social anxiety which may produce under-reporting of problems in a face-to-face interview format, or (2) when a client has difficulty reading and understanding the content of items in the self-report version. The DAST should *not* be administered to clients who are presently under the influence of drugs, or who are undergoing a drug withdrawal reaction. Under these conditions the

reliability and validity of the DAST would be suspect. Thus, one should ensure that clients are drug free (detoxified before the DAST is administered.

The following introduction should be used for either interview or self-report formats: "The following questions concern information about your potential involvement with drugs *not including alcohol beverages*."

"In the statements, 'drug abuse' refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non medical use of drugs. The various classes of drugs may include: cannabis, (e.g. marijuana, hash), solvents or glue, tranquillizers (e.g. valium), barbiturates, cocaine, stimulants, hallucinogens (e.g. LSD), or narcotics (e.g. heroin). Remember that the questions *do not* include alcoholic beverages."

The DAST total score is computed by summing all items that are endorsed in the direction of increased drug problems. Two items: #4 (Can you get through the week without using drugs) and #5 (Are you always able to stop using drugs when you want to), are keyed for a "No" response. The other 18 items are keyed for a "Yes" response. For example, if a client circled "Yes" for item #1 he/she would receive a score of 1, whereas if the client circled "No" for item #1 he/she would receive a score of 0. With items #4 and 5, a score of 1 would be given for a "No" response and a score of 0 for a "Yes" response. When each item has been scored in this fashion, the DAST *total score* is simply the sum of the 20 item scores. This total score can range from 0 to 20.

Interpretation

The DAST total score orders individual along a continuum with respect to their *degree* of problems or consequences related to drug abuse. A score of zero indicates that no evidence of drug related problems were reported. As the DAST score increases there is a corresponding rise in the level of drug problems reported. The maximum score of 20 would indicate substantial problems. Thus, as the DAST total score increases one may interpret that a given individual has accrued an increasingly diverse range of drug-related consequences. Then, one may examine the DAST item responses to identify specific problem areas, such as the family or work. The following tentative guidelines are suggested for interpreting the DAST total score.

DAST Interpretation Guide

	DAST-10	DAST-20	Action	ASAM
None	0	0	Monitor	
Low	1-2	1-5	Brief Counseling	Level I
Intermediate (likely meets DSM criteria)	3-5	6-10	Outpatient (intensive)	Level I or II
Substantial	6-8	11-15	Intensive	Level II or III
Severe	9-10	16-20	Intensive	Level III or IV

ASAM: American Society of Addiction Medicine Placement Criteria

A low score does not necessarily mean that the client is free of drug related problems. One must consider the length of time the client has been using drugs, the client's age, level of consumption and other data collected in the assessment in order to interpret the DAST score. Since most of the alcohol abuse clients scored 5 or below, whereas most of the mixed drug/alcohol clients and drug abuse group scored 6 or above, a DAST score of *6 or greater* is suggested for case finding purposes. Further research is planned to evaluate the diagnostic validity of alternative cutoff points on the DAST.

Availability

Copies of the 20-item and 10-item DAST may be obtained from the author (Harvey Skinner) or by contacting Marketing Services at the Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1 Telephone: 1-800-463-6273 or visit the following websites: Harvey Skinner at: www.HealthBehaviorChange.org CAMH: www.camh.net

Key References

Skinner, H.A. (2001). Assessment of substance abuse: Drug Abuse Screening Test. In R. Carson- DeWitt (Ed), Encyclopedia of Drugs, Alcohol & Addictive Behavior. Second Edition. Durham: North Carolina: Macmillan Reference USA p. 147-148.

Skinner, HA: The Drug Abuse Screening Test. Addictive Behavior, 1982, 7, 363-371.

Skinner, HA; and Goldberg, A: Evidence for a drug dependence syndrome among narcotic users. British Journal of Addiction, 1986, 81, 533-538.

Gavin, DR; Ross, HE; and Skinner HA: Diagnostic validity of the DAST in the assessment of DSM-III drug disorders. British Journal of Addiction, 1989, 84, 301-371.

Articles Using the DAST

Cocco, KM; and Carey, KB (1998). Psychometric properties of the Drug Abuse Screening Test in psychiatric outpatients. **Psychological Assessment**, 10, 408-414.

Carey, MP; Carey, KB; Maisto, SA; Gleason, JR; Gordon CM; and Brewer, KK (1999). HIV risk behavior among outpatients at a state psychiatric hospital: Prevalence and risk modeling. **Behavior Therapy**, 30, 389-406.

Maisto, SA; Carey, MP; Carey, KB; Gleason, JG; and Gordon CM (2000). Use of the AUDIT and the DAST-10 to identify alcohol and drug use disorders among adults with a severe and persistent mental illness. **Psychological Assessment**, 12, 186-192.

Carey, MP; Carey, KB; Maisto, SA; Gordon, CM; and Vanable, P (2001) Prevalence and correlates of HIV-related risk behavior among psychiatric outpatients. **Journal of Consulting and Clinical Psychology**, 69, 846-850.

Chapter Six:

Suicide Prevention Practices

Overview and state facts

Suicide is a public health issue that impacts everyone: patients, families, health care providers, school personnel, faith communities, friends, and the government. Suicide is the 10th-leading cause of death in the United States. Every 12 minutes someone takes their own life. The risk of suicide is highest within the first 30 days after an individual is discharged from the emergency room (ER) or an inpatient psychiatric hospitalization.[1]

Research shows that many individuals who died by suicide were undiagnosed with a mental health condition even though most had seen a primary care provider. Suicide is often preventable. Health care providers can have a critical role in preventing suicides by identifying individuals at risk and referring them for appropriate treatment.

Risk and protective factors for suicide

Warning signs of immediate risk*

- Putting their affairs in order and giving away possessions.
- Saying goodbye to family and friends.
- Mood shifting from despair to calm.
- Planning by looking to buy, steal, or borrow what is needed to complete suicide.

*** If an individual is an immediate risk, call 911 for help to transfer to the nearest ER.**

Risk factors for suicide

According to the National Alliance on Mental Illness, research shows that more than half of people (54 percent) who died by suicide did not have a known mental health condition.[3] Risk factors include:

- Family history of suicide.
- Risky substance use — drugs and alcohol can cause mood swings that can increase suicidal thoughts.
- Intoxication — more than one in three people who die from suicide are found to be under the influence.
- Access to firearms.
- Serious or chronic medical illness.
- Gender — more women attempt suicide, but men are four times more likely to die by suicide.
- A history of trauma or abuse.
- Prolonged stress.
- Isolation.
- Age — people under 24 or over 65 are at a higher risk for suicide.
- A recent tragedy or loss, especially if the loss was a family member or close friend.
- Agitation or sleep deprivation.

High-risk populations

Risk factors can vary among cultures, age groups, and genders. The following groups of people are at a higher risk for suicidal thoughts and behavior than the general population:[4]

- People who have attempted suicide.
- Lesbian, gay, bisexual, and transgender (LGBT) individuals — due to stress resulting from prejudice and discrimination.
- American Indians and Alaska Natives — due to historical trauma endured by this population.
- Individuals who have lost someone close to suicide.
- People with chronic or painful medical conditions.
- People with mental health or substance use disorders.
- Members of the armed forces and veterans.
- Men in their midlife or older years — due to stress resulting from unemployment, divorce, and isolation.

Sources

[1] www.integration.samhsa.gov/clinical-practice/suicide-prevention-update

[2] https://afsp.org/about-suicide/state-fact-sheets

[3] www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide

[4] https://www.integration.samhsa.gov/clinical-practice/suicide-prevention-update

Trauma is highly prevalent and a major risk factor for suicide. It is important for health care professionals to be aware of and understand the impact of trauma on an individual's health and overall well-being. A referral to a behavioral health provider who uses trauma-informed practices can help individuals in the recovery and healing process.

Precipitating events that can trigger suicidal behavior

- End of a relationship or marriage.
- Death of a loved one.
- An arrest.
- Serious financial problems.

Protective factors

Protective factors are personal or environmental characteristics that help guard people from suicide.

- Connections to individuals, family, friends, community, and social organizations.
- Effective behavioral health care.
- Life skills such as problem-solving, coping mechanisms, and the ability to adapt to change.
- Self-esteem and a sense of purpose or meaning in life.
- Cultural, religious, or personal beliefs that discourage suicide.

Screening and assessment tools

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends the following screening tools that can be integrated into primary care and other health care settings and foster earlier identification of suicide risk and other potential mental health disorders.[5]

- Columbia-Suicide Severity Rating Scale (C-SSRS): **www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf**.
- Patient Health Questionnaire (PHQ-9): **www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf**.
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): **www.integration.samhsa.gov/images/res/SAFE_T.pdf**.

Prevention and treatment

There are psychotherapies that can help a person with thoughts of suicide recognize unhealthy patterns of thinking and behavior, validate feelings, and learn new coping skills:[6]

- Cognitive behavioral therapy (CBT).
- Dialectical behavioral therapy (DBT).

Medication can be used to help treat underlying depression and anxiety and can decrease a person's risk of hurting themselves.[7]

A combination of medication and psychotherapy has been an effective treatment for many people.

Sources

[5] https://www.integration.samhsa.gov/clinical-practice/suicide-prevention-update

[6] https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide

[7] https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide

Resources for suicide prevention

Zero Suicide initiative

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems that incorporates a set of resources and tools. The project is supported by the Suicide Prevention Resource Center. There are seven main elements of Zero Suicide:

- **Lead:** Promote a system-wide culture change committed to reducing suicides.
- **Train:** Provide training that creates a competent, confident, and caring workforce.
- **Identify:** Use validated screening tools to identify patients with suicide risk.
- **Engage:** Create a suicide care management plan for all individuals at risk of suicide.
- **Treat:** Use evidence-based treatments for individuals who show suicidal thoughts and behaviors.
- **Transition:** Provide warm hand-offs for individuals who need further evaluation and treatment follow-up.
- **Improve:** Continue to review policies and procedures through quality improvement processes.[8]

Visit the Zero Suicide website at **zerosuicide.sprc.org** to learn more about available resources and technical assistance.

Ohio suicide prevention resources

- National Alliance on Mental Illness (NAMI) Ohio Helpline: **1-800-686-2646** or text **NAMI** to **741741**
- Ohio Suicide Hotlines **http://www.suicide.org/hotlines/ohio-suicide-hotlines.html**
- American Foundation for Suicide Prevention — Ohio Chapter **https://afsp.org/chapter/ohio** **1-800-273-8255** or text **TALK** to **741741**
- Ohio Suicide Prevention Resource Center **https://www.sprc.org/states/ohio**

Consumer resources (free and confidential help)

- **National Suicide Prevention Lifeline: 1-800-273-8255**. Available 24 hours a day, seven days a week; national network of local crisis centers that provide free emotional support to individuals in suicidal crisis or emotional distress. **https://suicidepreventionlifeline.org**
- **Veterans Crisis Line: 1-800-273-8255** and **press 1**, or text **838255**. Serves all veterans and service members; available 24 hours a day, seven days a week. https://**www.veteranscrisisline.net**
- **Crisis Text Line:** Text **741741.** Connect to a trained crisis counselor anywhere in the United States. Available 24 hours a day, seven days a week.
- **Teen Link: 1-866-TEENLINK (833-6546).** Available evenings from 6 p.m. to 10 p.m. PT; helpline for teens (ages 13 to 20) to call about issues such as relationships, problems at school, drugs and alcohol, self-harm, family problems, and suicidal thoughts; helpline is staffed by trained volunteers ranging in age from 15 to 20. **https://866teenlink.org/chat-now**
- **The Trevor Project: 1-866-488-7386**. Available 24 hours a day, seven days a week; national organization that provides crisis and suicide prevention among LGBT youth. **www.thetrevorproject.org**
- **National Alliance on Mental Illness (NAMI): 1-800-950-6264**, Monday through Friday, 10 a.m. to 6 p.m.

Sources

[8] https://zerosuicide.sprc.org

Provider resources

- **American Foundation for Suicide Prevention: https://afsp.org.**
- **National Action Alliance for Suicide Prevention: actionallianceforsuicideprevention.org.**
- **National Alliance on Mental Illness (NAMI): www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide.**
- **National Institutes of Health: www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml.**
- **Substance Abuse and Mental Health Services Administration (SAMHSA): www.integration.samhsa.gov/clinical-practice/suicide-prevention-update#Resources_for_Providers.**
- **Suicide Prevention Resource Center: www.sprc.org.**
- **Suicide Prevention Resource Center: Risk and Protective Factors: www.sprc.org/about-suicide/risk-protective-factors.**
- **Trauma-Informed Approaches: www.integration.samhsa.gov/clinical-practice/trauma-informed.**

Chapter Seven:

AmeriHealth Caritas Ohio Resources and Support

24/7 Nurse Line

Members don't always have health questions during business hours. That's why we offer a 24/7 Health Advice Line, a confidential service just for AmeriHealth Caritas Ohio members. We have nurses standing by 24 hours a day to answer health care questions. The 24/7 Health Advice Line can help members make informed health care decisions when their providers are not available.

Members can call **1-833-625-6446** to reach the 24/7 Health Advice Line.

Ohio CareLine

Behavioral health concerns can happen at any time. Members can contact the Ohio CareLine 24 hours a day, seven days a week. Licensed behavioral health professionals will provide assistance in addressing behavioral health concerns and connecting members to the appropriate community resources. This confidential service is available at no cost for our members.

Members can call **1-800-720-9616** to reach the Ohio CareLine.

Population Health Management (PHM):

The PHM strategy utilizes a person-centered approach that listens to and respects member and family choices, including cultural, spiritual, and linguistic preferences. The strategy delivers and coordinates services in a way that blends advanced data-driven stratification and analyses with appropriate levels of individual engagement such as advocacy, communication, problem solving, collaboration, and empowerment. This coordination aims to effectively and efficiently connect members to the right care at the right time. Components of the PHM strategy include:

- **Bright Start® (maternity) program:** The Bright Start program works to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The Bright Start Care Managers and Care Guides help to facilitate access to needed physical and behavioral health care services for both mom and baby. Members enrolled in the Bright Start program receive a variety of interventions depending on the assessed risk of their pregnancy and/or newborn post-delivery. The Bright Start team will reach out to help ensure members follow up with medical appointments, identify potential barriers to getting care, and coordinate member access to needed resources in the community. The Bright Start program provides in-home visits from Care Managers and Care Guides for extra help and follow-up, including information on prenatal visits, well-child visits, choosing a PCP for their infant, and connecting to resources to address unmet health needs. For more information about the Bright Start program, please call **1-833-606-2727**.

- **Wellness coordination — Rapid Response and Outreach Team:** The Rapid Response and Outreach Team operates as a front-line comprehensive population health call center that enhances member satisfaction and health care experience by linking members to the right support, at the right time, within the population health continuum. The team directly manages the urgent and episodic holistic needs of members from an inclusive and health-equity focused lens of short-term coordination with prevention- and wellness-focused activities. These include, but are not limited to:

  - Health risk screenings.
  - Connecting members to community resources to address social barriers such as transportation and access to medical supplies.
  - Prescription navigation.
  - Wellness education and prevention coaching activities, such as EPSDT reminders, scheduling appointments, and condition education.

  The Rapid Response and Outreach Team also strengthens each member's connection across the continuum of the population health strategy by providing warm transfers to other Population Health Management programs, such as Bright Start (maternity) and Care Coordination. To make a referral to the Population Health Management department, please call the Rapid Response and Outreach Team at **1-833-464-7768**.

Through our **Let Us Know** program, we encourage providers to let us know about members who may benefit from assistance with navigating their health journey. Call the Rapid Response and Outreach Team at **1-833-464-7768** or fax the **AmeriHealth Caritas Ohio Let Us Know Form (PDF)** to **1-833-564-3290**.

- **Care Coordination:** The Care Coordination program provides person-centered and trauma-informed whole-person care to optimize the health of the individual members and populations it serves. Care coordination encompasses the full spectrum of care coordination activities, ranging from short-term assistance to meet care gaps to longer-term, intensive, and holistic care coordination for members with the most intense needs.

Website

For additional resources and support, please visit our website at **www.amerihealthcaritasoh.com**.

Appendix F: Screener for AmeriHealth Caritas Ohio

LET US KNOW PROGRAM

AmeriHealth Caritas Ohio

Member Intervention Request Form

Date: _____

MEMBER INFORMATION

Member name:	Date of birth:
Member ID number:	Phone number:
Preferred language:	Preferred contact method (optional; select all that apply): ☐ Phone ☐ Text ☐ Mail
Is the member aware of this referral (optional): ☐ Yes ☐ No	Parent/guardian name (if applicable):

PROVIDER INFORMATION

Provider name:	Provider ID number:
Role in the member's care team: ☐ Primary care provider (PCP) ☐Specialist	Office contact name:
Phone number:	Email/fax:
Best time to call back:	Follow-up preference: ☐ Fax ☐ Call ☐ Email

Please check the identified need or intervention:

☐ Assistance locating a specialty provider, e.g., physical health, behavioral health, trauma specific

☐ Assistance with durable medical equipment (DME), e.g., wheelchair

☐ Assistance with translation services and preferred language materials

☐ Bright Start® maternity program referral

Estimated date of delivery: _____

☐ Care Coordination referral

☐ Caregiver resources

☐ Coaching and education on health conditions

☐ Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide)

☐ Education on alternative and proper use of urgent care and emergency services

☐ Education on plan benefits and resources

☐ Frequent emergency room utilization

☐ Identified care gaps

☐ In need of dental provider

☐ Multiple missed appointments or follow-up care

☐ Nonadherence with treatment plan

☐ Pharmacy consult on controlled substances

☐ Assistance with scheduling and transportation, e.g., recent discharge or appointments

☐ Recent exposure to trauma or stressful life events (e.g., natural disaster, bullying, violence, loss of job, or death in the support system)

☐ Risk of prescribed medication nonadherence

☐ Screening for mental health or substance use services

☐ Tobacco cessation

☐ Weight management

Assistance identifying resources for the following social determinants of health (SDOH):

- ☐ Education and employment
- ☐ Food and nutrition
- ☐ Financial (budget/utilities)
- ☐ Housing resources
- ☐ Transportation
- ☐ Vital records

☐ Treatment plan coaching and education support

☐ Additional comments:

Please fax this form to the Rapid Response and Outreach Team at 1-833-464-7768.
For guidance on completing this form, or to inquire about a submission, please call **1-833-564-3290**.

Internal use only:
Note: Rapid Response and Outreach Team to follow up with provider office staff after outreach to member to report interventions.

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Notes

Notes

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