Behavioral Health Provider Toolkit

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Behavioral Health Provider Toolkit:

Behavioral Health Education and Support for Our Network Providers

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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.

This overview intends to provide information on the diagnosis, types, symptoms, age of onset, treatment, Healthcare Effectiveness Data and Information Set (HEDIS®) standard, and a clinical practice guideline.

Diagnosis

The clinician should consult the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, to ensure the criteria are 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 finds it problematic to control 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 to occur.

- Generalized anxiety disorder (GAD) is 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 or 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: 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 pertains to anxiety that occurs during or soon after substance intoxication or withdrawal or after exposure to a medication.

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 of the anxiety disorders develop in childhood and persist to adulthood. Anxiety disorders can start as early as 6 years of age, but are most prevalent among adolescents between the ages of 13 and 18. Women are more prone to experience an anxiety disorder than men.

Treatment

- Medication: antidepressants, anti-anxiety drugs, or beta blockers can be effective in treating these symptoms.
- Psychotherapy (talk therapy).
  - Cognitive behavioral therapy 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.

- Follow-up after hospitalization for mental illness (FUH): Members aged 6 years and older who had an inpatient psychiatric hospitalization are required to have an outpatient appointment within seven and 30 calendar days of 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 guideline

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

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

- Cognitive behavioral therapy (CBT) is recommended as a treatment option due to its effectiveness in decreasing the 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.
- Anti-depressants 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, treatment options, and resources should be provided to the member and family as indicated to foster the 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® 2015 Technical Specifications for Health Plans, Volume 2

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	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/PaxilCR	Generic: alprazolam Brand: Xanax	
Generic: fluoxetine Brand: Prozac	Generic: buspirone Brand: Buspar	
Generic: sertraline Brand: Zoloft		

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

- 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 6 – 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 clinician should complete a comprehensive examination to include a medical, developmental, school history, and psychiatric history to rule out any underlying medical condition(s) and identify any other co-existing mental health condition(s). It is important to address these co-existing conditions that may affect one another. Anxiety disorders can co-exist with other mental health conditions that may include:

- Depression.
- Substance use disorders.
- 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 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).

Follow-up interventions

The following interventions are based on the individual's needs and his or her 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 anxiety disorder should be told the results of the screening.

- Individuals with positive results will need some type of intervention and will vary depending on the severity of the anxiety, such as:
  - Education on anxiety disorder(s).
  - 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 provider who can further assess and provide a treatment plan.
- If the individual is in a crisis, call 911 and refer 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 (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 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 **1-800-QUIT-NOW** (**1-800-784-8669**) toll-free number.

Job Corps
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
http://www.p2pusa.org
Parent to Parent USA provides a support for parents/ grandparents/families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teen and young adult siblings who have a sister or brother with a mental illness.

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

Provider resources

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

American Academy of Child & 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 <u>last 2 weeks</u>, 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?	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
(Marque con un " " para indicar su respuesta)				
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 is at school.	O	O	O	**SH**
3. My child doesn't like to be with people he/she doesn'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 feels 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.

		Never	Sometimes	Often	Always
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

		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	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	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

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Attention Deficit Hyperactivity Disorder

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, Healthcare Effectiveness Data and Information Set (HEDIS®) standard, and a clinical practice guideline.

Diagnosis

To diagnose ADHD for any child 4 through 18 years of age, the primary care clinician should determine that Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria 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 between 4 – 18 years of age 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-aged children (4 – 5 years of age), the primary care clinician 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 of age), the primary care clinician may prescribe U.S. Food and Drug Administration-approved medications for ADHD or follow parent/teacher evidence-based behavior management training as treatment for ADHD, preferably both.

For adolescents (12 – 18 years of age), the primary care clinician may prescribe U.S. Food and Drug Administration-approved medications for ADHD with the assent of the adolescent and/or recommend behavioral therapy for ADHD, preferably both.

For adults (18 years and older), the primary care clinician may prescribe U.S. Food and Drug Administration-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/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/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/caregiver, child, and school teachers/officials are required to occur 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/caregiver, child, and school teachers/officials are required to occur at least annually.

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.

- Follow-up care for children prescribed ADHD medication: Members aged 6 years 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 practitioner 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 practitioner within 270 days (nine months) after the initiation.

- Follow-up after hospitalization for mental illness (FUH): Members aged 6 years and older who had an inpatient psychiatric hospitalization are required to have an outpatient appointment with a licensed behavioral health practitioner within seven and 30 calendar days of 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 with 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 explanation of their feelings, symptoms, and how it is impacting the different domains of their life.
- 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/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/education is the first line of treatment for parents of pre-school children.
- Following a diagnosis of ADHD, the health care professional with the parent/caregiver consent should contact the child's pre-school 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, cognitive behavioral therapy (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

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

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

Medication management for attention deficit hyperactivity disorder (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 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: dexmethylphenidate Brand: Focalin	Generic: methylphenidate Brand: Concerta	
Generic: methylphenidate Brand: Ritalin	Generic: methylphenidate Brand: Daytrana (patch)	
	Generic: dexmethylphenidate HCL Brand: Focalin XR	
	Generic: methylphenidate Brand: Ritalin LA	
	Generic: lisdexamfetamine Brand: Vyvanse	

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

- Some common side 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 professional and parents/caregivers when medication management is used.

- Helpful strategies to relieve side effects for the prescribing physician to consider:
  - Try sustained-release stimulant.
  - Decrease dose.
  - Frequent healthy snacks.
  - Drug holidays.
  - Add reduced dose in late afternoon.
  - Reduce or eliminate afternoon dose.
  - Strict bedtime routine.
  - Move dosing regimen to earlier time.

Side effects will vary for each individual. The above strategies are options for the health care professional 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 attention deficit hyperactivity disorder (ADHD)

Assessment

The primary care clinician should include assessment for other conditions that might co-exist 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, sleep apnea) conditions.

Screening tools

Screening tools and checklists help clinicians 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 DSM-5 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).
- SWAN Rating Scale (strengths and weaknesses of ADHD symptoms).
- 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 professional is warranted.

Follow-up interventions

The following interventions are based on the individual's needs and his or her 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 and 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 to 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 – 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 provider for therapy if appropriate.
- Refer to the health plan Integrated Health Care Management program.
- Severe symptoms: Initiate a referral to a behavioral health provider who can further assess and provide a treatment plan.
- If the individual is in a crisis, call 911 and refer 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 (HIPAA).
- 42 CFR Part 2 (governs the confidentiality of alcohol and drug treatment information).

Resources for attention deficit hyperactivity disorder (ADHD)

Member resources

ADHD Directory and Resources
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 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 **1-800-QUIT-NOW** (**1-800-784-8669**) toll-free number.

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

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

Kids Health
kidshealth.org/teen
Provides education and resources regarding children and teen's 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
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 a support for parents/grandparents/families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teen and young adult siblings who have a sister or brother with a mental illness.

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

Provider resources

American Academy of Child & 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 (CDC)
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

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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

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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: _____

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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Depressive Disorders

Overview

Depression is a potentially life-threatening disorder that affects approximately 14.8 million Americans 18 years of age or older in a given year. Depression also affects many people younger than age 18.

Depression is associated with substantial morbidity and disability for individuals. Yet, depression is a highly treatable condition. Primary care providers should be equipped to screen for depression and provide immediate treatment either in their own practices or by referring to a mental health professional for a more severe depressive episode.

This overview intends to provide information on the diagnosis, types, symptoms, age of onset, treatment, Healthcare Effectiveness Data and Information Set (HEDIS®) standard, and a clinical practice guideline.

Diagnosis

The clinician should consult the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, to ensure the criteria are 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 clinician 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 to occur.

- 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 his or her 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 hormone 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.

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, pulling 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 STAR*D (Sequenced Treatment Alternatives to Relieve Depression) study found that nearly 40 percent of youth had their first depressive episode before the age of 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, tricyclics and MAOIs.

- The most widely prescribed antidepressants are SSRIs.

- Psychotherapy (talk therapy).

- Combination of medication and psychotherapy have 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 measure

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

- Antidepressant medication management (AMM): Members aged 18 years 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 aged 6 years and older who had an inpatient psychiatric hospitalization are required to have an outpatient appointment with a licensed behavioral health practitioner within seven and 30 calendar days of 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 guideline

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 clinicians when appropriate.
  - Assess and acknowledge potential barriers to treatment.
  - Provide patient and family education.
- Treatment:
  - Common medications to consider:
    » Selective serotonin reuptake inhibitors (SSRIs).
    » Serotonin norepinephrine reuptake inhibitors (SNRIs).
    » Mirtazapine.
    » Bupropion.
    » Nonselective monoamine oxidase inhibitors (MAOIs).
  - Refer to psychotherapy:
    » Cognitive behavioral therapy.
    » Interpersonal psychotherapy.
    » Psychodynamic.
    » 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® 2015 Technical Specifications for Health Plans, Volume 2

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

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, the 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	Tricyclic antidepressants (TCAs)	MAOIs
Generic: citalopram Brand: Celexa	Generic: duloxetine Brand: Cymbalta	Generic: venlafaxine Brand: Wellbutrin/ SR/XL	Generic: clomipramine hydrochloride Brand: Anafranil	Generic: phenelzine Brand: Nardil
Generic: fluvoxamine Brand: Luvox/ Luvox CR	Generic: desvenlafaxine Brand: Pristiq	Generic: trazadone HCL Brand: Desyrel	Generic: imipramine Brand: Tofranil	Generic: tranylcypromine Brand: Parnate
Generic: escitalopram Brand: Lexapro	Generic: milnacipran Brand: Savella	Generic: mitrazapine Brand: Remeron/ Remeron Solutab	Generic: trimipramine Brand: Sumontil	Generic: iscarboxacid Brand: Marplan
Generic: vilazodone Brand: Vilabyrd	Generic: venlafaxine Brand: Effexor/ Effexor XR	Generic: nefazadone HCL Brand: Serzone	Generic: nortriptyline HCL Brand: Pamelor	
Generic: paroxetine Brand: Paxil/PaxilCR			Generic: desipramine Brand: Norpramin	
Generic: fluoxetine Brand: Prozac				
Generic: sertraline Brand: Zoloft				

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

- 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 emptying or the stream not being as strong.
  - Sexual dysfunction, reducing sex drive and potentially enjoyment.
- 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 this 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 clinician 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 can influence mood.
- Use of alcohol and street drugs 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 system.
- 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.*
10 – 14	Moderate	Treatment plan, and 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 the member shows severe impairment or poor response to therapy, initiate an expedited referral to a mental health specialist for psychotherapy and/ or collaborative management.

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 (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 **1-800-QUIT-NOW** (**1-800-784-8669**) toll-free number.

Depression and Bipolar Support Alliance
www.dbsalliance.org
National organization that provides peer support groups and training, education, and support for parents and guardians for individuals who have mood disorders.

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

Kids Health
kidshealth.org/teen
Provides education and resources regarding children and teen's 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 to help individuals with suicidal crisis and/or emotional distress.

Parent to Parent USA
www.p2pusa.org
Provides a 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 teen and young adult siblings who have a sister or brother with a mental illness.

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

Provider resources

American Academy of Child & 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

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

</div>

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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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**
☐	☐	☐	☐

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.

		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	Clinician Use Item score
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:

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

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.

Substance Use Disorders

Overview

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

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

This overview intends to provide information on the diagnosis, types, symptoms, age of onset, treatment, and a clinical practice guideline.

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/dependence. Substance use disorders is the most recent term used, which further describes this condition as mild, moderate, or severe.

The clinician should consult the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, to ensure the criteria are met. It is also advised that a thorough examination be completed to rule out any underlying medical condition(s) and/or psychiatric condition(s). 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) is characterized by problems controlling alcohol intake, continued use of alcohol despite serious consequences, involvement in risky situations, development of substance tolerance, withdrawal symptoms occur.

- 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 primary care clinicians 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 inside 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 behavior problems at school.
- Involvement with the criminal justice system.
- Poor interpersonal relationships.

Age of onset

Unfortunately, substance use disorders are starting in our youth aged 12 and up who are mainly engaging in alcohol, tobacco, cannabis, and stimulant misuse. The use and abuse of alcohol and drugs is a common occurrence by 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 to provide social support and mentors (e.g., cognitive behavioral therapy).
- Intensive outpatient program offers intensive and regular treatment sessions three times a week for several hours per day.
- Partial hospital program offers intensive and regular treatment sessions four times a week for several hours per day.
- Inpatient hospitalization involves a brief hospitalization to address withdrawal symptoms, medication adjustment, individual/group sessions, and facilitate a recovery plan.
- Residential treatment facility offers a highly structured setting with the goal of intensive treatment and preparation for the return to community outpatient programs.
- Medication: The goal is to help reduce the symptoms of withdrawal so the person can better participate in treatment sessions.
- Case management services provide community-based supports, resources, and referrals.
- Recovery support services provide individuals with additional supports to help them be successful in their treatment, such as transportation services, support groups (e.g., AA meetings), employment or educational supports, peer-to-peer mentoring/coaching/sponsors, faith-based support, and education about wellness and recovery.

Clinical practice guideline

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 co-existing psychiatric and medical conditions.
- Develop and implement an overall treatment plan.
- Refer to specialists when needed.

The goals of treatment include:

- Achievement of abstinence 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

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, Subutex, Zubsolv
Generic: acamprosate calcium Brand: Campral	Nicotine replacement via chewing gum, patch, lozenges (over-the-counter medications)	Generic: naltrexone hydrochloride Brand: Revia Generic: naltrexone (injection) Brand: Vivitrol

* 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 about substance use to individuals. 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 his or her 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 Association of Pediatric 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?

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 and 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.

– Initiate a referral to a behavioral health and/or substance use provider for therapy.

– Refer to the health plan: Integrated Health Care Management program.

– Severe symptoms: Initiate a referral to a behavioral health and/or substance use 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 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 (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 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 **1-800-QUIT-NOW** (**1-800-784-8669**) toll-free number.

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

Kids Health
kidshealth.org/teen
Provides education and resources regarding children and teen's 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
Trained counselors to help individuals with suicidal
crisis and/or emotional distress.

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

Sibling Support Project
www.siblingsupport.org
Provides support for teen and young adult siblings
who have a sister/brother with a mental illness.

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

Provider resources

Alcoholics Anonymous
www.aa.org

American Academy of Child & 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
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 <u>alcohol</u> (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any <u>marijuana or hashish</u>?	☐	☐
3. Use <u>anything else</u> to <u>get high</u>? ("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 ☐   **Yes** ☐

Ask CAR question only, then stop   **Ask all 6 CRAFFT questions**

Part B

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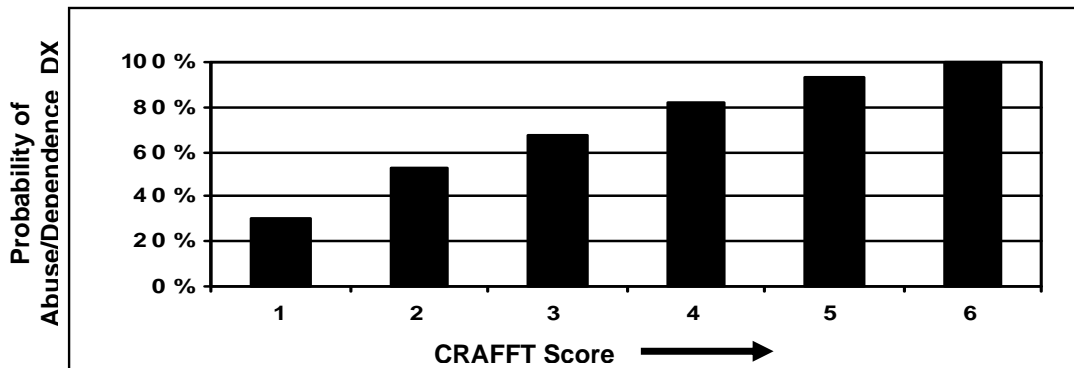
DSM-IV Diagnostic Criteria[3] (Abbreviated)

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

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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. Diagnostic 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 <u>bebidas alcohólicas</u> (más de unos pocos sorbos)? (Sin tomar en cuenta sorbos de bebidas alcohólicas consumidas durante reuniones familiares o religiosas)	☐	☐
2. ¿Ha fumado <u>marihuana</u> o probado <u>hachís</u>?	☐	☐
3. ¿Ha usado <u>algún otro tipo</u> de sustancias que alteren su estado de ánimo o de conciencia?	☐	☐

(El término "<u>algún otro tipo</u>" 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?	☐	☐

NOTA SOBRE EL CARÁCTER CONFIDENCIAL DE LA INFORMACIÓN:
La información incluida en esta página puede estar protegida por normas federales sobre confidencialidad (42 CFR Parte 2) que prohíben su divulgación, a no ser que medie una autorización escrita para el caso específico. NO basta con que se cuente con una autorización generalizada en materia de divulgación de la información médica.

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?	___	___

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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 also those who are at risk for developing these types of disorders.

The SBIRT process can help primary care providers and other health care specialists 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. It also shows many of these deaths may have been avoidable with routine preventive services and proper follow-up care for chronic medical diseases. Substance use disorders is a high comorbidity with individuals with serious mental illness.

Untreated chronic disease is a major reason in 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 primary care provider rather than a behavioral health provider.

Core components

There are three main components to delivering the SBIRT process:

- Screening: 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 for follow-up with individuals that have been identified with substance use disorder and/or mental illness that are in need of specialized treatment.

Refer for treatment

Referral to treatment is a vital component of the SBIRT process. This involves establishing a follow-up with the 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 underdiagnosed 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 facilitates the early identification of mental health conditions and substance use disorders that 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:

- AUDIT (Alcohol Use Disorders Identification Test) 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.
- DAST-10 (Drug Abuse Screen Test) 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 and 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 provider for therapy.
  - Referring to the health plan: Integrated Health Care Management program.
  - In the presence of severe symptoms: initiating a referral to a behavioral health and/or substance use 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 (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 one 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 changes. 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: _____

<u>DRUG USE QUESTIONNAIRE (DAST – 10)</u>

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 **<u>do not</u>** include alcoholic beverages.

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

<u>These questions refer to the past 12 months.</u>	<u>Circle Your Response</u>	
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.
York University, Toronto

Email: harvey.skinner@yorku.ca

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.

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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

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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.

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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

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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 play a critical role in preventing suicides by identifying individuals at risk and referring them for appropriate treatment.

As of 2018, suicide is the 11th leading cause of death in Louisiana. It is the third-leading cause of death for individuals ages 15 to 34. On average, one person dies by suicide every 13 hours in the state, and suicide claims nearly four times more lives annually in Louisiana than HIV.[2]

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.

1. **www.integration.samhsa.gov/clinical-practice/suicide-prevention-update**
2. **afsp.org/about-suicide/state-fact-sheets**
3. **www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide**
4. **www.integration.samhsa.gov/clinical-practice/suicide-prevention-update**

- 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.

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 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.

5. www.integration.samhsa.gov/clinical-practice/suicide-prevention-update
6. www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide
7. 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:

1. **Lead:** Promote a system-wide culture of change committed to reducing suicides.

2. **Train:** Provide training that creates a competent, confident, and caring workforce.

3. **Identify:** Use validated screening tools to identify patients with suicide risk.

4. **Engage:** Create a suicide care management plan for all individuals at risk of suicide.

5. **Treat:** Use evidence-based treatments for individuals who show suicidal thoughts and behaviors.

6. **Transition:** Provide warm hand-offs for individuals who need further evaluation and treatment follow up.

7. **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.

Louisiana suicide prevention resources

- **National Alliance on Mental Illness (NAMI) Louisiana Helpline: 1-800-950-6264**. NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. **www.namilouisiana.org**

- **AmeriHealth Caritas Crisis Hotline: 1-844-211-0971**. Crisis hotline for AmeriHealth Caritas members.

- **Mental Health America of Louisiana: 1-225-978-2177.** Mental Health America of Louisiana is the state affiliate of the country's oldest and largest nonprofit addressing all aspects of mental health and well-being. Mental Health America of Louisiana envisions a just, humane, and healthy society in which all people are accorded respect, dignity, and the opportunity to achieve their full potential free from stigma and prejudice. **http://mentalhealamerica.net/mental-health-america-louisiana**

**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. **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; help line 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; help line is staffed by trained volunteers ranging in age from 15 to 20. **https://866teenlink.org/chat-now**

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

- **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.

Provider resources

- **American Foundation for Suicide Prevention:
  https://afsp.org.**

- **National Action Alliance for Suicide Prevention:
  http://actionallianceforsuicideprevention.org.**

- **National Alliance on Mental Illness (NAMI):
  www.nami.org/Learn-More/Mental-Health-
  Conditions/Related-Conditions/Suicide.**

- **National Institute of Mental 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.**

AmeriHealth Caritas Louisiana Resources and Support

24-hour Nurse Call Line

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

Members can call **1-888-632-0009** to reach the 24-hour Nurse Call Line.

Peer Support Team

Members who have frequent hospital admissions and readmissions and are difficult to contact may be targeted for engagement by a member of the Peer Support Team. A Peer Support Specialist provides a high-touch, face-to-face engagement through a community-based team of nurses, social workers and community health workers to help members navigate and increase their access to needed medical, behavioral health and social services. The team also supports the development of member self-management skills through encouragement and coaching for chronic disease management. In addition to improving the care and health outcomes of members, this community-based team provides valuable information for and coordination with other health plan staff and services, as well as other providers in the community.

Peer Support is currently only available in the Baton Rouge area.

Integrated Health Care Management (IHCM)

The overall goal of the IHCM program is to proactively identify members with potential avoidable health care needs and to help members regain optimum health or improve functional capability. This is accomplished through a comprehensive assessment of the member's condition and determination of available benefits and resources. Care Managers complete a comprehensive assessment and holistic member-centered plan of care, and monitor progress for further interventions needed to meet goals.

Members have access to IHCM program staff 24 hours a day, seven days a week, through routine business hour coverage and the 24-hour Nurse Call Line.

Let Us Know program

AmeriHealth Caritas Louisiana is eager to partner with the provider community in the management of our chronically ill members. We are here to help you engage members in their health care, and to that end we are introducing the Let Us Know program. We have many support teams and tools available to assist in the identification, outreach and education of our members, as well as clinical resources for providers in their care management. Please refer to the enclosed Let Us Know Member Intervention Request Form to make a referral to our Integrated Health Care Management Team.

Rapid Response and Outreach Team (RROT)

The RROT addresses the urgent needs of our members and supports our providers and their staff. The RROT consists of registered nurses, social workers and nonclinical Care Connectors.

There are three key service functions performed in the RROT:

- Inbound call service — Members and AmeriHealth Caritas Louisiana providers may request RROT support via a direct, toll-free Rapid Response line.
- Outreach service — Outreach activities include telephonic contact to address care gaps and support special projects or quality initiatives, such as a fall flu vaccination campaign. RROT associates also initiate follow-up calls to members recently discharged from the hospital and members who contacted the 24/7 Nurse Call Line the previous day to help those members reconnect with their primary care provider office.
- Care management support — Care Connectors support Care Managers by completing tasks and reminder calls for the individualized plan of care. These include appointment scheduling and reminders, transportation support, member educational mailings, and other administrative tasks assigned by Care Managers.

  Please call **1-888-643-0005** to reach the RROT.

Website

For additional resources and supports, please visit our website: **www.amerihealthcaritasla.com**.

Appendix F: Screener for AmeriHealth Caritas Louisiana

LET US KNOW PROGRAM | **AmeriHealth** *Caritas*
Louisiana

Member Intervention Request Form for Provider Referrals

Date: _____

Member information:

Member name: _____   Date of birth: _____

Member ID number: _____   Phone number: _____

Parent or guardian name (if applicable): _____

Provider information:

Provider name: _____   Provider ID number: _____

Phone number: _____   Fax number: _____

Office contact name: _____   Follow-up preference? ☐ Call   ☐ Fax

Please check the appropriate reason(s) for referral (mark all that apply):

☐ Noncompliance with prescribed medication(s).*   ☐ Inappropriate behavior.*

☐ Inappropriate use of emergency room.*   ☐ Drug-seeking behavior.*

☐ Not showing up for appointments or follow-up care.* ☐ In need of behavioral health assistance or services.*

☐ Limited or no knowledge of plan benefits.   ☐ Fraudulent behavior.

☐ Frequent inpatient hospitalizations.*   ☐ Multiple missed appointments.*

☐ Persistent/chronic mental or physical health illness.* ☐ Assistance locating specialty provider.

☐ Inappropriate use of outpatient services.*   ☐ Problems/issues with care gaps.

☐ Noncompliance with treatment plan.*   ☐ Other: _____

Additional information or comments:

_____

_____

_____

Please fax this form to the Rapid Response and Outreach Team (RROT) at 1-866-426-7309.

Follow-up performed: _____

Comments: _____

For the RROT: Please check what interventions were used for issues of noncompliance marked with * above:

☐ RROT care connector: Refer member to RROT care manager.

☐ RROT care manager: Refer to Integrated Health Care Management Team for engagement and outreach interventions.

Note: RROT to follow up with provider office staff, after outreach to member, to report interventions.

AmeriHealth *Caritas*
Louisiana

www.amerihealthcaritasla.com

ACLA-1322-128

PROGRAMA LET US KNOW | AmeriHealth Caritas Louisiana

Formulario de solicitud de intervención del miembro para referencias médicas de proveedores

Fecha: _____

Información del miembro:

Nombre del miembro: _____   Fecha de nacimiento: _____

Número de identificación del miembro: _____   Número de teléfono: _____

Nombre del padre o tutor (si corresponde): _____

Información del proveedor:

Nombre del proveedor: _____   Número de identificación del proveedor: _____

Número de teléfono: _____   Número de fax: _____

Nombre del contacto en la oficina: _____   ¿Preferencia para seguimiento? ☐ Llamada   ☐ Fax

Marque los motivos apropiados para la referencia médica (marque todos los que correspondan):

☐ Incumplimiento respecto del medicamento recetado.*

☐ Uso inadecuado de la sala de emergencia.*

☐ No presentarse en las citas o seguimiento médico.*

☐ Conocimiento limitado o ningún conocimiento de los beneficios del plan.

☐ Hospitalizaciones frecuentes.*

☐ Enfermedad física o mental persistente/crónica.*

☐ Uso inadecuado de servicios para pacientes ambulatorios.*

☐ Incumplimiento del plan de tratamiento.*

☐ Comportamiento inadecuado.*

☐ Adicto a medicamentos bajo receta.*

☐ Necesidad de asistencia o servicios para la salud del comportamiento.*

☐ Comportamiento fraudulento.

☐ Múltiples citas perdidas.*

☐ Ayuda para localizar a un proveedor especialista.

☐ Problemas/cuestiones con brechas en la atención.

☐ Otros: _____

Información o comentarios adicionales:

_____

_____

_____

_____

Envíe este formulario por fax al Equipo de Alcance de Respuesta Rápida (RROT) al 1-866-426-7309.

Se realizó el seguimiento: _____

Comentarios: _____

Para el RROT: Verifique qué intervenciones se utilizaron para cuestiones de incumplimiento marcadas con * más arriba:

☐ Conector de atención del RROT: Referir al miembro a un administrador de cuidado del RROT.

☐ Administrador de cuidado del RROT: Refiérase al Equipo de Administración de cuidados médicos integrales para las intervenciones de enlace y alcance.

Nota: El RROT debe realizar el seguimiento con personal de la oficina del proveedor luego del alcance con el miembro para comunicar las intervenciones.

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ACLA-1322-128

Notes

Notes

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