



Behavioral Health Provider Toolkit



www.amerihealthcaritasnext.com

This page is intentionally blank.



Behavioral Health Provider Toolkit: **Behavioral Health Education and Support for Our Network Providers**

AmeriHealth Caritas Next and First Choice Next are individual and family health plans offered both on and off the Health Insurance Marketplace® by certain companies within the AmeriHealth Caritas Family of Companies. AmeriHealth Caritas Next is offered by AmeriHealth Caritas VIP Next, Inc., in Delaware; AmeriHealth Caritas Florida, Inc., in Florida; and AmeriHealth Caritas North Carolina, Inc., in North Carolina. First Choice Next is offered by Select Health of South Carolina, Inc., in South Carolina. Health Insurance Marketplace® is a registered trademark of the U.S. Department of Health & Human Services.

Links to other websites: The websites listed in this toolkit are maintained by organizations over which AmeriHealth Caritas Next and First Choice Next exercise no control, and AmeriHealth Caritas Next and First Choice Next expressly disclaim any responsibility for the content, the accuracy of the information, and/or quality of products or services provided by or advertised on these third-party sites. AmeriHealth Caritas Next and First Choice Next do not control, endorse, promote, or have any affiliation with any other website unless expressly stated herein.

This page is intentionally blank.

Table of Contents

Chapter One: Anxiety Disorders	3
Overview	3
Medication management for anxiety disorders.....	6
Assessment, screening tools, and follow-up for anxiety disorders	7
Resources for anxiety disorders.....	8
Appendix A: Screeners for anxiety disorders	9
Chapter Two: Attention-Deficit/Hyperactivity Disorder (ADHD)	17
Overview	17
Medication management for ADHD.....	20
Assessment, screening tools, and follow-up for ADHD	21
Resources for ADHD.....	22
Appendix B: Screeners for attention-deficit/hyperactivity disorder.....	24
Chapter Three: Depressive Disorders.....	28
Overview	28
Medication management for depressive disorders	31
Assessment, screening tools, and follow-up for depressive disorders.....	32
Resources for depressive disorders	34
Appendix C: Screeners for depressive disorder.....	35
Chapter Four: Substance Use Disorders.....	39
Overview	39
Medication-assisted treatment for substance use disorders	41
Assessment, screening tools, and follow-up for substance use disorders.....	42
Resources for substance use disorders	43
Appendix D: Screeners for substance use disorders	45
Chapter Five: Screening, Brief Intervention, and Referral to Treatment (SBIRT).....	52
Overview	52
Assessment, screening tools, and follow-up for SBIRT	53
Motivational interviewing	54
Appendix E: Screeners for SBIRT	55
Chapter Six: Suicide Prevention Practices.....	67
Overview and state facts.....	67
Risk and protective factors for suicide	67
Screening and assessment tools.....	68
Prevention and treatment	68
Resources for suicide prevention	69
Provider resources.....	70

This page is intentionally blank.

Chapter One:

Anxiety Disorders

Overview

Anxiety disorders in children and adults

Anxiety disorders are the most common behavioral health condition, affecting many people throughout the United States. The Household Pulse Survey found that, on average, 29% of adults experienced anxiety symptoms in 2022.¹ The Anxiety & Depression Association of America indicates that anxiety disorders impact 31.9% of youth ages 13 – 19 and, when untreated, have a negative impact on their educational, social, and personal lives.²

The research also suggests that cisgender females experience anxiety more often than cisgender males (32% compared to 24%), and transgender participants experienced the highest rates of anxiety (67%) in 2022.¹ With the exception of social anxiety disorder, women are twice as likely to experience the most common anxiety disorders, with the greatest differences in post-traumatic stress disorder (PTSD).² This overview intends to provide information on anxiety disorder diagnosis, types, symptoms, and age of onset.

If you have questions about HEDIS or need more information, please contact your Provider Network Account Executive or Provider Services: Delaware: **1-833-301-3377**; Florida: **1-833-983-3577**; North Carolina: **1-855-266-0219**; or South Carolina (First Choice Next): **1-833-986-7277**.

Diagnosis

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

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

Types

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

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

¹ “Anxiety and Depression: Household Pulse Survey, 2020–2023,” National Center for Health Statistics. U.S. Census Bureau, November 8, 2023, <https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>.

² “Anxiety Disorders — Facts & Statistics,” Anxiety & Depression Association of America, October 28, 2022, <https://adaa.org/understanding-anxiety/facts-statistics>.

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

The average age of onset for anxiety varies across anxiety disorders. Research shows that phobias, separation anxiety, and social anxiety typically first occur before age 13; and panic disorder, PTSD, and GAD typically first occur from 25 – 35 years.³

Many anxiety disorders develop in childhood and persist to adulthood. The Centers for Disease Control and Prevention (CDC) data also reveals that anxiety diagnoses become more common as youth get older. Anxiety often occurs with other mental and behavioral conditions.

For example:

- About three in four children ages 3 – 17 years with depression also have anxiety (73.8%), and almost one in two have behavior problems (47.2%).⁴
- For children ages 3 – 17 years with anxiety, more than one in three also have behavior problems (37.9%) and about one in three also have depression (32.3%).⁴
- For children ages 3 – 17 years with behavior problems, more than one in three also have anxiety (36.6%) and about one in five also have depression (20.3%).⁴

While co-occurring conditions don't necessarily cause each other, there may be overlapping factors that increase risk and the likelihood of developing comorbid or co-occurring conditions. For example, recent research found that children with adverse childhood experiences (ACEs) had increased likelihood of comorbid anxiety and depression, with emotional and physical abuse associated with highest risk.⁵

Anxiety rates have increased over time:

The CDC estimates that anxiety rates have increased over time, from 5.5% in 2007, 6.4% in 2011 – 2012, and 9.4% in 2016 – 2019.⁶ In addition, they estimate anxiety and

depression will increase for children and adolescents by 27% and 24%, respectively, from 2016 to 2019. Multiple factors may influence increased anxiety rates, such as community awareness and education, decreased stigma, increased access to treatment, and reporting symptoms of sub-diagnostic thresholds.⁷

Treatment rates vary among people with different mental disorders:

- About six in 10 children (59.3%) ages 3 – 17 years with anxiety received treatment.⁴

Treatment

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

HEDIS measure

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

³ Marco Solmi et al., "Age at onset of mental disorders worldwide: large scale meta-analysis of 192 epidemiological studies," *Mol Psychiatry*, Vol. 27, 2022, pp. 281–295, <https://doi.org/10.1038/s41380-021-01161-7>.

⁴ Reem M. Ghandour et al., "Prevalence and Conduct Problems in US Children," *J Pediatr*, Vol. 206, 2019, pp. 256 – 267, <https://doi.org/10.1016/j.jpeds.2018.09.021>.

⁵ Amanda Elmore and Elizabeth Crouch, "Anxiety, Depression, and Adverse Childhood Experiences: An Update on Risks and Protective Factors Among Children and Youth," *Academic Pediatrics*, Vol. 23, No.4, May 2023, pp. 720 – 721, <https://doi.org/10.1016/j.acap.2022.11.013>.

⁶ "Data and Statistics on Children's Mental Health," National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, March 21, 2021, www.cdc.gov/childrensmentalhealth/data.html.

⁷ Benjamin Klein et al., "Anxiety in Children and Youth: Part 1—Diagnosis," *Paediatrics & Child Health*, Volume 28, Issue 1, February 2023, pp. 45 – 51, <https://doi.org/10.1093/pch/pxac102>.

AmeriHealth Caritas Next and First Choice Next collect data on the following HEDIS measure for anxiety disorders:

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

Two rates are reported:

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

Clinical practice guidelines

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

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

- CBT is recommended as a treatment option due to its effectiveness in decreasing symptoms of anxiety, worry, and sadness. It also improves panic symptoms and quality of life.
- CBT should include techniques such as cognitive restructuring, exposure, relaxation, breathing exercise, psycho-education, and systematic desensitization.
- Antidepressants are recommended as a medication option if:
 - Symptoms are severe or are not improving apart from medication. If optimal dosages are ineffective or medication is not well tolerated, consider switching to another selective serotonin reuptake inhibitor (SSRI).
 - There is no improvement after 8 to 12 weeks.

In such cases, consider using another medication with a different mechanism of action, such as a serotonin-norepinephrine reuptake inhibitor (SNRI). A combination of CBT and antidepressants is an effective treatment approach.

- Information about the symptoms of, treatment options for, and resources about anxiety disorders should be provided to the member and family as indicated to foster self-management of the condition.

Additional information can be found at the Agency for Healthcare Research and Quality website:

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

Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024
<https://www.cms.gov/files/document/qrs-and-qhp-enrollee-survey-technical-guidance-2024.pdf>

National Agency for Healthcare Research and Quality
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

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

Antidepressants	Anti-anxiety drugs	Beta blockers
citalopram	diazepam	propranolol
venlafaxine	clonazepam	
escitalopram	lorazepam	
paroxetine	buspirone	
fluoxetine		
sertraline		

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

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

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

Assessment

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

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

Screening tools

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

- Generalized Anxiety Disorder 7-Item (GAD-7) Scale
- Screen for Child Anxiety Related Disorders (SCARED) Parent Version, to be completed by the parent
- Spence Children's Anxiety Scale (SCAS)
- Hamilton Anxiety Rating Scale (HAM-A)
- American Society for Addiction Medicine (ASAM) for substance abuse services
- Early Childhood Services Intensity Instrument (ECSII) — for Infants, Toddlers and Pre-Schoolers (ages 0 – 5)
- Children and Adolescents Needs and Strengths (CANS) — for Infants, Toddlers and Pre-Schoolers (ages 0 – 5)

Follow-up interventions

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

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

Confidentiality

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

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

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

Resources for anxiety disorders

Member resources

988 Suicide & Crisis Lifeline

<https://988lifeline.org>

Trained counselors to help individuals with suicidal crisis and/or emotional distress.

Anxiety and Depression Association of America

www.adaa.org

Provides education to individuals and their families with anxiety disorders and helps them find treatment, resources, and support.

Boys Town National Hotline

www.boystown.org

Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention

<https://www.cdc.gov/tobacco/campaign/tips/quit-smoking>

Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll-free at **1-800-QUIT-NOW (1-800-784-8669)**.

Job Corps

<https://www.jobcorps.gov>

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

National Alliance on Mental Illness (NAMI)

www.nami.org

Educates, advocates, and offers resources and support for individuals with mental illness.

National Institute of Mental Health

www.nimh.nih.gov/health/index.shtml

Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

Parent to Parent USA

www.p2pusa.org

Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Sibling Support Project

www.siblingsupport.org

Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration

www.ssa.gov/disability

May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

Anxiety and Depression Association of America

www.adaa.org/resources-professionals

American Academy of Child and Adolescent Psychiatry

www.aacap.org

American Academy of Family Physicians

www.aafp.org

American Academy of Pediatrics

www.aap.org

American 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 últimas 2 semanas, ¿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
<i>(Marque con un “ ” para indicar su respuesta)</i>				
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	☐	☐	☐	PN
2. My child gets headaches when he/she am at school.	☐	☐	☐	SH
3. My child doesn't like to be with people he/she does't know well.	☐	☐	☐	SC
4. My child gets scared if he/she sleeps away from home.	☐	☐	☐	SP
5. My child worries about other people liking him/her.	☐	☐	☐	GD
6. When my child gets frightened, he/she feels like passing out.	☐	☐	☐	PN
7. My child is nervous.	☐	☐	☐	GD
8. My child follows me wherever I go.	☐	☐	☐	SP
9. People tell me that my child looks nervous.	☐	☐	☐	PN
10. My child feels nervous with people he/she doesn't know well.	☐	☐	☐	SC
11. My child gets stomachaches at school.	☐	☐	☐	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	☐	☐	☐	PN
13. My child worries about sleeping alone.	☐	☐	☐	SP
14. My child worries about being as good as other kids.	☐	☐	☐	GD
15. When my child gets frightened, he/she feels like things are not real.	☐	☐	☐	PN
16. My child has nightmares about something bad happening to his/her parents.	☐	☐	☐	SP
17. My child worries about going to school.	☐	☐	☐	SH
18. When my child gets frightened, his/her heart beats fast.	☐	☐	☐	PN
19. He/she child gets shaky.	☐	☐	☐	PN
20. My child has nightmares about something bad happening to him/her.	☐	☐	☐	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.	☐	☐	☐	GD
22. When my child gets frightened, he/she sweats a lot.	☐	☐	☐	PN
23. My child is a worrier.	☐	☐	☐	GD
24. My child gets really frightened for no reason at all.	☐	☐	☐	PN
25. My child is afraid to be alone in the house.	☐	☐	☐	SP
26. It is hard for my child to talk with people he/she doesn't know well.	☐	☐	☐	SC
27. When my child gets frightened, he/she feels like he/she is choking.	☐	☐	☐	PN
28. People tell me that my child worries too much.	☐	☐	☐	GD
29. My child doesn't like to be away from his/her family.	☐	☐	☐	SP
30. My child is afraid of having anxiety (or panic) attacks.	☐	☐	☐	PN
31. My child worries that something bad might happen to his/her parents.	☐	☐	☐	SP
32. My child feels shy with people he/she doesn't know well.	☐	☐	☐	SC
33. My child worries about what is going to happen in the future.	☐	☐	☐	GD
34. When my child gets frightened, he/she feels like throwing up.	☐	☐	☐	PN
35. My child worries about how well he/she does things.	☐	☐	☐	GD
36. My child is scared to go to school.	☐	☐	☐	SH
37. My child worries about things that have already happened.	☐	☐	☐	GD
38. When my child gets frightened, he/she feels dizzy.	☐	☐	☐	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).	☐	☐	☐	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.	☐	☐	☐	SC
41. My child is shy.	☐	☐	☐	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/instruments.

March 27, 2012

SPENCE CHILDREN'S ANXIETY SCALE

Your Name: **Date:** _____

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

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

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

How often are you afraid of this thing?.....	Never	Sometimes	Often	Always

Attention-Deficit/Hyperactivity Disorder (ADHD)

Overview

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

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

If you have questions about HEDIS or need more information, please contact your Provider Network Account Executive or Provider Services: Delaware: 1-833-301-3377; Florida: 1-833-983-3577; North Carolina: 1-855-266-0219; or South Carolina (First Choice Next): 1-833-986-7277.

Diagnosis

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

Symptoms

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

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

Age of onset

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

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

Treatment

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

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

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

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

School-based services

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

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

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

HEDIS measures

AmeriHealth Caritas Next and First Choice Next collect data on the following HEDIS measures for ADHD:

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

Two rates are reported:

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

Clinical practice guidelines

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

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

Health care professionals should:

- Develop a trusting relationship with individuals with ADHD and their families by:
 - Respecting their knowledge and experience of ADHD
 - Being sensitive to stigma in relation to mental illness
- Provide individuals with ADHD and their families age-appropriate information about ADHD in regard to diagnosis, assessment, support options, treatment, and the use and potential side effects of medication.
- Allow individuals to provide their own explanations of their feelings, symptoms, and how ADHD is impacting the different domains of their lives.
- Involve the individual and family in treatment decisions.
- Become familiar with local and national resources pertaining to ADHD.

- Provide adults with ADHD written information about local and national support groups and voluntary organizations.
- Inquire about the impact of ADHD on patients and their families.
- Encourage participation in self-help and support groups when relevant.
- Discuss parent training and education programs to optimize parenting skills, and provide referrals.
- Determine the severity of the problems, how these affect the individual and family, and the impact on the different domains and settings.

Additional clinical practice guidelines:

- Parent training and education is the first line of treatment for parents of preschool-age children.
- Following a diagnosis of ADHD, the health care provider, with parent or caregiver consent, should contact the child's preschool or teacher to explain the diagnosis and severity of symptoms, the care plan, and any special education needs.
- Drug treatment should be provided for school-age children with moderate to severe impairments.
- For older adolescents with ADHD and moderate impairment, cognitive behavioral therapy 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

Health Insurance Exchange Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024

<https://www.cms.gov/files/document/qrs-and-qhp-enrollee-survey-technical-guidance-2024.pdf>

National Guideline Clearinghouse

www.guideline.gov/browse/by-topic.aspx

National Institute of Mental Health

www.nimh.nih.gov/index.shtml

Medication management for ADHD

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

Amphetamines (stimulants): short-acting (4 – 5 hours)	Amphetamines (stimulants): long-acting (7 – 12 hours)	Non-stimulants
amphetamine	dextroamphetamine	atomoxetine
dextroamphetamine	dextroamphetamine sulfate	bupropion
dexmethylphenidate	methylphenidate	clonidine extended release (ER)
methylphenidate	methylphenidate	guanfacine ER
	dexmethylphenidate hydrochloride (HCL)	
	methylphenidate	
	lisdexamfetamine	

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

- **Some common sides effects of stimulants:**

- Decreased appetite
- Sleep problems
- Transient headache
- Transient stomachache
- Behavioral rebound

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

- **Helpful strategies to relieve side effects for the prescribing provider to consider:**

- Sustained-release stimulant
- Decreased dose
- Frequent healthy snacks
- Drug holidays
- Adding reduced dose in late afternoon
- Reduced or eliminated afternoon dose
- Strict bedtime routine
- Moving dosing regimen to earlier time

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

Assessment, screening tools, and follow-up for ADHD

Assessment

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

Screening tools

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

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

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

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

Follow-up interventions

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

- All individuals who complete a screening tool for ADHD should be told the results of the screening.
- Individuals with positive results will need some type of intervention, which will vary depending on the severity of the condition, such as:
 - Provide education on ADHD.
 - Provide resource information on ADHD.

- Encourage participation in a support group.
- Discuss medication options if applicable.
- Assess the concern for possible medication misuse before initiation of stimulant therapy.
- Prepare the individual and family for the initial medication process, to include beginning with a low dose and incrementally increasing to the optimal dose to achieve maximum benefit and minimal side effects.
- Schedule a face-to-face follow-up appointment that is recommended within the first two to three weeks of initiation of the medication.
- For the first year of treatment, face-to-face visits are recommended every three months and then at least twice a year.
- Initiate a referral to a behavioral health care provider for therapy if appropriate.
- Refer to the health plan Integrated Health Care Management program.
- For severe symptoms: Initiate a referral to a behavioral health care provider who can further assess and provide a treatment plan.
- If the individual is in a crisis, call **911** and refer them to the closest emergency room.

Confidentiality

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

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

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

Resources for ADHD

Member resources

988 Suicide & Crisis Lifeline

<https://988lifeline.org>

Provides trained counselors to help individuals with suicidal crisis and/or emotional distress.

Attention Deficit Disorder Association (ADDA)

www.add.org

Provides information, resources, and networking opportunities to assist adults with attention deficit disorder lead more productive lives.

Boys Town National Hotline

www.boystown.org

Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention

<https://www.cdc.gov/tobacco/campaign/tips/quit-smoking>

Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll-free at **1-800-QUIT-NOW (1-800-784-8669)**.

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)

www.chadd.org

Provides education, advocacy, and support for individuals with ADHD.

Job Corps

<https://www.jobcorps.gov>

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

Kids Health

www.kidshealth.org

Provides education and resources regarding children and teens' health and development.

Mental Health America

<https://mhanational.org>

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.nclld.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.

PACER Center: Champions for Children with Disabilities

www.pacer.org

A parent training and information center on education, bullying, vocational training, and employment for youth and young adults with disabilities.

Parent to Parent USA

www.p2pusa.org

Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Sibling Support Project

www.siblingsupport.org

Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration

www.ssa.gov/disability

May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

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

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org

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

Attention-Deficit Disorder Association
www.add.org

Attention Research Update newsletter
www.helpforadd.com

Bright Futures
www.brightfutures.org

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

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

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

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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

Copyright ©2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality

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

Revised - 1102

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality



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: _____

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality



NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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

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

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

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

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

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

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Copyright ©2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality

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

Revised - 1102

NICHQ

National Initiative for Children's Healthcare Quality



Chapter Two: Attention-Deficit/Hyperactivity Disorder (ADHD)

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	Excellent	Average	Above Average	Somewhat of a Problem	Problematic
Academic Performance					
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: _____

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality



Depressive Disorders

Overview

An estimated 21 million adults in the United States had at least one major depressive episode in 2021, or 8.3% of all U.S. adults. Females have a higher prevalence of major depressive episodes (10.3%) than males (6.2%). These episodes were also most prevalent in young adults ages 18 – 25 (18.6%), and in those reporting two or more racial groups (13.9%). Depression is a potentially life-threatening disorder that affects approximately 14.5 million Americans adults in a given year, yet only 61% received treatment in 2021.¹

Depression also affects many people younger than age 18. SAMHSA data estimates nearly 5 million adolescents experienced a major depressive episode in 2021, or 20.1% of the U.S. population ages 12 – 17. Similarly, depression was more common in adolescent females (29.2%) than males (11.5%) and was highest among those reporting two or more races (27.2%). Only 40.6% of adolescents in the U.S. with major depressive episodes in 2021 received treatment.¹

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

Diagnosis

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

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

Types

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

- **Major depressive disorder or major depression:** The individual has a mixture of symptoms that interfere with the individual's ability to work, sleep, study, eat, and enjoy once-enjoyable activities. Major depression can be disabling if it is not treated and stops an individual from doing their usual activities. Some individuals may have only a single episode within their lifetimes, but more often an individual may have multiple episodes.

- **Dysthymic disorder, or dysthymia:** The individual has a long-term (two years or longer) depression, but it may not be severe enough to disable an individual. Still, it can stop the individual from doing usual activities or from feeling well. Individuals with dysthymia may also experience one or more episodes of major depression during their lifetimes.
- **Postpartum depression:** After giving birth, the individual experiences symptoms more serious than the “baby blues” when hormonal and physical changes occur and the new duties of caring for a newborn can be overwhelming. Symptoms may be similar to depression but may also include heightened anger or worry, emotional withdrawal, disconnectedness from the baby, or feelings of guilt.² CDC data found an aggregated 12.7% of women self-reported postpartum depressive symptoms, or about 1 in 8 women with recent live birth experiences.³
- **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.

¹ “Major Depression,” National Institute of Mental Health, July 2023, www.nimh.nih.gov/health/statistics/major-depression.shtml.

² “Depression Among Women,” Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, May 22, 2023, <https://www.cdc.gov/reproductivehealth/depression/index.htm#Postpartum>.

³ “Selected 2016 Through 2021 Maternal and Child Health (MCH) Indicators,” Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, November 28, 2023, <https://www.cdc.gov/prams/prams-data/selected-mch-indicators.html>.

Symptoms

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

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

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

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

Age of onset

Although the average age of an individual with depression is 32, research suggests that among individuals who develop depression at some point in their life, nearly half

experienced their first depressive episode by age 14, and about three quarters by age 24. Researchers found that individuals who experienced depression with adolescent-onset and did not receive helpful treatment during adolescence were more likely to experience functional outcomes like obesity and lower incomes, and were less likely to be married and have children.⁴

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: selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), atypical antidepressants, tricyclic antidepressants (TCAs), and nonselective monoamine oxidase inhibitors (MAOIs).
- The most widely prescribed antidepressants are SSRIs.
- Psychotherapy (talk therapy) has been found to be effective.
- Combination of medication and psychotherapy has been an effective treatment for many people.
- Some simple things can lift mood, such as exercise, healthy eating, and getting a healthy amount of sleep.
- Depression is a disease of isolation, so finding ways to spend time with family and friends can be helpful.

HEDIS measures

AmeriHealth Caritas Next and First Choice Next collect data on the following HEDIS measures for depressive disorders:

- **Antidepressant medication management (AMM):** Members age 18 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).

⁴ Katherine Chang and Kate Kuhlman, “Adolescent-onset Depression Is Associated With Altered Social Functioning into Middle Adulthood,” *Sci Rep*, Vol. 12, No. 17320, 2022, <https://doi.org/10.1038/s41598-022-22131-1>.

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

Two rates are reported:

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

Clinical practice guidelines

The following clinical practice guidelines include the major recommendations for the treatment of individuals with major depressive disorder.⁵

- **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 level.
 - Coordinate care with other providers when appropriate.
 - Assess and acknowledge potential barriers to treatment.
 - Provide patient and family education.
- **Treatment:**
 - Common medications to consider:
 - » SSRIs
 - » SNRIs
 - » Mirtazapine
 - » Bupropion
 - » MAOIs
 - Refer to psychotherapy:
 - » Cognitive behavioral therapy
 - » Interpersonal psychotherapy
 - » Psychodynamic therapy

- » Marital and family therapy
- » Problem-solving therapy in individual and group sessions
- Combination of medications and psychotherapy is an effective approach.

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

References

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

American Academy of Pediatrics
www.aap.org

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.dsm5.org

National Alliance on Mental Illness
www.nami.org

Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024
<https://www.cms.gov/files/document/qrs-and-qhp-enrollee-survey-technical-guidance-2024.pdf>

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

⁵“Depression (major depressive disorder),” Mayo Clinic, Retrieved 2024, www.mayoclinic.org/diseases-conditions/depression/diagnosis-treatment/drc-20356013.

Medication management for depressive disorders

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

SSRIs	SNRIs	Atypical antidepressants	TCAs	MAOIs
citalopram	duloxetine	vortioxetine	clomipramine HCL	phenelzine
fluvoxamine	desvenlafaxine	mirtazapine	imipramine	tranylcypromine
escitalopram	venlafaxine	nefazodone HCL	amitriptyline	isocarboxazid
paroxetine	levomilnacipran	bupropion	nortriptyline HCL	
fluoxetine		vilazodone	desipramine	
sertraline				

Note: 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 of sex
- **General recommendations:**
 - The FDA issued a “black box” warning label emphasizing that all individuals taking antidepressants should be closely monitored for possible side effects, such as worsening depression and/or suicidal ideation.
 - Assess an individual for mania prior to prescribing an antidepressant medication, as antidepressants can lead to increased manic episodes.
 - Potential side effects should always be discussed with the individual.
 - Antidepressants usually take four to six weeks before symptoms start to decrease.
 - Antidepressants should be continued for at least six to 12 months to obtain the maximum benefits.
 - Antidepressants should not be discontinued suddenly. Instead, gradually decrease over several weeks.

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

Assessment

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

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

Screening tools

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

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

Follow-up interventions

PHQ-9 proposed treatment actions:

PHQ-9 score	Depression severity	Proposed treatment actions
0 – 4	None to minimal	None
5 – 9	Mild	Watchful waiting. Repeat PHQ-9 at follow-up.*
10 – 14	Moderate	Treatment plan, consider counseling, follow-up, and/or pharmacotherapy.
15 – 19	Moderately severe	Active treatment with pharmacotherapy and/or psychotherapy.
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management. “Instruction Manual — Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures,” Retrieved 2024, www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf.

Confidentiality

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

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

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

Resources for depressive disorders

Member resources

988 Suicide & Crisis Lifeline

<https://988lifeline.org>

Trained counselors help individuals with suicidal crisis and/or emotional distress.

Boys Town National Hotline

www.boystown.org

Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention

<https://www.cdc.gov/tobacco/campaign/tips/quit-smoking>

Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll-free at **1-800-QUIT-NOW (1-800-784-8669)**.

Depression and Bipolar Support Alliance

www.dbsalliance.org

National organization that provides peer support groups and training, education, and support for parents and guardians of individuals who have mood disorders.

Job Corps

<https://www.jobcorps.gov>

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

Kids Health

www.kidshealth.org

Provides education and resources regarding children and teens' health and development.

Mental Health America

<https://mhanational.org>

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.

Parent to Parent USA

www.p2pusa.org

Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Sibling Support Project

www.siblingsupport.org

Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration

www.ssa.gov/disability

May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

American Academy of Child and Adolescent Psychiatry

www.aacap.org

American Academy of Family Physicians

www.aafp.org

American Academy of Pediatrics

www.aap.org

American Foundation for Suicide Prevention

www.afsp.org

American Psychiatric Association

www.psychiatry.org/mental-health

Centers for Disease Control and Prevention

www.cdc.gov/mentalhealth

Depression and Bipolar Support Alliance

www.dbsalliance.org

National Institute of Mental Health

www.nimh.nih.gov/health/index.shtml

Appendix C: Screeners for depressive disorder

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

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

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

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

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

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 últimas 2 semanas, ¿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 cualquiera de los problemas, ¿qué tanta dificultad 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
☐

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.

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

American Academy of Child and Adolescent Psychiatry, Retrieved 2024: www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf

Severity Measure for Depression—Child Age 11–17*

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

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

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

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

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

Instructions to Clinicians

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

Scoring and Interpretation

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

Interpretation Table of Total Raw Score

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

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

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

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

Frequency of Use

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

Chapter Four:

Substance Use Disorders

Overview

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

Coverage for mental health and substance use services applies whether treatment is voluntary on the part of the covered person or court-ordered as the result of contact with the criminal justice or legal systems. AmeriHealth Caritas Next and First Choice Next comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). We provide coverage for mental health and substance use services in parity with medical or surgical benefits within the same classification or subclassification.

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

Diagnosis

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

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

Types

The most common types of substance use disorders include:

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

Symptoms

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

Physical signs:

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

Psychiatric or behavioral signs:

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

Age of onset

Children and adolescents with substance use disorders mainly engage in alcohol, tobacco, cannabis, and stimulant misuse. The use and misuse of alcohol and drugs is a common occurrence in teens and can lead to serious consequences.

Treatment

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

- **Individual and group counseling:** The goal is to reduce or stop substance use, build skills, develop a recovery plan, and provide social support and mentors (e.g., CBT).

- **Intensive outpatient program:** This program offers intensive and regular treatment sessions three times a week for several hours per day.
- **Partial hospital program:** This program offers intensive and regular treatment sessions four times a week for several hours per day.
- **Inpatient hospitalization:** This involves a brief hospitalization to address withdrawal symptoms, medication adjustment, and individual and/or group sessions, as well as facilitate a recovery plan.
- **Residential treatment facility:** These facilities offer a highly structured setting with the goal of intensive treatment and preparation for the return to community outpatient programs.
- **Medication-assisted treatment (MAT):** Is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. It is also important to address other health conditions during treatment.¹
- **Case management services:** The goal is to provide community-based supports, resources, and referrals.
- **Recovery support services:** These services provide individuals with additional supports to help them be successful in their treatments, such as transportation services; support groups (e.g., Alcoholics Anonymous); employment or educational supports; peer-to-peer mentoring, coaching, or sponsors; faith-based supports; and education about wellness and recovery.

Clinical practice guidelines

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

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

¹“Medications, Counseling, and Related Conditions,” SAMHSA, Last updated March 2023, www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions.

The goals of treatment include:

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

References

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

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

American Psychiatric Association:
Diagnostic and Statistical Manual of Mental Disorders,
Fifth Edition (2013)
www.dsm5.org

Substance Abuse and Mental Health Services
Administration
www.samhsa.gov

Medication-assisted treatment for substance use disorders

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

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
naltrexone HCL naltrexone (injection)	bupropion	methadone
disulfiram	varenicline	buprenorphine and naloxone
acamprosate calcium	Nicotine replacement: • Chewing gum • Patch • Lozenges • Nasal and oral inhalers	naltrexone HCL naltrexone (injection)

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

Potential side effects should always be discussed with the individual.

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

Assessment

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

Screening tools

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

- **CAGE-AID** (<https://store.samhsa.gov/sites/default/files/d7/priv/sma12-3581.pdf>): a brief screening tool to use for individuals age 18 and older. Routinely asking the following questions of every adult is an efficient way of screening and identifying substance use problems at an early stage in the individual's development.
 - Have you ever felt you ought to cut down on your drinking or drug use?
 - Have people annoyed you by criticizing your drinking or drug use?
 - Have you felt bad or guilty about your drinking or drug use?
 - Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
- **Scoring:** Responses to questions are scored 0 for “no” and 1 for “yes” answers.
- **AUDIT (Alcohol Use Disorders Identification Test) Questionnaire:** A brief instrument that can be incorporated into a general health interview, lifestyle questionnaire, or medical history.
- **CRAFFT** (<https://crafft.org/>): Identifies adolescent alcohol and drug use and associated behaviors and is incorporated into the American Academy of Pediatrics Policy Statement on Substance Use Screening, Brief Intervention, and Referral to Treatment for pediatricians.
 - **C:** Have you ever ridden in a **car** driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
 - **R:** Do you ever use alcohol or drugs to **relax**, feel better about yourself, or fit in?

- **A:** Do you ever use alcohol or drugs while you are by yourself, **alone**?
- **F:** Do you ever **forget** things you did while using alcohol or drugs?
- **F:** Do your family or **friends** ever tell you that you should cut down on your drinking or drug use?
- **T:** Have you ever gotten into **trouble** while you were using alcohol or drugs?

Trauma and substance use

Exposure to traumatic experiences, especially those occurring in childhood, has been linked to substance use disorders (SUDs), including use and dependence. SUDs are also highly comorbid with post-traumatic stress disorder (PTSD) and other mood-related psychopathology. Enhanced awareness of PTSD and substance use comorbidity in high-risk, impoverished populations is critical to understanding the mechanisms of substance addiction, as well as in improving prevention and treatment.²

Follow-up interventions

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

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

² Lamya Khoury et al., “Substance Use, Childhood Traumatic Experience, and Posttraumatic Stress Disorder in an Urban Civilian Population,” *Depression and Anxiety*, Vol. 27, No. 12, 2010, pp. 1077 – 1086.

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

Confidentiality

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

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

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

Resources for substance use disorders

Member resources

988 Suicide & Crisis Lifeline

<https://988lifeline.org>

Provides trained counselors to help individuals with suicidal crisis and/or emotional distress.

Alcoholics Anonymous

www.aa.org

Mutual support group dedicated to individuals with substance use disorders.

Boys Town National Hotline

www.boystown.org

Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease Control and Prevention

<https://www.cdc.gov/tobacco/campaign/tips/quit-smoking>

Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling toll-free at **1-800-QUIT-NOW (1-800-784-8669)**.

Job Corps

<https://www.jobcorps.gov>

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

Kids Health

www.kidshealth.org

Provides education and resources regarding children and teens' health and development.

Mental Health America

<https://mhanational.org>

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 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.

Parent to Parent USA

www.p2pusa.org

Provides support for parents, grandparents, and families with children with special health care needs and mental illness.

Recoverd

<https://recovered.org>

Provides a resource for individuals who are struggling with alcoholism and addiction.

Sibling Support Project

www.siblingsupport.org

Provides support for teens and young adults who have a sibling with a mental illness.

Social Security Administration

www.ssa.gov/disability

May provide financial assistance to people with disabilities through the Social Security and Supplemental Security Income disability programs.

Provider resources

Alcoholics Anonymous

www.aa.org

American Academy of Child and Adolescent Psychiatry

www.aacap.org

American Academy of Family Physicians

www.aafp.org

American Academy of Pediatrics

www.aap.org

American Foundation for Suicide Prevention

www.afsp.org

American Psychiatric Association

www.psychiatry.org/mental-health

Centers for Disease Control and Prevention

www.cdc.gov/mentalhealth

Narcotics Anonymous

www.na.org

National Institute of Mental Health

www.nimh.nih.gov/health/index.shtml

Recoverd

<https://recovered.org>

Substance Abuse and Mental Health Services Administration

<https://www.samhsa.gov>

Appendix D: Screeners for substance use disorders

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The CRAFFT 2.1+N Interview

To be verbally administered by the clinician

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, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none. # of days
2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or **"synthetic marijuana"** (like "K2," "Spice")? Say "0" if none. # of days
3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Say "0" if none. # of days
4. Use a **vaping device* containing nicotine and/or flavors**, or use any **tobacco products†**? Say "0" if none. # of days
*Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.

If the patient answered...

"0" for all questions in Part A



Ask 1st question only
in Part B below, then STOP

"1" or more for Q. 1, 2, or 3



Ask all 6 questions
in Part B below

"1" or more for Q. 4



Ask all 10 questions
in Part C on next page

Part B

Circle one

- | | | | |
|----------|--|-----------|------------|
| C | Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | No | Yes |
| R | Do you ever use alcohol or drugs to RELAX , feel better about yourself, or fit in? | No | Yes |
| A | Do you ever use alcohol or drugs while you are by yourself, or ALONE ? | No | Yes |
| F | Do you ever FORGET things you did while using alcohol or drugs? | No | Yes |
| F | Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? | No | Yes |
| T | Have you ever gotten into TROUBLE while you were using alcohol or drugs? | No | Yes |

Two or more YES answers in Part B suggests a serious problem that needs further assessment. See Page 3 for further instructions. →

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent.

Part C

*“The following questions ask about your use of any **vaping devices containing nicotine and/or flavors**, or use of any **tobacco products**.*”*

	Circle one	
	Yes	No
1. Have you ever tried to QUIT using, but couldn't?		
2. Do you vape or use tobacco NOW because it is really hard to quit?		
3. Have you ever felt like you were ADDICTED to vaping or tobacco?		
4. Do you ever have strong CRAVINGS to vape or use tobacco?		
5. Have you ever felt like you really NEEDED to vape or use tobacco?		
6. Is it hard to keep from vaping or using tobacco in PLACES where you are not supposed to, like school?		
7. When you HAVEN'T vaped or used tobacco in a while (or when you tried to stop using)...		
a. did you find it hard to CONCENTRATE because you couldn't vape or use tobacco?		
b. did you feel more IRRITABLE because you couldn't vape or use tobacco?		
c. did you feel a strong NEED or urge to vape or use tobacco?		
d. did you feel NERVOUS, restless, or anxious because you couldn't vape or use tobacco?		

One or more YES answers in Part C suggests a serious problem with nicotine that needs further assessment. See Page 3 for further instructions. ➡

**References:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health*, 35(3), 225–230;
McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open*, 1(6), e183535.

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent.

Entrevista con el instrumento CRAFFT 2.1+N

Que deberá realizar el médico de forma oral

Comienzo: “Te voy a hacer algunas preguntas que les hago a todos los pacientes. Por favor responde sinceramente. Tus respuestas serán confidenciales”.

Parte A

Durante los ÚLTIMOS 12 MESES, cuántos días:

1. ¿Has bebido algo más que unos sorbos de cerveza, vino o alguna bebida con alcohol? Di “0” si la respuesta es ninguno.

N° de días

2. ¿Has usado algún tipo de **marihuana** (cannabis, aceite, cera, para fumar, vaporizar, fumar dosis muy concentradas o “dabs” o en los alimentos) o “marihuana sintética” (como “K2”, “Spice”)? Di “0” si la respuesta es ninguno.

N° de días

3. ¿Has usado **algo más para drogarte** (como otras drogas ilegales, medicamentos recetados o de venta libre, y cosas para inhalar, esnifar, vaporizar o inyectarse)? Di “0” si la respuesta es ninguno.

N° de días

4. ¿Has usado un **dispositivo vaporizador*** que contiene nicotina o sabores, o algún **producto de tabaco†**? Di “0” si la respuesta es ninguno.

N° de días

* Como cigarrillos electrónicos, “mods”, dispositivos “pod” como JUUL, vaporizadores descartables como Puff Bar, vaporizadores tipo bolígrafo o pipas de agua electrónicas.
† Pitillos, cigarros, cigarrillos, pipas, tabaco de mascar, tabaco rapé, “snus” o solubles.

Si el/la paciente respondió...

“0” en todas las preguntas de la Parte A



Solo hágale la primera pregunta de la Parte B a continuación y luego **DETÉNGASE**

“1” o más en las P. 1, 2, o 3



Hágale las 6 preguntas de la Parte B a continuación

“1” o más en la P. 4



Hágale las 10 preguntas de la Parte C en la siguiente página

Parte B

Marca con un círculo

C	¿Alguna vez has viajado en un vehículo (CAR) conducido por alguien (incluido/a tú mismo/a) que estaba drogado o que había consumido alcohol o drogas?	No	Sí
R	¿Alguna vez consumes alcohol o drogas para relajarte (RELAX), sentirte mejor contigo mismo/a o integrarte en un grupo?	No	Sí
A	¿Alguna vez consumes alcohol o drogas cuando estás solo/a (ALONE) o sin compañía?	No	Sí
F	¿Alguna vez te olvidas (FORGET) de cosas que has hecho mientras consumías alcohol o drogas?	No	Sí
F	¿Tus familiares o amigos (FAMILY or FRIENDS) alguna vez te dicen que deberías disminuir el consumo de alcohol o drogas?	No	Sí
T	¿Alguna vez te has metido en problemas (TROUBLE) al consumir alcohol o drogas?	No	Sí

Dos o más respuestas afirmativas sugieren un problema grave con la que requiere continuar evaluando el caso. Para obtener más instrucciones consulte la página 3. ➡

AVISO PARA EL PERSONAL DE LA CLÍNICA Y EXPEDIENTES MÉDICOS:

La información consignada en esta página se encuentra protegida por normas federales especiales en materia de confidencialidad (Título 42 del Código de Reglamentos Federales [CFR], Parte 2), que prohíben su divulgación salvo que se autorice mediante consentimiento específico por escrito.

Parte C

“Las siguientes preguntas son sobre el uso de **dispositivos vaporizadores que contienen nicotina o sabores**, o sobre el uso de **productos de tabaco**.*”

	Marca con un círculo	
1. ¿Alguna vez has intentado DEJAR de consumir, pero no pudiste?	Sí	No
2. ¿ ACTUALMENTE usas vaporizador o tabaco porque te resulta muy difícil dejar de consumir?	Sí	No
3. ¿Alguna vez has sentido que eres ADICTO/A al vaporizador o al tabaco?	Sí	No
4. ¿Alguna vez sientes muchas GANAS de usar vaporizador o tabaco?	Sí	No
5. ¿Alguna vez has sentido que realmente NECESITABAS usar vaporizador o tabaco?	Sí	No
6. ¿Te resulta difícil evitar usar vaporizador o tabaco en LUGARES donde supuestamente no debes hacerlo, como la escuela?	Sí	No
7. Cuando NO HAS USADO vaporizador o tabaco durante un tiempo (o cuando has intentado dejar de usarlo)...		
a. ¿te resultó difícil CONCENTRARTE porque no podías usar vaporizador o tabaco?	Sí	No
b. ¿te sentiste más IRRITABLE porque no podías usar vaporizador o tabaco?	Sí	No
c. ¿sentiste NECESIDAD o ganas intensas de usar vaporizador o tabaco?	Sí	No
d. ¿te sentiste NERVIOSO/A , inquieto/a o ansioso/a porque no podías usar vaporizador o tabaco?	Sí	No

Una o más respuestas afirmativas en Parte C sugieren un problema grave con la nicotina que requiere continuar evaluando el caso. Para obtener más instrucciones consulte la página 3. ➡

**Referencias:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health*, 35(3), 225–230;

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open*, 1(6), e183535.

AVISO PARA EL PERSONAL DE LA CLÍNICA Y EXPEDIENTES MÉDICOS:

La información consignada en esta página se encuentra protegida por normas federales especiales en materia de confidencialidad (Título 42 del Código de Reglamentos Federales [CFR], Parte 2), que prohíben su divulgación salvo que se autorice mediante consentimiento específico por escrito.

CAGE-AID – Overview

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

Clinical Utility

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

Scoring

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

Psychometric Properties

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

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

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

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

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

Permission for use granted by Richard Brown, MD.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Overview

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

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

Importance of SBIRT

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

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

Core components

There are three main components to the SBIRT process:

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

Referral to treatment

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

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

References

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

American Academy of Pediatrics
www.aap.org

National Institute on Alcohol Abuse and Alcoholism
www.niaaa.nih.gov/publications/educationtrainingmaterials/pages/youthguide.aspx

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

Assessment, screening tools, and follow-up for SBIRT

Assessment

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

Screening tools

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

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

These tools can be found at <https://www.samhsa.gov/sbirt>.

(See other chapters for further screening assessments.)

Follow-up interventions

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

- All individuals who complete a screening tool for alcohol or drug use should be told the results of the screening.
- Individuals who do not appear to have any substance use disorder problems require no further intervention.

- Individuals with positive results will need some type of intervention, which will vary depending on the severity of the use and symptoms, such as:
 - Providing education on the hazards of alcohol and drug use or other mental health comorbidities
 - Providing resource information on substance use disorders or other mental health comorbidities
 - Encouraging participation in Alcoholics Anonymous and/or other mental health support groups
 - Discussing medication options if applicable
 - Scheduling a follow-up appointment
 - Initiating a referral to a behavioral health and/or substance use care provider for therapy
 - Referring to the health plan's Integrated Health Care Management program
 - For severe symptoms: initiating a referral to a behavioral health and/or substance use care provider who can further assess and provide a treatment plan
 - Calling **911** and referring to the closest emergency room if the individual is showing signs of withdrawal and/or is in a crisis

Confidentiality

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

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

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

Motivational interviewing

Evidence-based practice

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

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

Core components

The approach consists of four components:

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

Techniques

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

Ask permission

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

Use open-ended questions

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

Elicit change talk

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

Reflective listening

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

References

SAMHSA-HRSA Center for Integrated Health Solutions

<https://www.samhsa.gov/national-coe-integrated-health-solutions>

Motivational Interviewing Strategies and Techniques

<https://www.nova.edu/gsc/forms/mi-techniques-skills.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.

© Copyright 1982 by Harvey A. Skinner, PhD and the Centre for Addiction and Mental Health, Toronto, Canada. You may reproduce this instrument for non-commercial use (clinical, research, training purposes) as long as you credit the author Harvey A. Skinner, Department of Public Health Sciences, University of Toronto.

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 of 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 |

© Copyright 1982 by Harvey A. Skinner, PhD and the Centre for Addiction and Mental Health, Toronto, Canada. You may reproduce this instrument for non-commercial use (clinical, research, training purposes) as long as you credit the author Harvey A. Skinner, Department of Public Health Sciences, University of Toronto.

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 of drug use? | Yes | No |
| 7. Do you ever 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 |

© Copyright 1982 by Harvey A. Skinner, PhD and the Centre for Addiction and Mental Health, Toronto, Canada. You may reproduce this instrument for non-commercial use (clinical, research, training purposes) as long as you credit the author Harvey A. Skinner, Department of Public Health Sciences, University of Toronto.

NAME: _____

DATE: _____

DRUG USE QUESTIONNAIRE (DAST – 10)

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

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

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

These questions refer to the past 12 months.

Circle Your Response

- | | | |
|--|-----|----|
| 1. Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. Do you abuse more than one drug at a time? | Yes | No |
| 3. Are you always able to stop using drugs when you want to? | Yes | No |
| 4. Have you had “blackouts” or “flashbacks” as a result of 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 |

© Copyright 1982 by Harvey A. Skinner, PhD and the Centre for Addiction and Mental Health, Toronto, Canada. You may reproduce this instrument for non-commercial use (clinical, research, training purposes) as long as you credit the author Harvey A. Skinner, Department of Public Health Sciences, University of Toronto.

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 than heroin. With respect to psychopathology, the largest correlations were with the sociopathic scales of Impulse Expression and Social Deviation. High scorers on the DAST tended to engage in reckless actions and express attitudes that are markedly different from common social codes.

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

Advantages

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

Limitations

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

Administration and Scoring

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

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

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

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

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

Interpretation

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

DAST Interpretation Guide

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

ASAM: American Society of Addiction Medicine Placement Criteria

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

Availability

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

Key References

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

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

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

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

Articles Using the DAST

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

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

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

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

Suicide Prevention Practices

Overview

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

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

Suicide is a serious public health problem. Suicide rates increased approximately 36% from 2000 to 2021. Suicide was responsible for 48,183 deaths in 2021, which is about one death every 11 minutes. The number of people who think about or attempt suicide is even higher. In 2021, an estimated 12.3 million American adults seriously thought about suicide, 3.5 million planned a suicide attempt, and 1.7 million attempted suicide.

Suicide affects people of all ages. In 2021, suicide was among the top nine leading causes of death for people ages 10 to 64. Suicide was the second leading cause of death for people ages 10 to 14 and 20 to 34.

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%) who died by suicide did not have a known mental health condition.² 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:¹

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

¹ "Suicide and Suicidal Behavior," SAMSHA, April 24, 2023, <https://www.samhsa.gov/mental-health/suicidal-behavior>.

² "Risk of Suicide," National Alliance on Mental Illness, August 2022, www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Risk-of-Suicide.

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

Precipitating events that can trigger suicidal behavior

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

Protective factors

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

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

Screening and assessment tools

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends the following screening tools that can be integrated into primary care and other health care settings and foster earlier identification of suicide risk and other potential mental health disorders.¹

- Columbia-Suicide Severity Rating Scale (C-SSRS): https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf.
- Patient Health Questionnaire (PHQ-9): https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): <https://store.samhsa.gov/product/safe-t-pocket-card-suicide-assessment-five-step-evaluation-and-triage-clinicians/sma09-4432>.

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:²

- 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.²

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

Resources for suicide prevention

Zero Suicide initiative

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

- **Lead:** Promote a system-wide culture change committed to reducing suicides.
- **Train:** Provide training that creates a competent, confident, and caring workforce.
- **Identify:** Use validated screening tools to identify patients with suicide risk.
- **Engage:** Create a suicide care management plan for all individuals at risk of suicide.
- **Treat:** Use evidence-based treatments for individuals who show suicidal thoughts and behaviors.
- **Transition:** Provide warm hand-offs for individuals who need further evaluation and treatment follow-up.
- **Improve:** Continue to review policies and procedures through quality improvement processes.³

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

Member resources (free and confidential help)

- **988 Suicide & Crisis Lifeline:** Offers 24/7 call, text, and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, or mental health crises, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.⁴ **Call or text 988, or chat at 988lifeline.org.**
- **Veterans Crisis Line:** Call **1-800-273-8255** and **press 1**, or text **838255**. Serves all veterans and service members; available 24 hours a day, seven days a week. **<https://www.veteranscrisisline.net>.**
- **Crisis Text Line:** Text **741741**. Connect to a trained crisis counselor anywhere in the United States. Available 24 hours a day, seven days a week.
- **Teen Link: 1-866-TEENLINK (833-6546).** Available evenings from 6 p.m. to 10 p.m. PT; helpline for teens (ages 13 to 20) to call about issues such as relationships, problems at school, drugs and alcohol, self-harm, family problems, and suicidal thoughts; helpline is staffed by trained volunteers ranging in age from 15 to 20 years old. **<https://www.teenlink.org/text/>.**
- **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 LGBTQIA+ youth. **www.thetrevorproject.org.**
- **National Alliance on Mental Illness (NAMI): 1-800-950-6264**, Monday through Friday, 10 a.m. to 6 p.m. **www.nami.org.**

³ Zero Suicide, Educational Development Center, <https://zerosuicide.sprc.org>.

⁴ 988 Suicide & Crisis Lifeline, 988lifeline.org.

Provider resources

- American Foundation for Suicide Prevention: <https://afsp.org>.
- National Action Alliance for Suicide Prevention: <https://theactionalliance.org>.
- National Alliance on Mental Illness (NAMI): <https://www.nami.org/about-mental-illness/common-with-mental-illness/risk-of-suicide>.
- National Institutes of Health: www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml.
- **Recommended Standard Care for People with Suicide Risk:** <https://www.samhsa.gov/resource/ebp/recommended-standard-care-people-suicide-risk>.
- Substance Abuse and Mental Health Services Administration (SAMHSA): <https://www.samhsa.gov/suicide>.
- Suicide Prevention Resource Center: www.sprc.org.
- Suicide Prevention Resource Center: Risk and Protective Factors: www.sprc.org/risk-and-protective-factors.
- Trauma-Informed Approaches: <https://www.samhsa.gov/resource/ebp/practical-guide-implementing-trauma-informed-approach>.



Delaware
1-833-301-3377
www.amerihealthcaritasnext.com/de

Florida
1-833-983-3577
www.amerihealthcaritasnext.com/fl

North Carolina
1-855-266-0219
www.amerihealthcaritasnext.com/nc

South Carolina
1-833-986-7277
www.firstchoicenext.com