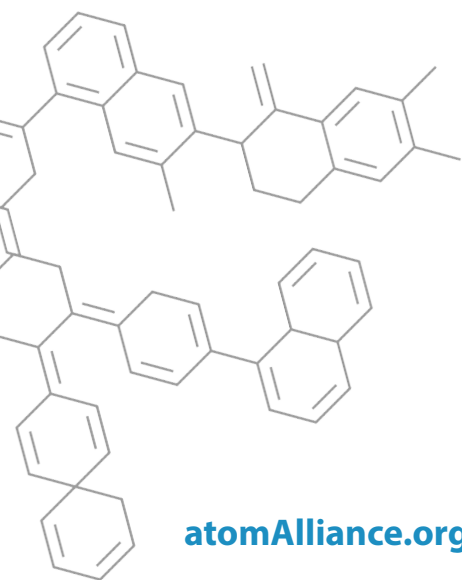




Enhancing Primary Care: Screening for Depression & Substance Misuse

Train the Trainer Manual



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Resource Material Legend



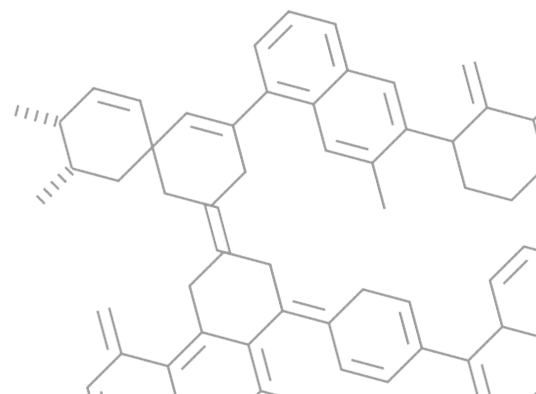
This icon represents materials that may be used by a patient. Please review these materials with your patient, provide instructions and encourage discussion.



This icon represents materials that may be used by a clinician to gauge a patient's condition, level of severity and allow for patient engagement.



Depression & Substance Misuse: General Information



Depression

Depression is a common health condition that affects patients' thoughts, feelings, behavior, and physical health. However, only about half of those affected by depression receive treatment, and most of those who are treated receive treatment in primary care. Moreover, many primary care patients have untreated depression, which contributes to poorer health outcomes and inflated healthcare costs.

Although depression can present in many forms, the most salient symptoms are often sadness, irritability, loss of interest, changes in sleep and appetite, fatigue, social withdrawal, concentration difficulties, and feelings of hopelessness or guilt. These symptoms often occur episodically and cause functional impairment. Patients with a history of depressive episodes are at increased risk for experiencing future episodes of depression.

Best-practice treatment of depression usually involves both medication and behavioral interventions. Treatment with antidepressant medication should be considered for patients with: current moderate to severe symptoms of depression, previous episodes of moderate to severe depression, chronic experience of mild depressive symptoms, and mild symptoms of depression that persist following other interventions (NICE Clinical Guidance 90). Several behavioral interventions for depression have demonstrated efficacy in primary care: Cognitive Behavioral Therapy, Problem-Solving Therapy, and Behavioral Activation. *Cognitive Behavioral Therapy* aims to identify and correct distorted cognitions that underlie depressive symptoms. *Problem-Solving Therapy* assists patients in resolving or coping with stressful experiences through the acquisition of adaptive coping skills. *Behavioral Activation* assists patients in developing a plan to re-engage in activities they once found enjoyable and meaningful, based on the rationale that symptoms often improve following re-engagement in pleasurable activities.

Provider Action:

The Resource Materials section of this manual includes a patient handout entitled **What is Depression?** that provides brief overview of depression as well as a description of its symptoms and common treatment recommendations. Additionally, this section contains a list of frequently asked questions regarding antidepressant medications and a behavioral activation patient handout. This latter handout, **Do What You Used to Enjoy to Help Depression**, describes the rationale for behavioral activation—that deactivation, or the absence of engagement in pleasurable and meaningful activities, maintains or exacerbates depressive symptoms. Additionally, the handout guides the provider and patient through the process of identifying enjoyable and valued activities, developing a goal to act opposite his/her emotions, and a plan to engage in the identified activity despite their enduring lack of interest.

Substance Misuse

Substance misuse includes a continuum of substance use in excess of recommended patterns, ranging from at-risk consumption to severe substance use disorders. The World Health Organization defines at-risk consumption as five or more alcoholic drinks in a day for a man, four or more drinks in a day for a woman, and any illicit or prescription drug misuse in the past year. Most patients identified by screening for substance misuse will not exhibit significant substance misuse. The majority of those identified by positive screenings will exhibit at-risk patterns of consumption that negatively impact health and may progress in some patients to dependence without early detection and intervention.

Best-practice treatment for substance misuse involves selecting intervention and referral options matched to the patient's severity of symptoms, functional impact, and motivation for sobriety and treatment engagement. Most patients will not be ready and motivated to follow a referral following initial screening and brief intervention. Referring to alcohol and drug treatment before the patient is ready is not only likely to fail, but may also make the patient less likely to return to primary care for treatment. Minimization and denial of the consequences of use are hallmarks of substance misuse. These characteristics are not flaws within the patient but rather a common symptom of the illness and target for early intervention in primary care. Some level of recognition of the problematic nature of use is a prerequisite to facilitating a successful referral. In the absence of this recognition, the most appropriate interventions include education, motivational interviewing, and monitoring in primary care.

Motivational interviewing (MI) is a style of interacting with patients that elicits intrinsic motivation for change from the patient. MI guides conversations with patients using Socratic questioning to elicit statements about the possibility and potential benefits of change. MI strives to avoid making the patient defensive using instead a collaborative style that avoids harsh criticism and rolls with resistance. The “spirit” of MI is embedded in the protocols and guidance described in this manual.

Provider Action:

Patients motivated to obtain and/or sustain sobriety will benefit from assistance identifying triggers for use and developing a relapse prevention plan. The Resource Materials section of this manual includes a **Coping with Triggers to Use and Relapse Prevention Plan** patient handout. The Coping with Triggers handout assists patients in identifying things they associate with substance use and developing a plan to avoid or cope with identified triggers. The Relapse Prevention Plan handout normalizes cravings to use and assists the patient in developing a plan to avoid relapse.

Fast Facts: Depression and Substance Misuse

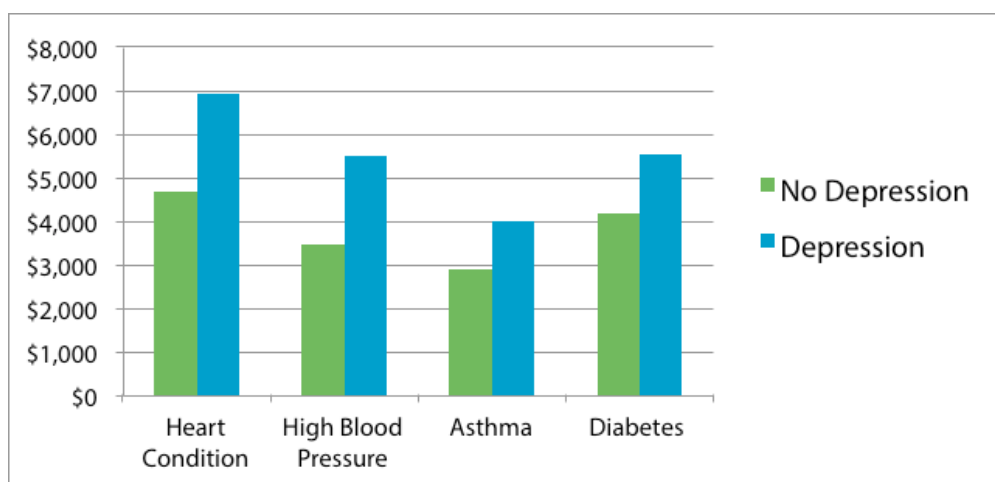
Depression and substance misuse are common behavioral health concerns that also impact physical health status, yet they are often under-identified in primary care settings.

Untreated depression and alcohol misuse negatively impact healthcare quality and cost. Additionally, challenges in effective care coordination for these and other behavioral health conditions contribute to high hospital readmission rates and poor treatment adherence.

Most people do not go to specialty providers for treatment of behavioral health needs. In fact, of the 41 percent of people who do receive care for behavioral health needs, 56 percent of these people get this care from primary care providers.

Depression

- In a 12-month period, the incidence of depression in the general population is 3.2 percent. The incidence increases to 9.3 percent - 23 percent among patients with comorbid chronic medical conditions.¹
- Patients with depression are three times as likely as patients without depression to be non-adherent with medical treatment, have more severe functional impairment, and poorer overall health outcomes.²
- Depression treatment in primary care for those with chronic health considerations resulted in **increased** total health care cost over 24 months.^{5,7}



Substance Misuse

- The incidence of high-risk patterns of drinking in a primary care population is 24 percent.³
- Three percent of primary care patients report regular use of illicit substances.³
- Substance use is associated with increased morbidity and mortality, increased healthcare costs, and increased ER utilization.^{3,4}
- Approximately **217 million days of work** are lost annually to related mental illness and substance misuse disorders (costing employers **\$17 billion/year**).⁶

¹Moussavi, S et al. *Lancet*. 2007; 370(9590) 851-858; ²DiMatteo MR, et al. *Arch Intern Med*. 2000;160(14):2101-2107; ³Cherpitel, CJ et al. *Drug and Alcohol Dependence*. 2008; 9: 226-230; ⁴Nutt, DJ et al. *Lancet* 2010; 376: 1558-1565; ⁵Katon et al., *Diabetes Care*. 2006;29:265-270; ⁶Hertz RP, et al. *Pfizer Outcomes Research*. Publication No P0002981. Pfizer; 2002; ⁷U.S. Dept of HHS the 2002 and 2003 MEPS



Screening



Reimbursement for Screening in Primary Care

Beginning January 2017, The Centers for Medicare and Medicaid Services (CMS) announced that the services listed below can be billed by the treating primary care provider. The intent is to incorporate the services of the collaborative care team into the service of the PCP.

G0502 – First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating primary care provider. Must include:

- Outreach and engagement of patients directed by a PCP
- Initial assessment, including administration of valid scales and resulting treatment plan
- Review by psychiatric consultant and modification as recommended
- Entering patients into a registry and tracking patient follow-up and progress, participation in weekly caseload review with psychiatric consult
- Provision of brief interventions using evidenced-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities

G0503 – First 60 minutes in subsequent month of behavioral health care manager activities. Must include:

- Tracking patient follow-up and progress
- Participation in weekly caseload review with psychiatric consult
- Ongoing collaboration and coordination with PCP and any other treating providers
- Ongoing review by psychiatric consultant and modification as recommended
- Provision of brief interventions using evidenced-based treatments
- Monitoring of patient outcomes using validated rating scales
- Relapse prevention planning and preparation for discharge from active treatment

G0504 – Each additional 30 minutes in a calendar month of behavioral care manager activities listed above.

- Listed separately but used in conjunction with G0502 and G0503

G0507 – Care management services for behavioral health conditions, at least 20 minutes of clinical staff time per calendar month. Must include:

- Initial assessment for follow-up monitoring, including use of applicable validated rating scales
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation
- Continuity of care with a designated member of the care team

HCPCS	Description	Payment Pt. Primary Care	Payment Pt. Inpatient
G0502	Initial psych care mgmt., 70 min. CoCM	\$142.84	\$90.08
G0503	Subsequent psych care mgmt., 60 min. CoCM	\$126.33	\$81.11
G0504	Initial/subsequent psych care mgmt., additional 30 min. CoCM	\$66.04	\$43.43
G0507	Care mgmt. services, minimum 20 min., Other care models	\$47.73	\$32.30

Screening Recommendations

Depression

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in adult patients with a grade of B for the prevention and early detection of symptoms when an infrastructure is in place to address screening results. The Centers for Medicare & Medicaid Services (CMS) encourages and covers an annual screening for depression.

US Preventive Service Task Force Summary of Recommendations

Population	Recommendation	Grade
Adults age 18 and over – when staff-assisted depression care supports are in place	The USPSTF recommends screening for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up	B The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
Adults age 18 and over – when staff-assisted depression care supports are not in place	The USPSTF recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient.	C The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.

Substance Misuse

The USPSTF recommends screening and brief counseling for alcohol misuse in adult patients with a grade of B. Alcohol screening followed by brief counseling intervention was the third highest priority among all preventive recommendations offered by the USPSTF. CMS encourages and covers annual screening of adult patients for substance misuse and, when screening is positive, brief counseling to reduce substance misuse.

US Preventive Service Task Force Summary of Recommendations

Population	Recommendation	Grade
Adults aged 18 and over – when staff-assisted depression care supports are in place	The USPSTF recommends that clinicians screen adults aged 18 years and older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse	B The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

continued on next page...

US Preventive Service Task Force Summary of Recommendations

Population	Recommendation	Grade
Adolescents (under 18 years of age)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.	I Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Selecting Pre-Screening Tools

Screening begins with a brief pre-screen to determine if more comprehensive assessment is indicated. A positive pre-screen neither establishes a diagnosis nor necessarily indicates symptom severity, but it does suggest distress that should be further evaluated.

There are several evidence-based pre-screening tools that can be used to assess depression and substance misuse. Thus, it is possible to tailor the screening process to best meet the needs of the clinic and patient population. Below is a selection of the most commonly utilized evidenced-based pre-screening tools.

Depression Prescreen

PHQ-2 (Patient Health Questionnaire-2)

The PHQ-2 assesses frequency of depressed mood and anhedonia within the past two weeks and includes the first 2 items of the more comprehensive PHQ-9. PHQ-2 scores range from 0-6. A score of 3 or higher is generally considered positive and suggests that further screening is indicated.

Languages – Wide variety, including English, Spanish, Arabic, Chinese (Cantonese, Mandarin), French, German, Greek, Hindi, Hebrew, Italian, Japanese, Russian, Swahili.

Literacy level – 8th grade reading level

Time to administer – 1 minute

Sensitivity – High

Specificity – Moderate to High

Reliability – High

Substance Misuse Prescreening Tools

Alcohol Use Disorder Identification Test (AUDIT-C)

The AUDIT-C is a three question screener used to identify patients with alcohol misuse and uses the first three items that assess alcohol consumption from the full AUDIT. It is scored on a scale of 0-12. Scores are interpreted differently for men and women. For men, a score of four or more is considered positive, whereas a score of three or more is considered positive for women.

Languages – English

Literacy level – 8th grade reading level

Time to administer – 1 minute

Sensitivity – Moderate to High

Specificity – High

Reliability – High

National Institute on Drug Abuse (NIDA) Quick Screen

The NIDA Quick Screen assesses frequency of alcohol, tobacco, prescription and illegal drug use in the past year. If the patient answers “never” for all drugs, the screening is considered negative. Any answer other than “never” indicates a positive screen and the need for additional assessment.

Languages – English

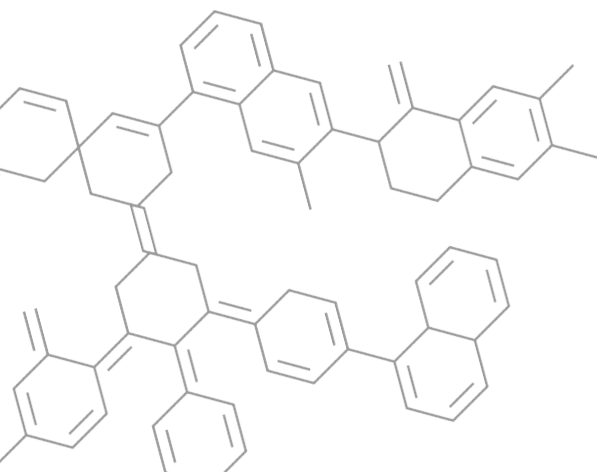
Literacy level – 8th grade or below

Time to administer – 5 minute

Sensitivity – High

Specificity – High

Reliability – High



Selecting Screening Tools

The majority of patients will generate negative pre-screens, indicating that no additional assessment is warranted. However, patients with a positive pre-screen need additional assessment to help guide intervention and treatment planning. There are numerous evidence-based screening tools. Included below is a non-exhaustive list of screeners commonly used in primary care. It is important to remember that a positive screen does not necessarily indicate diagnosis, but that further assessment is warranted.

Depression Screening Tools

Geriatric Depression Scale (Short Form) (GDS)

The Geriatric Depression Scale (Short Form) is a 15-question assessment of depression in patients who are elderly. The scale assesses the presence of depression-related distress in the previous week. A score greater than five is considered positive.

Languages – Available in 30 languages including English, Spanish, Chinese, Arabic, Dutch, Farsi, French, German, Greek, Hebrew, Hindi, Japanese, Italian, Korean, etc.
Literacy level – 4th grade reading level

Time to administer – 5-7 minutes
Sensitivity – High
Specificity – High
Reliability – High

Hamilton Depression Rating Scale (HAM-D)

The HAM-D is a 21-item assessment of depressive symptoms. A score greater than seven is positive. HAM-D scoring also categorizes symptom severity with 10-13 indicating mild symptoms, 14-17 mild to moderate, and greater than 17 moderate to severe.

Languages – English, Spanish, Dutch, French, Chinese, Turkish, German, Thai
Literacy level – 8th grade reading level

Time to administer – 20-30 minutes
Sensitivity – Moderate to High
Specificity – High
Reliability – High

Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is emerging as the standard measure of adult depression in primary care. It assesses the frequency of depressive symptoms in the prior two weeks. The first two questions of the PHQ-9 are the two questions which compose the PHQ-2. Four responses in the shaded section (see appendix) indicate a positive screen. Scores 5-14 indicate mild symptoms, 15-19 moderate, and 20 and above severe.

Languages – Wide variety including English, Spanish, Arabic, Mandarin, French, German, Greek, Hindi, Hebrew, Italian, Japanese, Russian, Swahili.
Literacy level – 8th grade reading level

Time to administer – <5 minutes
Sensitivity – High
Specificity – High
Reliability – High



Tips from CHS: We use the PHQ-2 and the PHQ-9 to screen for depressive symptoms because of its psychometric properties, ease of administration, and short administration time. Our medical assistants and/or nurses administer these as a component of patients' behavioral health vitals

Substance Misuse Screening Tools

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

The ASSIST assesses lifetime history of alcohol, tobacco, and drug use; cravings for use, and consequences related to use in the subsequent three-month period. Scores of 11 and higher indicate the need for a brief intervention for alcohol, with all other substances having a lower threshold of 4 indicating intervention.

*Languages – English, Spanish, Portuguese,
Hindi, Thai, Shona.
Literacy level – 8th grade reading level
Time to administer – Average of 10 minutes;
of substances used increases admin time.*

*Sensitivity – High
Specificity – High – better at discriminating
between use and abuse than between abuse and
dependence.
Reliability – High*

Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT is a 10 item tool for assessing alcohol consumption and related behaviors. A score of 8 or more indicates at-risk consumption, and a score of 13 or more in women and 15 or more in men indicate severe alcohol misuse.

*Languages – English, Spanish, French
Literacy level – Interview version can be used
if low literacy
Time to administer – 5 minutes*

*Sensitivity – High
Specificity – High
Reliability – High*

CAGE-AID

The CAGE-AID is an expanded version of the CAGE screener that assesses both alcohol and drug misuse. CAGE is an acronym for key words in the four questions (Cut Down, Annoyed, Guilty, Eye-Opener) and AID indicates it is Adapted to Include Drugs. Each “yes” response earns one point. One point indicates a possible problem, whereas two points indicates probable substance misuse.

*Languages – English, Spanish, Chinese,
Creole, Japanese
Literacy level – Grade 4.9
Time to administer – 1-2 minutes*

*Sensitivity – High
Specificity – High
Reliability – High*

Drug Abuse Screening Test (DAST-10)

The DAST is a 10-item questionnaire that assesses drug use in the past 12 months. It does not assess alcohol use. Patients receive 1 point for each “yes” response (except question #3 where a “no” response earns a point). Scores of 3 and above indicate that further assessment and intervention may be warranted.

Languages – English, Spanish, Portuguese,

Hebrew, Arabic, Thai

*Literacy level – Can be administered by
interviewer if low literacy*

Time to administer – 5 minutes

Sensitivity – Moderate to High

Specificity – Moderate to High

Reliability – High

Michigan Alcoholism Screening Test (MAST)

The MAST is a 25-item assessment of alcohol misuse. A score of six or more indicates at-risk or problematic alcohol consumption and that additional assessment and treatment is warranted.

Languages – English, Spanish

Literacy level –

Time to administer – 8 minutes

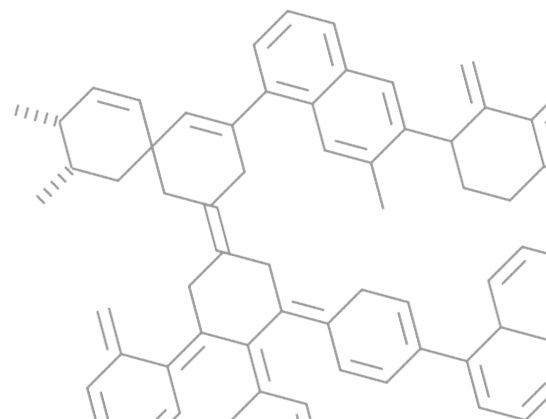
Sensitivity – High

Specificity – High

Reliability –



Tips from CHS: We embed the NIDA Quick Screen questions and treat them as red flag questions; if either of these two questions is positive, we then administer the CAGE-AID. If both are negative, we end the screening process. Use of red flag questions helps us to guide clinical decision-making in the moment.



Screening Implementation: Embedding Screening into Existing Primary Care Workflow

It is essential that screening for depression and substance use be embedded into the existing clinic workflow. Primary care workflow is complex and fast-paced. Buiding screening into existing workflow improves acceptance and sustainability of the screening process, as it becomes a routine aspect of care. Many clinics find that it is helpful to view depression and substance misuse as “behavioral health vitals.” Behavioral health vitals are often measured concurrently with medical vitals by a nurse or medical assistant who is triaging and rooming the patient. Therefore, the results of screening will be known by the provider in advance of the visit.

When developing your clinic workflow, which includes routine screening of depression and substance use, it can be helpful to consider the following:

Q: Who will you screen and with what frequency?

A: Most clinics that embed routine depression and substance use screenings into their clinic workflow recommend routinely screening all new patients and re-screening established patients annually.

Q: What screeners will you use?

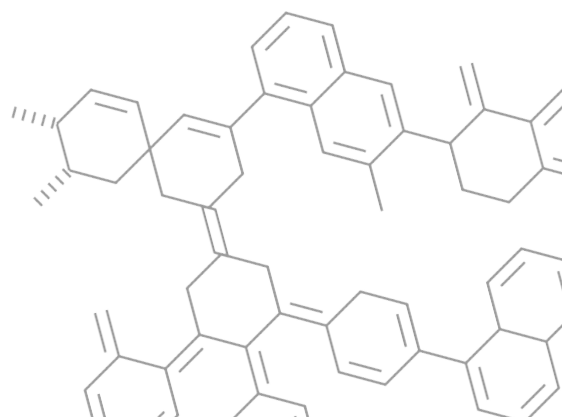
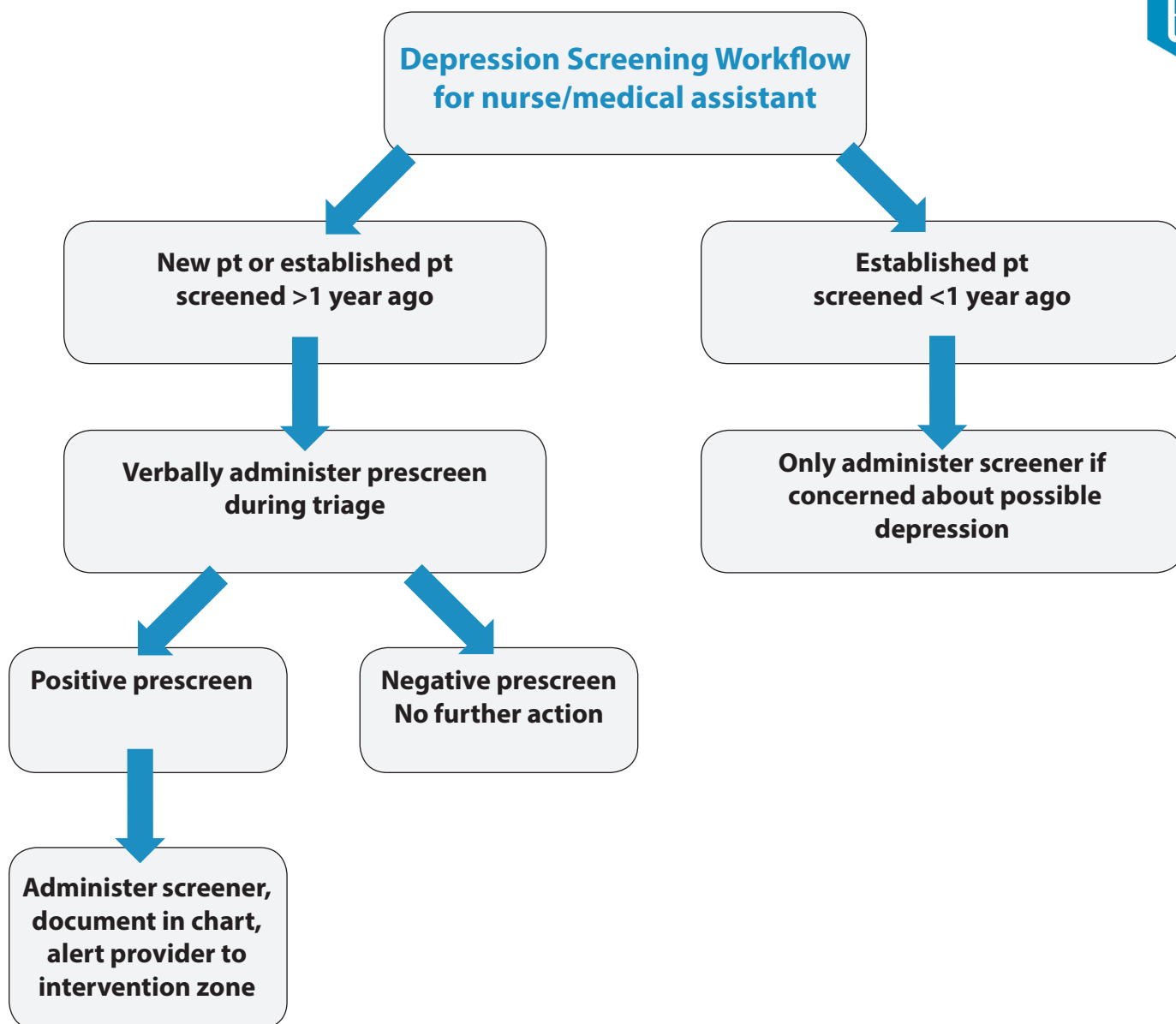
A: Consistent with the information presented above, most clinics choose to utlize psychometrically-sound, easy-to-admininster, and quick screeners that are easily understandable by patients with a wide range of literacy levels.

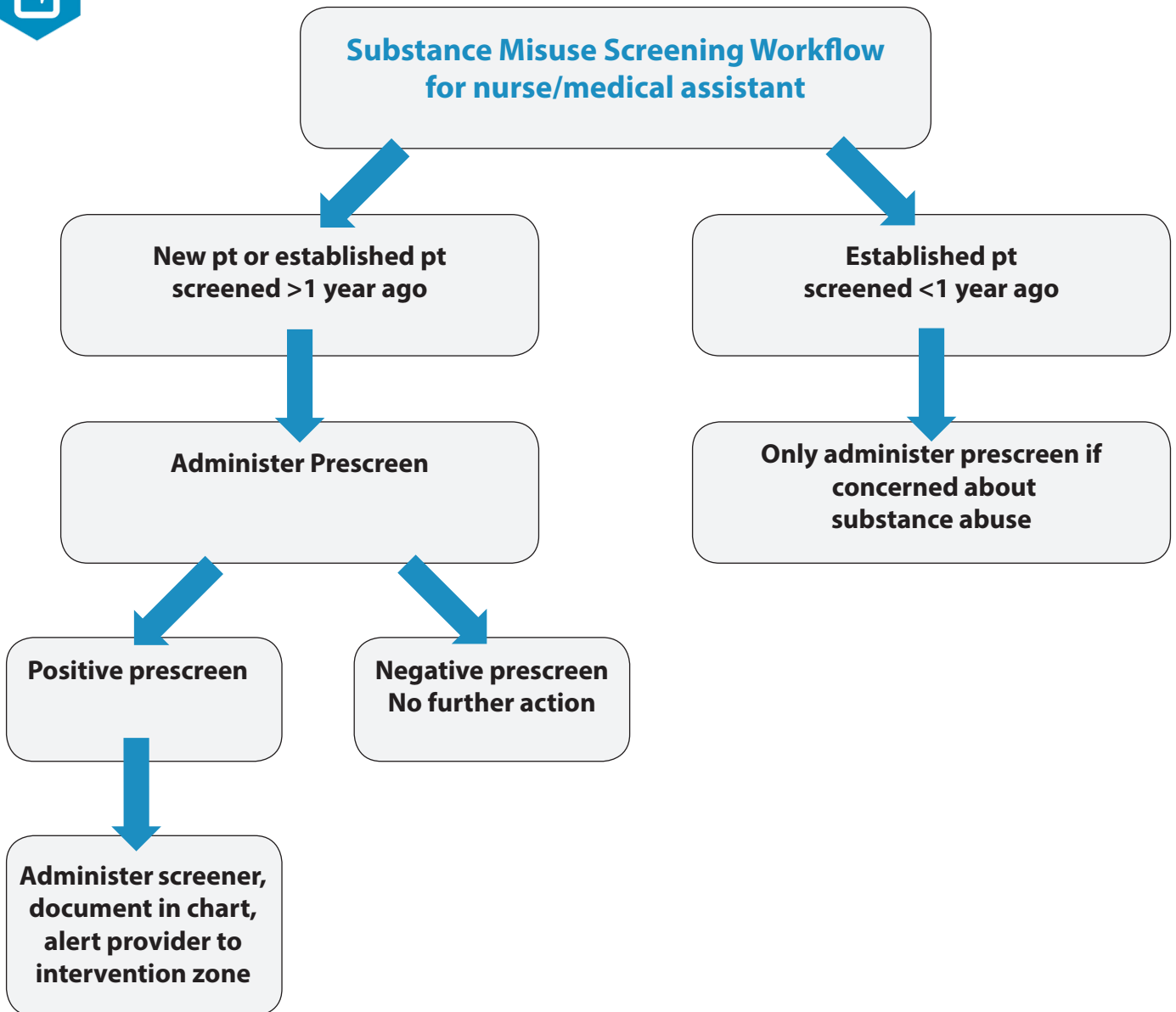
Q: Who will administer the screeners?

A: If screeners are embedded into the clinic workflow, it may be helpful to consider having nurses or medical assistants incorporate them into their vitals and triage flow so that it becomes a regular component of patients’ primary care visits.



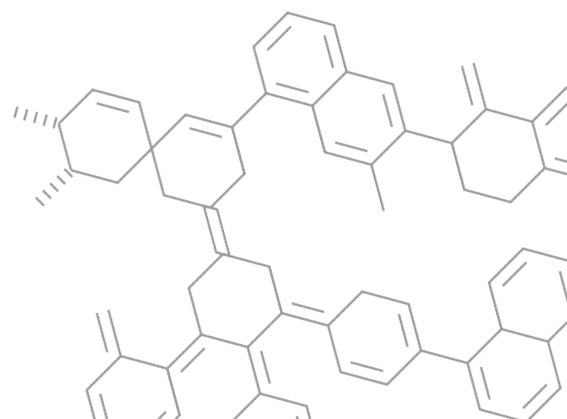
Tips from CHS: Our medical assistants and/or nurses administer our behavioral health vitals in conjunction with physical health vitals. As a result, our patients have grown accustomed to having their behavioral health needs addressed as a routine component of their care. This reduces stigma and helps with early identification and prevention efforts.







Triage





Screening Administration & Triage Guidance

Step 1: Introduce and Administer Prescreens

Say: “May I ask you a few questions to help us care for you better? We routinely ask these questions to all patients seen in our clinic.”

Screen: Administer depression & substance misuse prescreen

Triage: Was either prescreen positive?

Yes ➡ Continue to Step 2

No ➡ Screening complete. ●
Inform provider of negative prescreening results

Step 2: Introduce and Administer Screeners

Say: “Thank you for your honesty. May I ask you a few more questions to help us help you?”

Screen: Administer screener for each positive prescreen.

Triage: Was either screener positive?

Yes ➡ Depression Screen Positive:

Ask: “Are you currently having thoughts about ending your own life or suicide?”

Yes ➡ Screening complete. ●
Inform provider of intervention **Zone Red** result.

No ➡ Go to Step 3.

Substance Misuse Screen Positive:

Ask: “Are you currently trying to stop using alcohol or nerve pills?”

Yes ➡ Screening complete. ●
Inform provider of intervention **Zone Red** result

No ➡ Go to Step 3.

No ➡ Reinforce healthy behavior.
Inform provider of negative screening results. ●

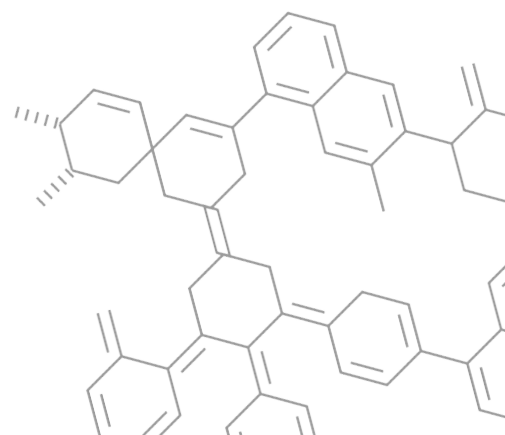
Step 3: Triage & Care Coordination

1. Determine the intervention zone corresponding with patient’s screening results: **Green (at-risk)** or **Yellow (positive)**.

➡ Inform provider of zone. ●



Intervention



Clinical Decision Making Considerations

Once a patient has completed screeners and scores have been triaged into intervention zones, the primary care provider can plan clinically indicated intervention and follow up care using the following clinical decision making tool. These “TERMS” can be applied to most/all clinical scenarios to provide guidance for triage and intervention based on screening outcomes, patient need, and patient engagement.

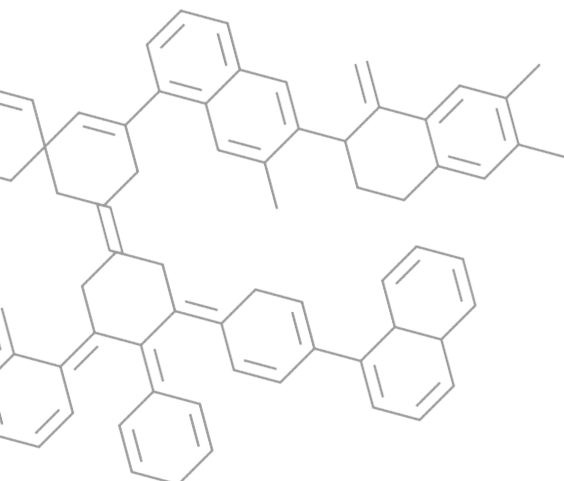
Task demand (clinic flow, available clinic resources, type of visit, etc.)

Engaging the patient

Referral Resources

Moving patient towards motivation for change

Severity of symptoms





Provider Guide to Brief Intervention Following Positive Screening: Zones Green and Yellow

Step 1: Offer Feedback

Provide Feedback: Ask the patient's permission to talk about his or her screening results. If possible, connect the results to patient's current health problem(s) or risk posed to future health status.

Ask: "Have you ever thought about getting treatment for depression/substance use?"

Yes ➡ Continue to Step 2

No ➡ Proceed to Step 3

Step 2: Assess Motivation

Ask: "On a scale of 1-10, with 10 being the most, how interested are you in working with me to improve your depression/substance misuse today?"

Score of:

7-10 ➡ Proceed to Brief Interventions for Depression and/or Brief Interventions for Substance Misuse Guidance.

1-6 ➡ Continue to Step 3.

Step 3: Enhance Motivation

Ask: "If, hypothetically, you decided to partner with me to improve your depression/substance misuse, what might be the potential benefits?"

Yes ➡ Proceed to Brief Interventions for Depression and/or Brief Interventions for Substance Misuse Guidance.

Listen for statements about motivation to change.

Ask: "Would you like to talk about some treatment options today?"

No ➡ Express willingness to help in the future, offer a handout, and reassess patient's symptoms and motivation at next appointment.



Brief Interventions for Substance Misuse

Zone Green Intervention: Ask-Risk Use

- **Educate** patient about low-risk consumption limits and the health benefits associated with reducing intake.
- **Engage in collaborative goal setting** to reduce use. Problem-solve barriers to reduction.
- **Monitor** in primary care.

Suggested patient handouts:

Did You Know? Fast Facts about Substance Misuse

Triggers

Zone Yellow Intervention: Positive Screen

- **Educate** patient about substance misuse and the benefits of reducing substance intake.
- **Engage in collaborative goal setting** to reduce/cease use.
 - **Consider problem-solving barriers** to cessation using *Triggers* handout.
 - **Consider developing relapse prevention plan** using *Relapse Prevention Plan* handout.
- **Offer referral** to alcohol and drug treatment.
- **Monitor closely** in primary care.

Suggested patient handouts:

Did You Know? Fast Facts about Substance Misuse

Triggers

Relapse Prevention Plan

Zone Red Intervention: Crisis Due to Acute Withdrawal Risk (see pg 24)

- **Educate** patient about the potentially life-threatening risk of withdrawal associated with abrupt discontinuation of alcohol, benzodiazepines, and barbituates.
- **Offer referral** to detox. If withdrawal symptoms are present and detox is not immediately accessible, consider referral to the ER.
- **Recommend** engagement in alcohol and drug treatment following detox. Educate patient that detox is not treatment, but a way to stop using that is medically safe.
- **Monitor closely** in primary care.



Brief Interventions for Depression

Zone Green Intervention: Ask-Risk For Depression

- **Educate** patient about the benefits of healthy lifestyle choices, including exercise.
- **Monitor** in primary care.

Suggested patient handouts:

Did You Know? Fast Facts about Depression

Zone Yellow Intervention: Positive Screen

- **Educate** patient about best-practice treatment for depression (i.e., medication and behavior change).
- **Engage in collaborative** treatment planning.
 - **Consider** antidepressant medication.
 - **Consider** encouraging behavioral activation using *Managing Depression by Engaging in Activities You Enjoy* handout.
- **Offer referral** for behavioral health treatment if symptoms and functional impairment are severe or treatment refractory.
- **Monitor closely** in primary care.

Suggested patient handouts:

Did You Know? Fast Facts about Depression

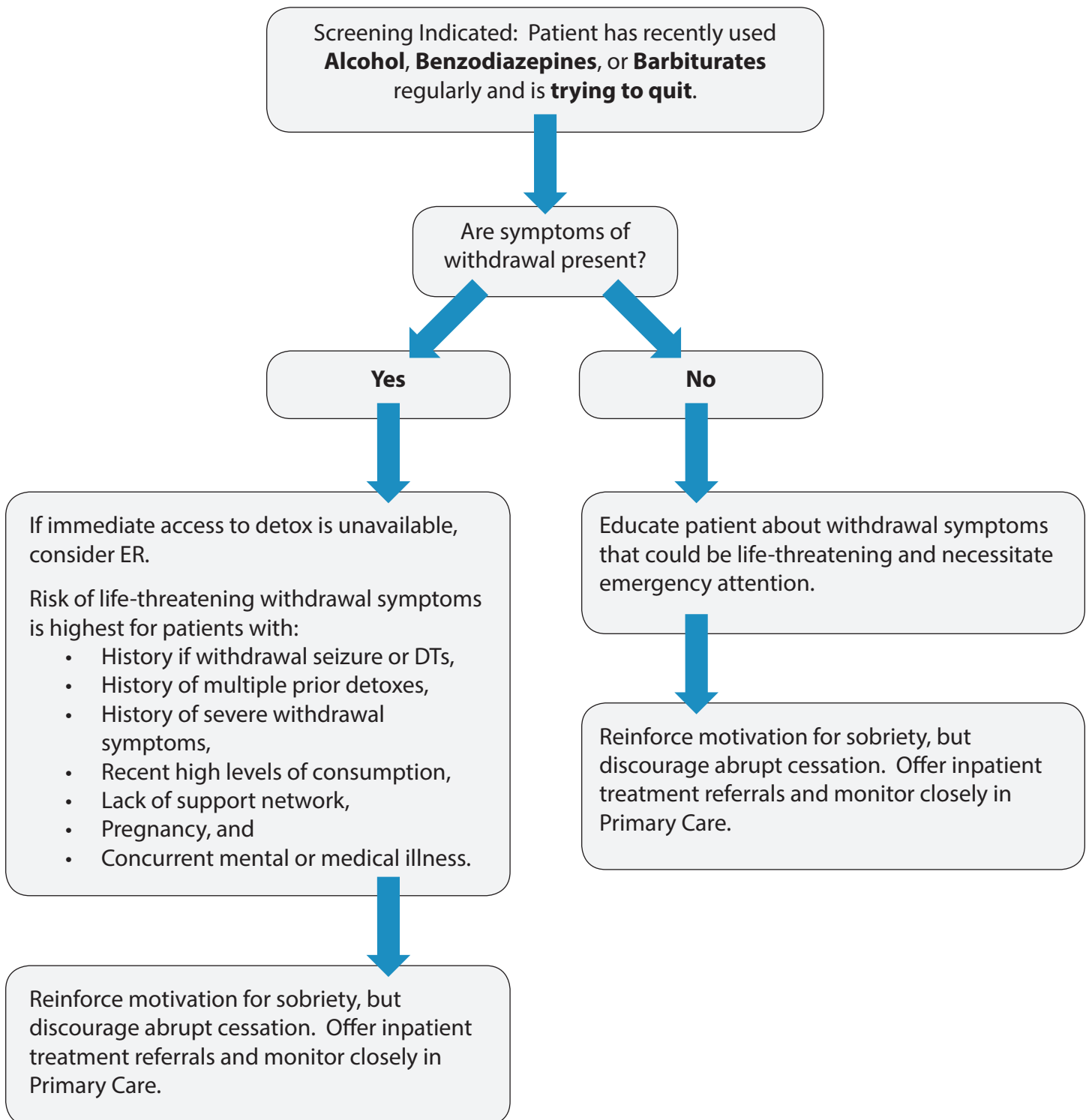
Managing Depression by Engaging in Activities You Enjoy

Zone Red Intervention: Crisis Due to Acute Suicidal Ideation (see pg 25 & 26)

- **Remain calm.** Reinforce patient's honesty and indicate willingness to help.
- **Offer referral** for continued risk assessment and behavioral health treatment. See *Crisis Management in Primary Care* for assistance determining level of risk and appropriate level of crisis response (i.e., outpatient clinic, Mobile Crisis, or ER, etc.).
- **Engage another supportive adult**, with patient's permission, in the implementation of a safety and monitoring plan. Educate him/her about the need to monitor patient closely, engage in means restriction, and call crisis numbers/proceed to ER if symptoms intensify.
- **Monitor closely** in primary care.



Provider Guide to Brief Intervention for Substance Misuse: Zone Red.





PCP Suicide Risk Assessment & Intervention Plan

(Screening):

1. “Do things ever get so bad you think about ending your own life or suicide?”
- Yes** ➡ Go to Question 2.
- No** ➡ Discontinue suicide risk assessment.
-

(Previous Suicide Attempt(s)):

2. “Have you ever tried to kill yourself before?”
- Yes** ➡ Ask, “When did this happen” and “How did you try to kill yourself?” Go to Question 3.
- No** ➡ Go to Question 3.
-

(Current Suicidal Episode):

3. “Are you currently having thoughts about ending your own life or suicide?”
- Yes** ➡ Go to Question 4.
- No** ➡ “When is the last time you had those thoughts?” and “Tell me more specifically about what you were thinking at that time.” Go to Questions 6 and 7, and refer to decision tree.
-
4. “Have you thought about how you might kill yourself?”
- Yes** ➡ Go to Question 5.
- No** ➡ Go to Question 6.
-
5. “Do you have access to [method]?”
- Yes** ➡ Go to Question 6.
- No** ➡ Go to Question 6.
-

(Protective Factors):

6. “What is keeping you alive right now?”
- Listen for reasons to live such as religious beliefs and social supports.
- Then, go to Question 7.
-

(Substance Use):

7. “Are you currently using any substances such as alcohol, marijuana, cocaine, or pain or nerve pills?”
- Yes** ➡ Ask, “How much and how often do you use [substance(s)]?” Then, refer to decision tree.
- No** ➡ Refer to decision tree.



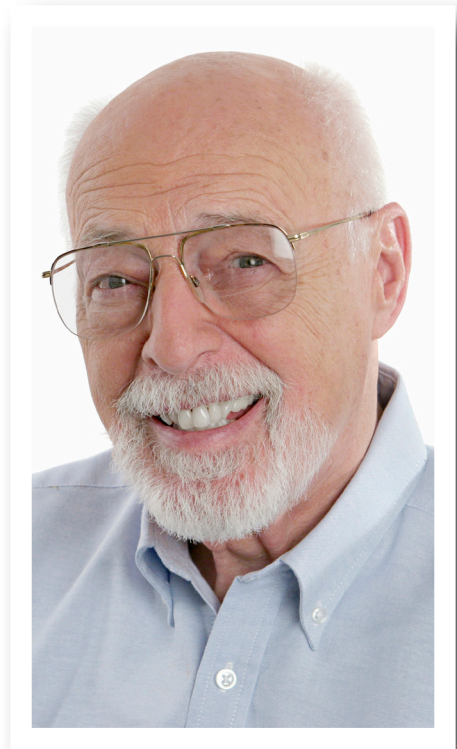
Decision Tree

Risk	Summary of Symptoms	Action
Low	<ul style="list-style-type: none">• May feel depressed and have periodic thoughts of death, but no active suicidal ideation• No current plan or intent to harm self• No previous suicide attempts• Feels cared for by family/ friends• Wants things to change, some hope for the future• No or minimal substance use	<ul style="list-style-type: none">• Reinforce healthy coping mechanisms and utilizing social support• Provide crisis numbers for the patient to use if active suicidal ideation were to develop
Moderate	<ul style="list-style-type: none">• Regularly occurring thoughts of death or wanting to die that are difficult to get rid of• May be ambivalent about suicide plan and dying, not sure when but soon• May have access to means to carry out plan (e.g., has a friend who owns a gun)• Limited social support• Negative about future plans, may feel hopeless• May have had a previous suicide attempt• May be using substances to cope	<ul style="list-style-type: none">• Develop safety plan with patient (i.e. restricting means, including family/friend for monitoring, crisis numbers) if suicidal ideation worsens or they have concerns about ability to keep themselves safe• Consider medication therapy for depression if clinically appropriate and close follow-up• If you are concerned about patient's safety or have doubts they will access crisis resources if suicidal ideation worsens, help them access care for voluntary admission via local resources or facilitate crisis assessment for involuntary admission
High	<ul style="list-style-type: none">• Thoughts of death or wanting to die are intense and feel impossible to get rid of• Has plan for suicide with date and time in mind, access to lethal means to carry out plan, clear threats• Does not give reasons for living, wants to die• Limited or no social support, feels rejected and hopeless• Previous suicide attempts or severe self-mutilation• Current substance use	<ul style="list-style-type: none">• Make sure the patient is in a safe location. If the patient is a flight risk notify designated staff member to keep an eye on the patient• See if patient would be willing to consider a voluntary hospitalization and help them access care via local resources• If unwilling to consider involuntary hospitalization facilitate crisis assessment for involuntary admission via local resources

* **Yes** responses to suicide risk assessment questions indicate patient is at an increased risk.

Patient Example #1

Patient:	Clyde Myers
Reason for Visit:	Chronic disease management: Diabetes & Hypertension
History:	66-years-old Last seen in the clinic 6 months ago
Medical Vitals:	Height: 5'11" Weight : 244 lbs. BP: 158/96 Pulse: 82 and regular
Behavioral Vitals:	PHQ-2—Positive PHQ-9—Score of 11 NIDA Quick Screen—Negative



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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input checked="" type="checkbox"/>	Extremely difficult <input type="checkbox"/>
--	--	---	---

Mr. Myers denies current suicidal ideation. Intervention zone = yellow

Patient Example #2

Patient:	Jane Doe
Reason for Visit:	ER follow up and discussion of recent aggressive behavior
History:	71-years-old Last seen in the clinic 3 months ago
Medical Vitals:	Height: 5'10" Weight: 168 lbs. BP: 132/80 Pulse: 82 and regular
Behavioral Vitals:	PHQ-2—Positive PHQ-9—Score of 4 NIDA Quick Screen—Negative



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 <input type="checkbox"/>	Somewhat difficult <input checked="" type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
--	---	--	---

Significant symptoms were denied and patient denied ongoing impact of recent aggressive behavior. Intervention zone = green and will continue to monitor symptoms

Patient Example #3

Patient:	Johnny Woods
Reason for Visit:	Same day sick appointment: Flu-like symptoms including nausea, vomiting, and fever
History:	51-years-old Last seen in the clinic 1 year ago; receives social security disability for injury obtained in a car crash 18 months ago
Medical Vitals:	Height: 5'11" Weight: 183.80 lbs. BP: 127/70 Pulse: 73 and regular
Behavioral Vitals:	PHQ-2—Negative NIDA Quick Screen—Positive AUDIT—Positive (score of 35 of 40)



AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
Total					35

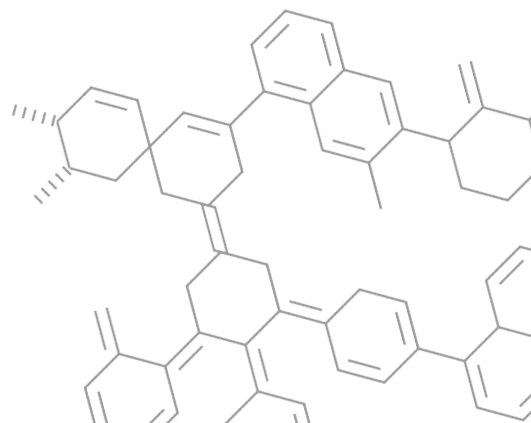
Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org.

Excerpted from NIH Publication No. 07-3769 National Institute on Alcohol and Alcoholism www.niaaa.nih.gov/guide

Mr. Woods endorsed symptoms of ETOH dependence including current symptoms of withdrawal. Intervention zone = red



Resources



Overcoming Common Challenges When Implementing Screening for Depression and Substance Misuse in Primary Care

Challenges	Potential Solutions
There isn't enough time for screening.	Make screening a routine component of existing primary care workflow by implementing behavioral health vitals.
The visit is complicated enough without identifying additional problems requiring treatment.	The problem is present even if it is not identified through screening. Identification and treatment of substance misuse and depression will likely improve management of comorbid conditions.
Worry about offending the patient.	Introduce screening as means of offering comprehensive healthcare and describe depression and substance misuse as treatable health conditions.
Limited confidence and competence to treat the problems identified by screenings.	Primary care offers first-line interventions (i.e., education, advice, medication, etc.). As with other health conditions, a specialty referral may be needed to provide a more intensive level of care.
Not sure how to refer.	Identify a referral issue the patient is concerned about. Ask the patient to meet with the referral source so that he/she "can help me, help you" address the patient's primary area of concern.
Inadequate referral options.	The atom Alliance will assist you in developing a network of referral sources to treat the depression and substance misuse needs identified in your patient panel.
Concern that the patient won't follow through with the referral.	Patients may need assistance recognizing a problem and building motivation to engage in treatment. Education and motivational interviewing, provided in primary care, can assist patients in following through with referrals.

Stage-Matched Brief Interventions

Readiness to Change Stages	Brief Interventions
"I resent your assertion that I have a problem."	Stop, don't push. Convey readiness to help in the future. <i>"I respect that you don't want to talk about __ today. I'd like to partner with you to improve all aspects of your health. Maybe we could talk about __ at another time."</i>
"I don't have a problem."	Don't push. Ask permission and build awareness by providing personalized information. <i>"Would it be okay if I told you why I am concerned about your __?"</i> <i>"I worry that your __ is..."</i>
"I know I have a problem, but I have no interest in changing at this time."	Don't push too hard. Encourage the patient to talk about his/her perception of the problem and discuss the potential benefits of changing. <i>"Would you tell me why you think your __ is a problem?"</i> <i>"If you decided you wanted to, can you think of potential benefits of changing?"</i>
"I'd like to change soon, but need some help determining how to begin."	Reinforce desire to change. <i>"Excellent, we'd like to partner with you to make changes in your __."</i> Problem-solve barriers and identify small action steps. <i>"Are there things that are getting in the way of you starting to make changes?"</i> <i>"Patients often find that __, __, or __ are helpful first steps. Would you like to try one of these options?"</i>
"I'm starting to make changes, but need help to continue to make progress."	Reinforce any progress thus far. Problem-solve barriers and refine action plan. <i>"Are there things that are getting in the way of you making more progress?"</i> <i>"What have you already tried (or considered trying)?"</i> <i>"What has been most helpful so far?"</i>
"I've made changes and am stable, but need help to stay that way."	Reinforce maintenance of progress. Identify successful strategies and problem-solve ways to continue to employ these. <i>"Can you identify strategies that have helped you manage your __ successfully?"</i> <i>"Can you identify any barriers to continuing these strategies to manage your __?"</i>



What is Depression?

Here are a few things to know about depression and ways that we can help you manage your symptoms and do the things in life that you enjoy again.

Depression is very common.

Depression is not just feeling down or sad. Some people say they also:

- Feel restless or really slowed down
- Have trouble enjoying things that used to be fun
- Have trouble getting stuff done
- Have trouble sleeping
- Feel tired all the time
- Have a poor appetite OR eat more than they usually do
- Lose weight OR gain weight
- Feel guilty
- Feel pain in their bodies
- Feel worthless, hopeless, or helpless
- Feel like they would be better off dead



Depression is treatable just like many other medical illnesses.

Treatment Options for Depression

Your doctor may recommend one or more of the following things to help you feel better and start doing the things that matter to you again:

1. **Medicine.** The most common medicine is called an antidepressant. Your doctor can talk to you more about that and if this type of medicine is best for you.
2. **Behavior change.** Your doctor may help you find a list of things that are fun to do and help you start planning ways to make time for those things again.
3. **Counseling/therapy.** Your doctor may be able to give you a list of therapists in your community who can help treat your symptoms and improve your functioning.
4. **Regular check-ins.** Even if you do not start medicine or therapy, your doctor will want to check in with you often to be sure your symptoms do not get worse and to help you if they do.



Antidepressant FAQ

If you are talking with your primary care provider about starting an anti-depressant, it is important to understand what to expect from the medications. It is also very important that you speak with your provider and the nursing staff before stopping medications, changing the dose, or if you have concerns about medications.

What are antidepressants?

Antidepressants are medications designed to help the symptoms of clinical depression and other conditions like anxiety and sleep difficulty.

How do antidepressants work?

Antidepressants work by adjusting certain chemicals (neurotransmitters) in the brain.

Are antidepressants addictive?

No, antidepressants are not addictive.

How might antidepressants help me?

Scientific research has shown that people who take antidepressants and make changes in their daily habits experience more relief from their depression and/or anxiety sooner than people who do not.

Who can prescribe me antidepressants?

Your primary care provider, psychiatric provider, or other specialists may prescribe antidepressant medication for you.

Why has my primary care provider tried me on one antidepressant when I heard from a friend that they started taking another?

Different antidepressants will affect different people in different ways. Your provider may have to try several medications before they find one that works well for you.

When can I expect my antidepressants to work?

It may take 10-21 days before you notice any reduction in symptoms; this will depend on the specific medication prescribed and your response to the medication. It may take up to three months for symptoms to significantly decrease.

What kind of symptoms may be improved if I start taking antidepressants?

Sleep	Sex Drive	Feeling physically slowed down
Appetite	Restlessness	Feeling worse in the morning
Fatigue	Agitation	Poor Concentration

Can I drink alcohol while taking antidepressants?

Do not drink alcohol if you are taking antidepressant medication. Alcohol can block the effects of the medication. If you desire to drink occasionally or socially (never more than one drink per day), discuss this with your provider.

Antidepressant FAQ (cont...)

What kind of symptoms may not be improved if I start taking antidepressants?

Some symptoms like depressed mood and low self-esteem may respond only partially to medication. The medication you'll be taking is not a "happy pill;" it is unlikely to totally erase feelings of sadness or emptiness.

How long will it take before I begin to feel better?

Typically, it may take up to three months for the major depressive symptoms to significantly decrease. In general, medication treatment goes at least six months beyond the point of symptom improvement. Occasionally, a person may need to be on long-term medication management.

Will I experience any side effects?

There is the possibility of side effects and some people may experience one or two of the following. However, these side effects usually go away in 7-10 days and can often be managed by changing the dose or by changing medication. *Please call your provider if you have concerns about side effects.*

Dry Mouth - Drink plenty of water, chew sugarless gum, eat sugarless candy.

Constipation - Eat more fiber rich foods, take a stool softener.

Drowsiness - Take frequent walks, take medication earlier in the evening, or, if taking medication during the day, ask your primary care provider if you can take it at night.

Wakefulness - Take medications early in the day.

Blurred Vision - Remind yourself that this is a temporary difficulty; talk with provider if it continues.

Headache - Usually temporary and can often be managed by aspirin or acetaminophen, if needed and as directed by your primary care provider.

Feeling Antsy - Tell yourself this will go away in 3-5 days. If not, call your provider.

Sexual Problems - Talk with your provider; a change in medications may help.

Nausea or Appetite Loss - Take medication with food.

Adapted from the "Antidepressant Medications" Handout from the Center for Integrated Healthcare, Department of Veterans Affairs



Do What You Used to Enjoy to Help Depression

When people feel depressed, they stop doing things they once found enjoyable or meaningful. The less active they are, the worse they feel. And, the worse they feel the less active they become. This is the cycle of depression.



To break this cycle, it is helpful to identify the things you once enjoyed and plan to do them again, even though you don't feel like it. Enjoyable activities don't have to cost money or be special. Calling a friend, talking a short walk, or reading a good book are examples of enjoyable activities. Repeatedly doing things you used to enjoy, even when you don't feel like it, will help your depression.

Setting a Goal:

I used to enjoy: _____

Something important to me is: _____

Even though I won't feel like it I will: _____

When? _____

Where? _____

How? _____

For How Long? _____



Coping with Triggers to Use

Cutting back or quitting seems simple, but often it isn't. Many people who want to cut back or quit are surprised at how often they want to use. The things that make us want to use are called triggers. Identifying your triggers and making a plan to avoid or cope with them can help.

Identifying Your Triggers

To identify triggers, think about the things you associate with use. You will likely have many triggers, but it may be hard to identify them at first. Think about the people, places, things, and feelings that make you want to use. List some of your triggers below.

_____	_____
_____	_____
_____	_____

Avoiding or Coping with Triggers

Now that you have identified some of your triggers, let's make a plan. Determine which triggers you can avoid and develop a plan to cope with those you cannot. For example, you can avoid your friend who continues to use, but cannot completely avoid stress.

My Plan

I will avoid these triggers: _____

I will cope with these triggers I cannot avoid:

Trigger	Coping Plan
<i>Example</i> Weekends	I will stay busy and around people
	who don't use by playing outside
	with my kids.

Trigger

Coping Plan



Relapse Prevention Plan

Quitting seems simple, but often isn't. Many people who want to quit are surprised at how often they want to use. Cravings to use are normal and don't have to lead to use. It is important to expect and plan for cravings to prevent relapse.

When I think about using I will:

I. Remember my reasons for being sober.

II. Think of the consequence of using.

III. Call someone supportive of my sobriety.

Name

Number

IV. Go to a safe place.

V. Do something I enjoy until the craving passes.

When to Refer to Specialty Mental Health or Substance Abuse Providers

It is a routine practice to refer patients to specialty providers when additional assistance with diagnostic clarification, treatment planning, and interventions is needed. Unfortunately, there is a mismatch between the rate of referrals (e.g., referrals increased from 41 million to 105 million annually between 1999 and 2009) and patients' likelihood to attend the specialty provider appointments (e.g., there is a 50 percent no-show rate for most new referrals).

Before referring a patient to a specialty mental health provider or substance abuse program and to increase your ability to provide the best care for your patients, consider the following:

Is there a safety risk involved?

- Has the patient expressed suicidal intent with plan, means, or access to a way to harm his or herself?
- Is your patient demonstrating symptoms of active withdrawal from a substance?
- This patient should be given immediate access to a higher level of care including but not limited to an inpatient psychiatric facility (or an evaluation for appropriateness) and/or a local ER for immediate stabilization of symptoms and functioning.

What is your patient's preference?

- Remember, just because you make the referral, it does not mean your patient will go
- Does your patient believe the referral is necessary? At this time? For this problem?
- To increase the likelihood that your patient will attend a specialist referral appointment and to increase the likelihood that your patient will remain engaged in care, it is important to ensure that the patient believes the referral is appropriate and/or necessary

What is the patient's level of engagement?

- Has he or she consistently missed appointments (e.g., PCP, nurse, labs) in your clinic?
- Consider using a change ruler; if the patient rates his/her likelihood of attending this appointment as a seven or higher (and/or has consistently attended all of your appointments), your patient may be more likely to attend a referral appointment to a specialty provider

What interventions have you tried in-house?

- A positive screen is not always indicative of a need for a higher level of care
- Evidence-based practice recommends several effective, *brief* interventions for depression and substance abuse (e.g., behavioral activation, change rulers, initiation of medication, psychoeducation) that you or another member of the primary care team can implement at the point of care

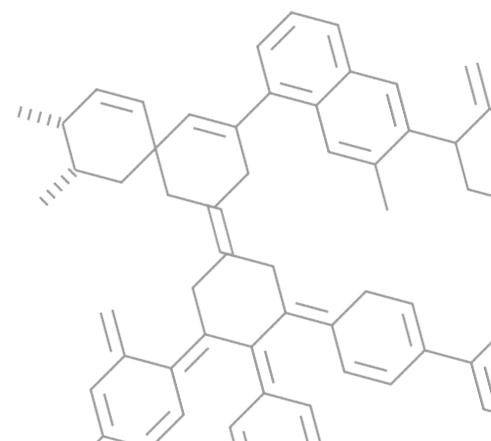
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Building Community Resources and Referral Protocols

For patients whose level of engagement is high and whose symptoms require additional intervention above and beyond what can be effectively implemented in the primary care setting, appropriate referrals are necessary. When working to build collaborative relationships with community partners to facilitate these referrals, several general guidelines may be worth considering.

1. Reach out to community partners (e.g., psychologists, licensed clinical social workers, licensed counselors, university counseling centers, community mental health centers, substance abuse treatment centers, crisis units, etc.) to establish protocols for referrals.
2. When developing protocols, consider:
 - When and how to refer (e.g., for crisis only? Once patient engagement and motivation has increased? See *“When to Refer to Specialty Mental Health or Substance Abuse Providers”* for additional recommendations)
 - The type and amount of information that is needed to complete the referral
 - What forms are needed?
 - What information will be shared and how that information will be transmitted securely?
 - How will each organization obtain consent?
3. Create a list of local organizations that patients may access for additional assistance or education including but not limited to: local emergency services including crisis and detox centers; community service agencies; community mental health centers; and the local branches of the Department of Public Health, the Bureau of Substance Abuse Service, and the Department of Mental Health.



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Link to PHQ Screeners in multiple languages: <http://www.phqscreeners.com/select-screener>

[Southeast Consortium for Substance Abuse Training, videos of AUDIT alcohol screen with positive and negative results](#)

These peer resources may be valuable in providing support regarding both medical and behavioral health needs for patients of the practice as well as for the overall administration of the practice. Such peer supports for the families of pediatric patients may be recruited from the pool of "Family Support Specialists" that exist through the Child Behavioral Health Initiative.

[Alcohol, Other Drugs, and Health: Current Evidence](#)

Regular updates of SBIRT and other alcohol and drug research. Also lists available free Continuing Education opportunities for physicians, nurse practitioners, and counselors, as well as downloadable and modifiable teaching slide presentations.

Integrated Care Resources

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Websites for Integrated Care

Academy for Integrating Behavioral Health and Primary Care: www.integrationacademy.ahrq.gov

Agency for Healthcare Research and Quality: www.ahrq.gov

Collaborative Family Healthcare Association: www.cfha.net

Institute for Clinical Systems Improvement: www.icsi.org

SAMHSA-HRSA Center for Integrated Health Solutions: www.integration.samhsa.gov

Websites with Useful Clinical Tools

Addressing Suicide in Primary Care: www.sprc.org/for-providers/primary-care

Agency for Healthcare Research and Quality – Spanish Evidence-Based Practice Resource: www.ahrq.gov/patients-consumers/treatmentoptions/esp/

AIMS Center at the University of Washington: uwaims.org

American Academy of Pediatrics: www.brightfutures.aap.org

American Academy of Pediatrics - Primary Care Tools: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx

American Academy of Pediatrics - Trauma Toolbox For Primary Care: www.aap.org/traumaguide

American Diabetes Association: www.diabetes.org

Anxiety – CBT resources: www.anxietybc.com

Behavior Management – printable child-friendly charts: www.freeprintablebehaviorcharts.com

Center for Clinical Interventions – Consumer & Provider Resources: www.cci.health.wa.gov.au/resources/index.cfm

Center for Integrated Healthcare: www.mentalhealth.va.gov/coe/cih-visn2/Clinical/Clinical_Resources.asp

Center on Aging Studies Without Walls: cas.umkc.edu/casww/caregivg.htm

Child Development - Resources for Parents in English and Spanish: www.kidsgrowth.com/stages/guide/index.cfm | www.pbs.org/parents/child-development

Child Health & Development – Parent & Child Resources: www.kidshealth.org

Cornell Self-Injury and Recovery Program: <http://selfinjury.bctr.cornell.edu/resources.html>

Diabetes Self-Management: www.diabetesselfmanagement.com/

The Disparities Solutions Center at Massachusetts General Hospital: www.massgeneral.org/disparitiessolutions

Eat Smart Move More & Let's Move – Initiatives to address childhood obesity: www.letsmove.gov/en-espanol | www.eatsmartmovemorenc.com/Media/PrintAds.html

Gero Central: gerocentral.org/

Health & Wellness – includes healthy eating & physical activity, free to register for account: www.sparkpeople.com

Health & Wellness – University of Tennessee Wellness Website: ewellness.tennessee.edu/Resources.aspx

Health Psychology Website by Dan Bruin: www.healthpsych.com/

Help with Aging: helpwithaging.com

Integrated Behavioral Health Project Screening Tools: <http://www.ibhp.org/uploads/file/IBHScreeningToolsRevFinal100313.pdf>

Johns Hopkins Center for Mental Health Services in Pediatric Primary Care: web.jhu.edu/pedmentalhealth/index.html

National Center for Cultural Competence: nccc.georgetown.edu

National Heart Lung and Blood Institute: www.nhlbi.nih.gov/health/

National Institute for Health and Clinical Excellence: www.nice.org.uk/cg90

National Institute on Aging at the NIH: <https://go4life.nia.nih.gov>

National Network to Eliminate Disparities in Behavioral Health: www.nned.net

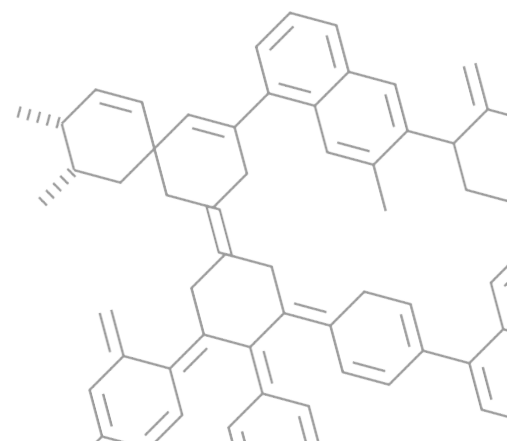
Palliative Care Institute Comfort Curriculum: <http://pccinstitute.com/comfort-curriculum/>

Parenting resources – Love & Logic: www.loveandlogic.com

Patient-Centered Primary Care Collaborative: www.pcpcc.net

SAMHSA's Evidence-based Practice Website: [www.samhsa.gov/ebpwebguide/appendixB.asp#Health Treatment](http://www.samhsa.gov/ebpwebguide/appendixB.asp#Health_Treatment)

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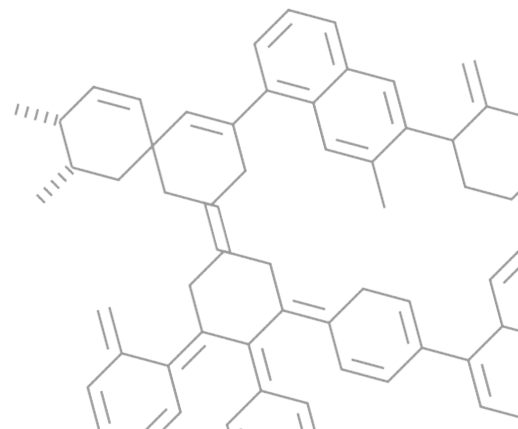


Appendix



Geriatric Depression Scale

Short Form (GDS)





Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.

A score ≥ 10 points is almost always indicative of depression.

A score > 5 points should warrant a follow-up comprehensive assessment.

Source: <http://www.stanford.edu/~yesavage/GDS.html>

This scale is in the public domain.

The Hartford Institute for Geriatric Nursing would like to acknowledge the original author of this Try This, Lenore Kurlowicz, PhD, RN, CS, FAAN, who made significant contributions to the field of geropsychiatric nursing and passed away in 2007.

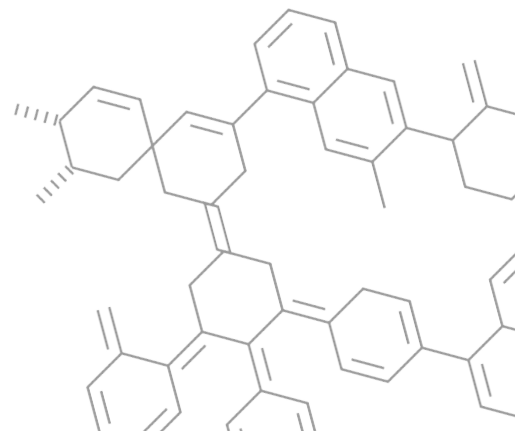


A series provided by The Hartford Institute for Geriatric Nursing,
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CLINICAL NURSING WEBSITE www.ConsultGerIRN.org



Depression Screening Tool

Hamilton Depression Rating Scale (HAM-D)





The Hamilton Rating Scale for Depression

(to be administered by a healthcare professional)

Patient's Name _____

Date of Assessment _____

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

For each item, write the correct number next to the item. (Only one response per item)

- ☐ **1. DEPRESSED MOOD** (Sadness, hopeless, helpless, worthless)
- 0= Absent
 - 1= These feeling states indicated only on questioning
 - 2= These feeling states spontaneously reported verbally
 - 3= Communicates feeling states non-verbally—i.e., through facial expression, posture, voice, and tendency to weep
 - 4= Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and nonverbal communication

- ☐ **2. FEELINGS OF GUILT**
- 0= Absent
 - 1= Self reproach, feels he has let people down
 - 2= Ideas of guilt or rumination over past errors or sinful deeds
 - 3= Present illness is a punishment. Delusions of guilt
 - 4= Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

- ☐ **3. SUICIDE**
- 0= Absent
 - 1= Feels life is not worth living
 - 2= Wishes he were dead or any thoughts of possible death to self
 - 3= Suicidal ideas or gesture
 - 4= Attempts at suicide (any serious attempt rates 4)

- ☐ **4. INSOMNIA EARLY**
- 0= No difficulty falling asleep
 - 1= Complains of occasional difficulty falling asleep—i.e., more than 1/2 hour
 - 2= Complains of nightly difficulty falling asleep

- ☐ **5. INSOMNIA MIDDLE**
- 0= No difficulty
 - 1= Patient complains of being restless and disturbed during the night
 - 2= Waking during the night—any getting out of bed rates 2 (except for purposes of voiding)

- ☐ **6. INSOMNIA LATE**
0= No difficulty
1= Waking in early hours of the morning but goes back to sleep
2= Unable to fall asleep again if he gets out of bed
- ☐ **7. WORK AND ACTIVITIES**
0= No difficulty
1= Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2= Loss of interest in activity; hobbies or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3= Decrease in actual time spent in activities or decrease in productivity
4= Stopped working because of present illness
- ☐ **8. RETARDATION: PSYCHOMOTOR** (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0= Normal speech and thought
1= Slight retardation at interview
2= Obvious retardation at interview
3= Interview difficult
4= Complete stupor
- ☐ **9. AGITATION**
0= None
1= Fidgetiness
2= Playing with hands, hair, etc.
3= Moving about, can't sit still
4= Hand wringing, nail biting, hair-pulling, biting of lips
- ☐ **10. ANXIETY (PSYCHOLOGICAL)**
0= No difficulty
1= Subjective tension and irritability
2= Worrying about minor matters
3= Apprehensive attitude apparent in face or speech
4= Fears expressed without questioning
- ☐ **11. ANXIETY SOMATIC:** Physiological concomitants of anxiety, (i.e., effects of autonomic overactivity, “butterflies,” indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e., dry mouth, constipation)
0= Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

- ☐ **12. SOMATIC SYMPTOMS (GASTROINTESTINAL)**
0= None
1= Loss of appetite but eating without encouragement from others. Food intake about normal
2= Difficulty eating without urging from others. Marked reduction of appetite and food intake
- ☐ **13. SOMATIC SYMPTOMS GENERAL**
0= None
1= Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability
2= Any clear-cut symptom rates 2
- ☐ **14. GENITAL SYMPTOMS** (Symptoms such as: loss of libido; impaired sexual performance; menstrual disturbances)
0= Absent
1= Mild
2= Severe
- ☐ **15. HYPOCHONDRIASIS**
0= Not present
1= Self-absorption (bodily)
2= Preoccupation with health
3= Frequent complaints, requests for help, etc.
4= Hypochondriacal delusions
- ☐ **16. LOSS OF WEIGHT**
A. When rating by history:
0= No weight loss
1= Probably weight loss associated with present illness
2= Definite (according to patient) weight loss
3= Not assessed
- ☐ **17. INSIGHT**
0= Acknowledges being depressed and ill
1= Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2= Denies being ill at all
- ☐ **18. DIURNAL VARIATION**
A. Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none
0= No variation
1= Worse in A.M.
2= Worse in P.M.
☐ B. When present, mark the severity of the variation. Mark "None" if NO variation
0= None
1= Mild
2= Severe

☐ **19. DEPERSONALIZATION AND DEREALIZATION** (Such as: Feelings of unreality; Nihilistic ideas)

- 0= Absent
- 1= Mild
- 2= Moderate
- 3= Severe
- 4= Incapacitating

☐ **20. PARANOID SYMPTOMS**

- 0= None
- 1= Suspicious
- 2= Ideas of reference
- 3= Delusions of reference and persecution

☐ **21. OBSESSIONAL AND COMPULSIVE SYMPTOMS**

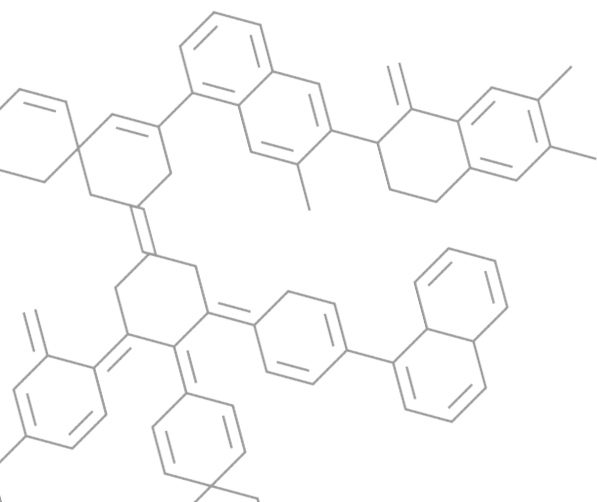
- 0= Absent
- 1= Mild
- 2= Severe

Total Score



Depression Screening Tool

Patient Health Questionnaire-9 (PHQ-9)





Over the past 2 weeks, how often have you been bothered by any of the following problems?
(Write number according to your answer in the corner. Tally all answers for your final score.)

1. Little interest or pleasure in doing things

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

2. Feeling down, depressed or hopeless

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

3. Trouble falling or staying asleep, or sleeping too much

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

4. Feeling tired or having little energy

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

5. Poor appetite or over eating

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

7. Trouble concentrating on things, such as reading the newspaper or watching TV

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite of being so fidgety or restless that you have been moving around a lot more than usual

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

9. Thoughts that you would be better off dead or of hurting yourself

- (0) Not at All
- (1) Several Days
- (2) More than Half the Days
- (3) Nearly Every Day

Score

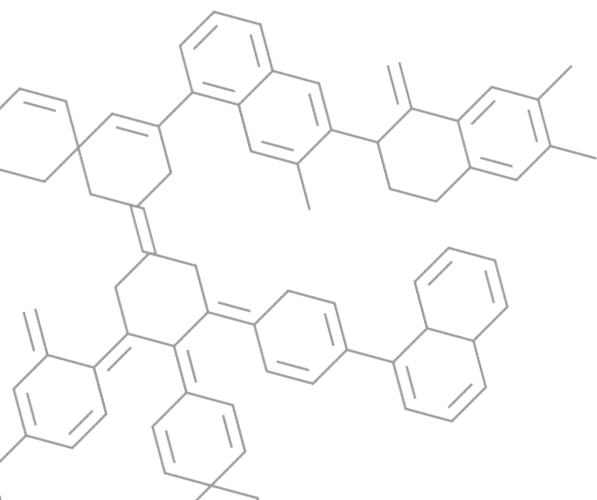
PHQ-9 Results

- 1-4: Minimal Depression
- 5-9: Mild Depression
- 10-14: Moderate Depression
- 15-19: Moderately Severe Depression
- 20-21: Severe Depression



Substance Misuse Screening Tool

*Alcohol, Smoking and Substance Involvement
Screening Test (ASSIST)*



A. WHO - ASSIST V3.0

INTERVIEWER ID	<input type="text"/>	COUNTRY	<input type="text"/>	CLINIC	<input type="text"/>
PATIENT ID	<input type="text"/>	DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>

INTRODUCTION (Please read to patient)

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT

Question 1

(if completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you <u>ever used</u> ? (NON-MEDICAL USE ONLY)	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serenax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.



Question 2

In the <u>past three months</u> , how often have you used the substances you mentioned (<i>FIRST DRUG, SECOND DRUG, ETC</i>)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the <u>past three months</u> , how often have you had a strong desire or urge to use (<i>FIRST DRUG, SECOND DRUG, ETC</i>)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6



Question 4

During the <u>past three months</u> , how often has your use of (<i>FIRST DRUG, SECOND DRUG, ETC</i>) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the <u>past three months</u> , how often have you failed to do what was normally expected of you because of your use of (<i>FIRST DRUG, SECOND DRUG, ETC</i>)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8



Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you <u>ever</u> tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3



Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you <u>ever</u> used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING

Once weekly or less or
Fewer than 3 days in a row

More than once per week or
3 or more days in a row

INTERVENTION GUIDELINES

Brief Intervention including "risks associated with injecting" card

Further assessment and more intensive treatment*

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

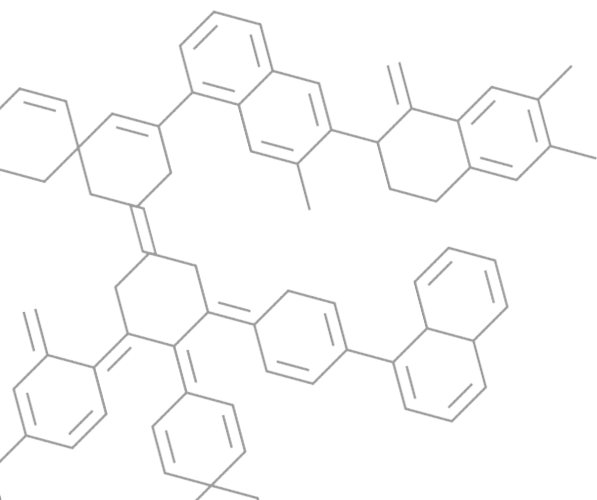
NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.





Substance Misuse Screening Tool

Alcohol Use Disorders Identification Test (AUDIT)





AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or “pure” alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



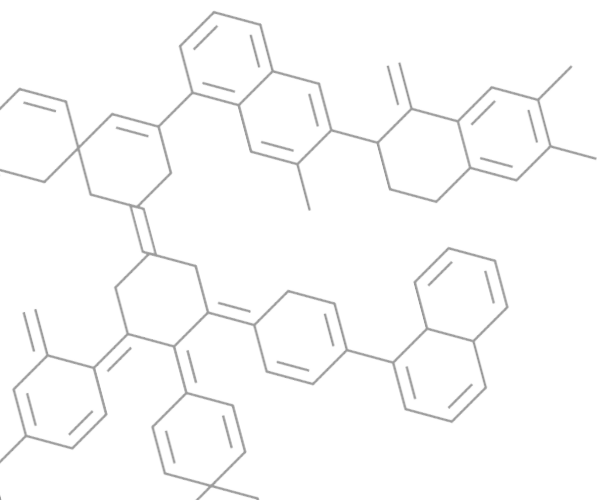
Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org.



Substance Misuse Screening Tool

CAGE-AID





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.

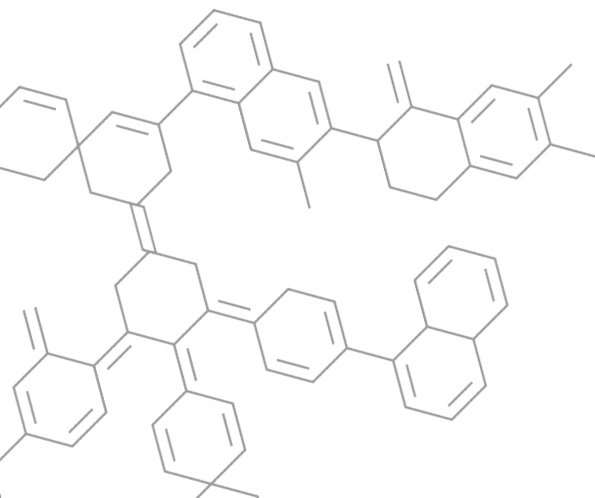
Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

Permission for use granted by Richard Brown, MD.



Substance Misuse Screening Tool

Drug Abuse Screening Test (DAST-10)



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.



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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 |

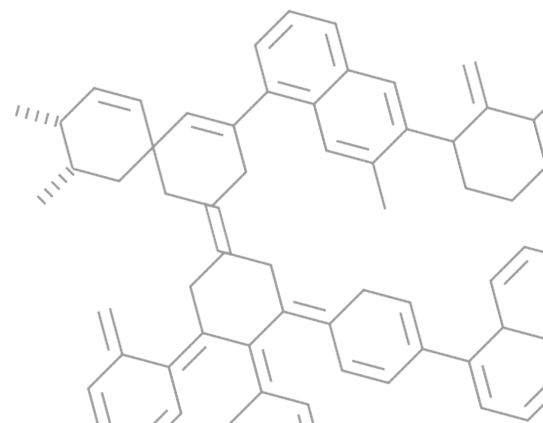


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Substance Misuse Screening Tool

Michigan Alcoholism Screening Test (MAST)



Patient Name: _____

Date: _____

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.



1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	Yes	No
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	No
3. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	Yes	No
4. Can you stop drinking without a struggle after one or two drinks?	Yes	No
5. Do you ever feel guilty about your drinking?	Yes	No
6. Do friends or relatives think you are a normal drinker?	Yes	No
7. Are you able to stop drinking when you want to?	Yes	No
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes	No
9. Have you gotten into physical fights when drinking?	Yes	No
10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	Yes	No
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	Yes	No
12. Have you ever lost friends because of drinking?	Yes	No
13. Have you ever gotten into trouble at work or school because of drinking?	Yes	No
14. Have you ever lost a job because of drinking?	Yes	No
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes	No
16. Do you drink before noon fairly often?	Yes	No
17. Have you ever been told you have liver trouble? Cirrhosis?	Yes	No
18. After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices or seen things that really were not there?	Yes	No
19. Have you ever gone to anyone for help about your drinking?	Yes	No
20. Have you ever been in a hospital because of drinking?	Yes	No
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes	No
22. Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?	Yes	No
23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, how many times? _____)	Yes	No
24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? If YES, how many times? _____)	Yes	No

