Behavioral Health Toolkit

For Scott and White Health Plan Providers

May 28, 2019

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Provider Behavioral Health Toolkit

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Provider Materials:

Depression Screening: We recommend the use of the ***PHQ-9 Depression Assessment Tool*** to assess depression.

- A component of the longer *Patient Health Questionnaire,* the *PHQ-9* is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
- The tool is a ***diagnostic measure*** for Major Depression as well as for recognizing subthreshold depressive disorders.
- It can be administered repeatedly – reflecting improvement or worsening of depression in response to treatment.
- For claims billing confirmation:
  - Use HCPCS G8431 if positive screen for clinical depression and follow-up plan is documented
  - Use HCPCS G8510 if negative screen for clinical depression.
  - Use the codes indicated above only if appropriate for the service/s rendered.

Over the last 2 weeks, how often has the patient been bothered by the following problems?	**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 and/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 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 thoughts of hurting yourself in some way	0	1	2	3
Scoring:	0	+ _____	+ _____	+ _____
TOTAL SCORE:	_____			

10. If the patient checked off any problems, how difficult have those problems made it for him/her to do work, take care of things at home, or get along with other people?
□ **Not difficult at all** □ **Somewhat difficult** □ **Very difficult** □ **Extremely difficult**

Consider total score as possible indicator of level of depression. Circle the appropriate score/severity indicator	
	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression
Q.10 – a non-scored question used to assign weight to the degree to which depressive problems have affected the patient's level of function.	

NOTE: The clinician should rule out physical causes of depression, normal bereavement and a history of manic/hypomanic episode

Screening tool available at the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website:
http://www.integration.samhsa.gov/clinical-practice/screening-tools

- Kroenke K, Spitzer RL, and Williams JBW. *The PHQ-9: validity of a brief depression severity measure.* J Gen Intern Med. 2001 Sep; 16(9): 606-613.

DSM-5 Diagnostic Criteria – Diagnosing Depression

Complete *diagnostic* criteria for *Depressive Disorders* can be found in the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Major Depressive Disorder (adapted from DSM-5)

Single Episode: 296.2x/F32.x; Recurrent Episode: 296.3x/F33.x

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Additional Provider Resource

- The MacArthur Foundation Initiative on Depression and Primary Care's Depression Management Tool Kit can be found at http://otgateway.com/articles/13macarthurtoolkit.pdf

Depression Clinical Guidelines QRG

To ensure that all our providers are using a standardized and, effective model for managing the quality of care for members with Depression. For the purposes of this process, the member's score on the Patient Health Questionnaire (PHQ-9) will be a determinant on frequency and scope of interventions provided.

The PHQ-9, scoring instructions, and description of the depression risk levels (low/maintenance level, moderate, high/severe) can be found on the SAMHSA website at *http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf*

NOTE: If member answers YES to question #9 no matter what the overall scoring is, crisis protocols should be followed. At al l levels, crisis policies for the practice should be followed.

LOW/MAINTENANCE (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score 0-9
- A member may also have a diagnosis of depression, but symptoms are managed by medication, therapy, or a combination of both and is maintaining self advocacy through community supports – the member is in what is considered the maintenance phase of treatment.

Interventions that can be provided at this Level:

- Provide health education/coaching on Wellness Self-Management
  - Identification of and recognition of triggers
  - Review with member self-identified healthy coping management techniques
  - Provide medication education (if member is currently on anti-depressant medications) to ensure adherence.
- Provide service coordination including transportation coordination and appointment scheduling
- Provide additional community based referrals based on member identified needs for psychosocial support needs such as: AA/Alanon, Consumer Credit Counseling, Food Assistance, Victim Assistance

MODERATE RISK (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score between 10-19
- A member may also have identified one or more moderate risk depression items on the PHQ-9 but none in the severe range but still has a score of 9 or below
- Member has had recent hospitalization for depression (within last 6 months)

Interventions that can be provided at this Level:

- All interventions listed for LOW RISK
- Conduct medication review and education on efficacy, side effects, and proper administration to ensure adherence to treatment plans
- If member is not currently on anti---depressant medication, member should be evaluated for medication needs
- Have member identify internal and external supports – including social supports, providers, social service agency involvement, cultural supports, family as well as self identified strengths.
- Rule---out potential medical disorders that may be mimicking, masking, or affecting symptoms
- Consider referral to Molina Case Management Team for additional support

Depression Clinical Guidelines QRG

MODERATE INTERVENTIONS (CONTINUED)

- Review for ROI for coordination of care with behavioral health provider (if there is established behavioral health provider)
  - If ROI is present, contact providers and inform of current treatment plan
  - If ROI is not present, request member sign and send ROI paperwork to member with provider information completed
  - If member does not have current behavioral health provider, offer to assist member with locating provider and obtaining appointment. Coordinate ROI paperwork with provider and member once appointment is secured
- Refer for therapy if warranted and/or psychiatric assessment with psychiatrist and assist with appointment scheduling
  - If member has current behavioral health provider (medication management and/or talk therapy):
    - Contact provider to confirm next appointment and coordinate services including transportation for appointments and medication refills (can engage Health Plan CM to assist)
    - If member has BH talk therapy provider, if there is no improvement within 4-6 weeks, discuss possible assessment for medication
    - If member has Medication therapy only provider, discuss with member augmenting through talk therapy (especially if increased psychosocial stressors are present)
    - If member has a provider but no upcoming appointments, coordinate appointment scheduling
  - If member does not have behavioral health provider: (Evaluate for next steps)
    - Is member's BH medication needs being met through PCP?
      - If so, then consider referral to psychiatric prescriber (psychiatrist or nurse practitioner).
    - If not, then does member have a preference for treatment?
      - Talk therapy - counselor/therapist
      - Medication only - psychiatrist
      - Considerations for both types of providers
        - ✓ Provider gender preference
        - ✓ Cultural preferences and language needs
        - ✓ Transportation needs (i.e. on a bus line?)
        - ✓ Specific scheduling needs - Office hour needs (days, times, evening appointments needed)

HIGH RISK (MEMBER WILL HAVE ONE OR MORE OF THE FOLLOWING)

- PHQ-9 Score 20 or higher
- A member may also have identified one or more severe risk depression items on the PHQ-9 but has a score below 20
- Member has had recent hospitalization for depression (within last 1-3 months)

Interventions that can be provided at this Level:

- All interventions listed for **MODERATE RISK**
- Monitoring of post-discharge aftercare and encourage patient to be seen within the first week following discharge from inpatient psychiatric care if applicable by a behavioral health practitioner
  - Phone contact with the member to encourage them to make this scheduled aftercare appointment
  - Consider a nutritional assessment and meal plan completed by a registered dietitian
  - Referral to Case Management Team for additional support

- The member should receive regular re-evaluation until the member's PHQ-9 drops below 20 or the member's high-risk items have been resolved (supplemental mental health screening tools may be considered when score increases or stays constant $\geq$ 3 months)

- At the choice of the member, provide "coaching" in the form of phone contact to review member's tolerance of initial side effects of antidepressants during the 6 to 12 weeks following its prescription, given the risk this period presents to medication adherence

Edinburgh Postnatal Depression Scale (EPDS)

Cox JL, Holden JM Sagovsky R (1987) Detection of postnatal depression: development of the 10-item Edinburgh postnatal depression scale. Brit J Psychiatry 150 782-86. Reproduced with permission.

Name: _____ **Date:** _____

We would like to know how you have been feeling in the past week. Please indicate which of the following comes closest to how you have been feeling over the past seven days, not just how you feel today. Please tick one circle for each question that comes closest to how you have felt in the **last seven days.**

Here is an example already completed.

I have felt happy:

- ☐ Yes, all of the time
- ■ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: 'I have felt happy most of the time during the past week'.

Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things

- ☐ As much as I always could
- ☐ Not quite so much now
- ☐ Definitely not so much now
- ☐ Not at all

2. I have looked forward with enjoyment to things

- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ Not very often
- ☐ No, never

4. I have been anxious or worried for no good reason

- ☐ No, not at all
- ☐ Hardly ever
- ☐ Yes, sometimes
- ☐ Yes, very often

5. I have felt scared or panicky for no very good reason

- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all

6. Things have been getting on top of me

- ☐ Yes, most of the time I haven't been able to cope at all
- ☐ Yes, sometimes I haven't been coping as well as usual
- ☐ No, most of the time I have coped quite well
- ☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all

8. I have felt sad or miserable

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all

9. I have been so unhappy that I have been crying

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No, never

10. The thought of harming myself has occurred to me

- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

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2 Definitely not so much now
3 Not at all

2. I have looked forward with enjoyment to things

0 As much as I ever did
1 Rather less than I used to
2 Definitely less than I used to
3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong

3 Yes, most of the time
2 Yes, some of the time
1 Not very often
0 No, never

4. I have been anxious or worried for no good reason

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1 Hardly ever
2 Yes, sometimes
3 Yes, very often

5. I have felt scared or panicky for no very good reason

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2 Yes, sometimes
1 No, not much
0 No, not at all

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2 Yes, sometimes I haven't been coping as well as usual
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2 Yes, quite often
1 Not very often
0 No, not at all

9. I have been so unhappy that I have been crying

3 Yes, most of the time
2 Yes, quite often
1 Only occasionally
0 No, never

10. The thought of harming myself has occurred to me

3 Yes, quite often
2 Sometimes
1 Hardly ever
0 Never

Selective Serotonin Reuptake Inhibitors (SSRIs)						
Fluoxetine (Prozac)	10-80	20 mg. in the a.m. with food (10 mg. in elderly, children and those with comorbid panic disorder).	Maintain 20 mg. for 4-6 weeks and 30 mg. for 2-4 weeks before additional dose increases. Increase in 10 mg. increments at 7-day intervals. If significant side effects occur within 7 days, lower dose or change medication.	No auth required.	Helpful for anxiety disorders. Long half-life, good for poor adherence. Missed dose – less frequent discontinuation symptoms. Reduces all three-symptom groups of PTSD.	Slower to reach stead state and eliminate when discontinued. Sometimes too stimulating. Active metabolite has half-life – 1- days and renal elimination. Inhibitor of cytochrome P450 2D6 and 3A4. Use cautiously in the elderly and others taking multiple medications.
Fluoxetine Weekly (Prozac Weekly)	90	Initiate only after patient stable on 20 mg. daily.	Start 7 days after last dose of 20 mg.	Not covered.	Generic available.	No generic available.
Citalopram (Celexa)	20-40	20 mg. in a.m. with food (10 mg. in elderly, children or those with panic disorder).	Maintain initial dose for 4 weeks before dose increase. If no response, increase in 10 mg. increments every 7 days as tolerated.	No auth required.	Helpful for anxiety disorders. Few drug interactions. Generic available.	
Escitalopram (Lexapro)	10-30	10 mg.	Increase to 20 mg. if partial response after 4 weeks.	No auth required.	More potent s-enantiomer of citalopram. 10-mg. dose effective for most. FDA labeling for general anxiety disorder. Reduces all three-symptom groups of PTSD.	More expensive than citalopram.

Sertraline (Zoloft)	25-200	50 mg. once daily usually in the a.m. with food (25 mg. for elderly).	Maintain 50 mg. for 4 weeks. Increase in 25-50 mg. increments at 7-day intervals as tolerated. Maintain 100 mg. for 4 weeks before next dose increase.	No auth required.	FDA labeling for anxiety disorders including PTSD. Safety shown post MI. Generic available.	Weak inhibitor of CYP2D6 – drug interactions less likely.
Paroxetine (Paxil)	10-50 (40 in elderly)	20 mg. once daily, usually in a.m. with food (10 mg in elderly and those with comorbid panic disorder).	Maintain 20 mg for 4 weeks before dose increase. Increase in 10 mg. increments at intervals of approximately 7 days up to maximum dose of 50 mg/day (40 mg/day in elderly).	No auth required.	FDA labeling for most anxiety disorders. Reduces all three-symptom groups of PTSD, Generic available.	Sometimes sedating. Anticholinergic effects can be troublesome. Inhibitor of CYP2D6 (drug interactions). Not indicated for children/adolescents due to discontinuation/withdrawal symptoms.
Paroxetine CR (Paxil CR)	25-62.5 (50 in elderly)	25 mg daily (12.5 mg in elderly and those with panic disorder).	Increase by 12.5 mg. at weekly intervals. Maintain 25 mg. for 4 weeks before dose increase.	No auth required.	May cause less nausea and GI distress.	Generic not available.
Serotonin and Norepinephrine Antagonist						
Mirtazapine (Remeron)	15-45	15 mg. at bedtime.	Increase in 15 mg. increments (7.5 in elderly) as tolerated. Maintain 30 mg. for 4 weeks before further dose increase.	No auth required.	Few drug interactions. Less or no sexual dysfunction. Less sedation as doses increase. May stimulate appetite. Generic available.	Sedation at low doses only (<15 mg.). Weight gain due to appetite stimulation.

Norepinephrine and Dopamine Reuptake Inhibitor						
Bupropion (Wellbutrin)	200-450	100 mg. twice a day (once a day in elderly).	Increase to 100 mg. three times a day after 7 days (slower titration for elderly). Third dose should not be at bedtime due to potential for insomnia. After 4 weeks, increase to maximum 150 mg. three times a day if necessary. Hepatic impairment: 75 mg./day.	No auth required.	Can be less stimulating. Less or no sexual dysfunction. Generic available.	At higher doses may induce seizures. Contraindicated in persons with seizure disorders or eating disorders. Stimulating effect can increase anxiety or insomnia.
Bupropion SR (Wellbutrin SR)	200-400	150 mg. once a day (100 mg. in elderly).	Increase to 150 mg. twice a day after 7 days (100 twice a day in elderly). Second dose should not be at bedtime due to potential for insomnia. Increase to 200 mg. twice a day after 4 weeks (150 mg. twice a day in elderly) if insufficient response. Hepatic impairment: 2100 mg. daily.	No auth required.	Also indicated for smoking cessation (Zyban). Generic available.	Do not split or crush SR or SL products. CYP2B6 inhibitor.
Bupropion XL (Wellbutrin XL)	300-450	150 mg. once daily (in a.m.).	Increase to 300 mg. daily after 7 days. Increase to 450 mg. per day after 4 weeks if necessary. Hepatic impairment: 150 mg.	No auth required.		Generic XL not available.

Serotonin and Norepinephrine Reuptake Inhibitors						
Venlafaxine (Effexor, Effexor XR)	75-375	75 mg. with food, 37.5 mg. if anxious, elderly, children or debilitated.	Immediate release (IR) dose should be divided two or three times a day. For extended release (XR) give 37.5 mg. in am, and then increase to 75 mg. in am after 1 week. 150 mg. in the am after 2 weeks. If partial response after 4 weeks increase to 225 mg. in the am. Norepinephrine effect only occurs above 150 mg.	No auth required.	Helpful for anxiety disorders, neuropathic pain and vasomotor symptoms. XR version should be taken once a day. May reduce all three-symptom groups of PTSD. Generic available (IR and XR).	May increase blood pressure at higher doses. Risk for drug interactions similar to fluoxetine. Discontinuation/withdrawal symptoms.
Desvenlafaxine (Pristiq)	50-400	50 mg. once daily.	No evidence that higher doses are associated with greater effect. Gradually increase dosing interval when discontinuing when taken for >6 weeks (taper dose if dose >50 mg/day).	No auth required.	Active metabolite of venlafaxine.	Dose adjustment if CrCl <30 ml./min. Generic not available.
Duloxetine (Cymbalta)	40-60	40 or 60 mg. as a single or divided dose (20 or 40 mg. for elderly and children).	Dose can be increased after 1 week. Maximum dose 120 mg per day although doses >60 mg. per day have not been shown to be more effective.	No auth required.	Also approved for general anxiety disorder and pain associated with diabetic neuropathy and fibromyalgia.	Dose adjustment if CrCl <30 ml./min. Urinary hesitance. Generic not available.

Tricyclic Antidepressants: Secondary Amines						
Desipramine (Norpramin)	100-300 (25-100 in elderly)	50 mg. in a.m. (10 or 25 mg for elderly).	Increase by 25 to 50 mg. every 3-7 days to initial target dose of 150 mg. (75 or 100 mg elderly) for 4 weeks. Target serum concentration: >115 ng/mL.	No auth required.	More effect on Norepinephine than serotonin. Effective for diabetic neuropathy and neuropathic pain. Compliance and effective dose can be verified by serum concentration. Generic available.	Can be stimulating, but sedating to some patients. Anticholinergic, cardiac, and hypotensive (less than tertiary amines). Caution in patients with BPH or cardiac conduction disorder or CHF.
Nortriptyline (Pamelor)	25-100	25 mg. (10 mg. in elderly) in the evening.	Increase in 10-25 mg. increments every 5-7 days as tolerated to 75 mg/day. Obtain serum concentration after 4 weeks: target range: 50-150 ng/mL.	No auth required.	Less orthostatic hypotension than other tricyclics. Compliance and effective dose can be verified by serum concentration. Generic available.	Anticholinergic, cardiac and hypotensive (less than tertiary amines). Caution in patients with BPH or cardiac conduction disorder or CHF.

Alcohol and Other Drug Abuse & Dependence Screening

We recommend the use of the ***CAGE-AID Screening Tool*** to assess alcohol and other drug abuse & dependence:

- The CAGE-AID questionnaire is used to test for alcohol and other drug abuse and dependence in adults
- The tool is not diagnostic but is indicative of the existence of an alcohol or other drug problem
- Item responses on the CAGE-AID are scored 0 or 1, with a higher score indicating alcohol or drug use problems
- *A total score of 2 or greater is considered clinically significant*, which then should lead the physician to ask more specific questions about frequency and quantity
- CAGE is derived from the four questions of the tool:
  - *Cut down*
  - *Annoyed*
  - *Guilty*
  - *Eye-opener*
- AID refers to *"Adapted to Include Drug Use"*

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.	**YES**	**NO**
1. Have you ever felt that you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you ever felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		
TOTAL 'YES' SCORE:		

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

Screening tool available at the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website:
http://www.integration.samhsa.gov/clinical-practice/screening-tools

o Brown RL, Rounds LA. *Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice*. Wis Med J. 1995; 94: 135-40.

DSM-5 Diagnostic Criteria – Diagnosing Alcohol and Other Drug Abuse & Dependence

Complete diagnostic criteria for *Substance-Related and Addictive Disorders* can be found in the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Substance Use Disorder (adapted from DSM-5)

A problematic pattern of [substance] use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

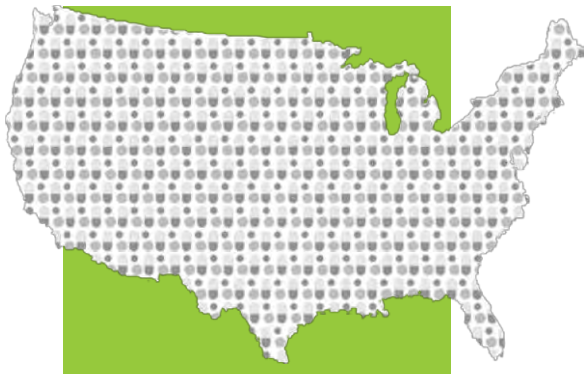
1. [Substance] is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control [substance] use.
3. A great deal of time is spent in activities necessary to obtain [substance], use [substance], or recover from its effects.
4. Craving, or a strong desire or urge to use [substance].
5. Recurrent [substance] use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued [substance] use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of [substance].
7. Important social, occupational, or recreational activities are given up or reduced because of [substance] use.
8. Recurrent [substance] use in situations in which it is physically hazardous.
9. [Substance] use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by [substance].
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of [substance] to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of [substance].
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for [substance].
    b. [Substance] (or a closely related substance) is taken to avoid withdrawal symptoms.

Severity

- **Mild (Abuse)**: Presence of 2-3 symptoms
- **Moderate (Dependence)**: Presence of 4-5 symptoms
- **Severe (Dependence)**: Presence of 6 or more symptoms

Primary Care
Substance Use Disorder Toolkit

Coordinated Care manages the behavioral health benefits for your patients. Enclosed is a package of supporting tools proven to be effective in the identification and treatment of Substance Use issues. The goal of the Behavioral Health toolkit is to support the screening for recognition of, and treatment of behavioral health and substance use disorders at the primary care level. Approximately 20 million Americans with alcohol or illicit drug dependence do not receive treatment resulting in health care costs that are nearly twice as high as patients without these disorders. Recent research indicates that basic screening and identification of substance use in primary care settings can substantially reduce overall negative health impacts associated with substance use, as well as increase the access to appropriate treatment services. In the largest study on how primary care physicians address substance use disorders, less than 20% of PCPs described themselves as prepared to identify alcoholism or illegal drug use, (*The National Center on Addiction and Substance Use at Columbia University, 2012*).



Approximately
20 MILLION
Americans
with alcohol or illicit drug dependence do not receive treatment resulting in health care costs that are nearly twice as high as patients without these disorders.

What are Substance Use Disorders?

Substance Use Disorder encompasses a pattern of behaviors that range from misuse to dependency or addiction, whether it is alcohol, legal drugs or illegal drugs. It is a progressive and chronic disease, but also one that can be successfully treated. People with substance use disorders often don't recognize or seek help for the problem, and may not be screened for substance use when they seek treatment for other health conditions, which means that substance use and dependence disorders are often under-recognized and undertreated.

Who is Affected by Substance Use Disorders?

Substance Use Disorder can affect anyone regardless of age, occupation, economic circumstances, ethnic background or gender. However, certain factors can affect the likelihood of developing an addiction:

- Family history of addiction: Drug addiction is more common in some families and likely involves the effects of many genes. If a blood relative, such as a parent or sibling, has alcohol or drug problems, then a greater risk of developing a drug addiction exists.
- Being male: Men are twice as likely to have problems with drugs.
- Having another psychological diagnosis: If someone has psychological problem, such as depression, attention-deficit/hyperactivity disorder or post-traumatic stress disorder, they are more likely to become dependent on drugs.

- Peer pressure: Particularly for young people, peer pressure is a strong factor in starting to use and use drugs.
- Lack of family involvement: A lack of attachment with one's parents may increase the risk of addiction, as can a lack of parental supervision.
- Anxiety: Using drugs can become a way of coping with these painful psychological feelings.
- Taking a highly addictive drug: Some drugs, such as heroin and cocaine, cause addiction faster than do others.

Types of Substance Use Disorders

Substance Dependence

A pattern of substance use that leads to significant impairment or distress in three (or more) of the following ways:

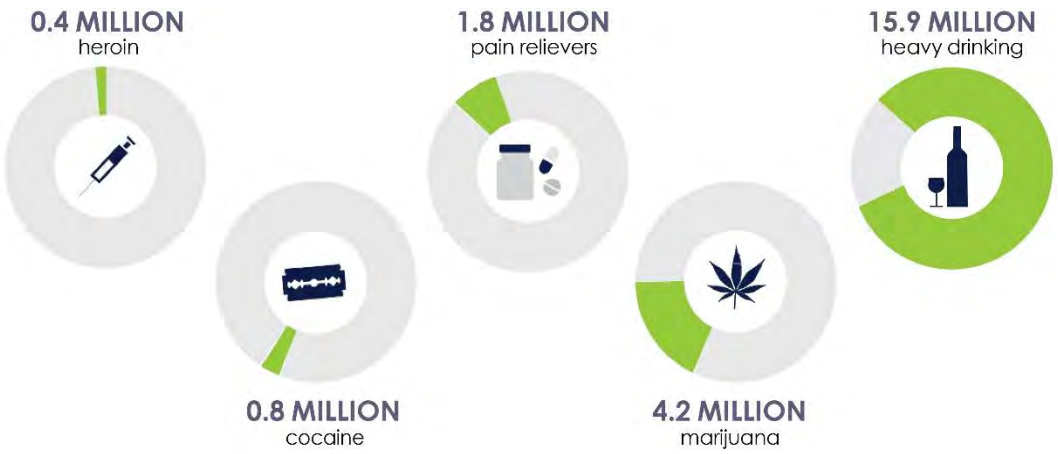
- Tolerance, as defined by either:
    1. a need for markedly increased amounts of the substance to achieve the desired effect, or
    2. a markedly diminished effect with continued used of the same amount of the substance
- Withdrawal symptoms characteristic for the substance, or increased use to relieve or avoid withdrawal symptoms
- Increased use - the substance is taken in larger amounts or over a longer period than intended
- A persistent desire or unsuccessful efforts to cut down or control substance use
- Much time is spent in activities to obtain the substance, use the substance, or recover from its effects
- Important social, occupational, or recreational activities are given up or reduced
- The substance use is continued despite it causing a persistent or recurrent physical or psychological problem (e.g., current cocaine use despite recognition of cocaine-induced depression)

Substance Use

A pattern of substance use that leads to significant impairment or distress in one (or more) of the following ways:

- A failure to fulfill major role obligations at work, school or home
- Recurrent substance use in situations in physically hazardous
- Recurrent substance-related legal problems
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or worsened by the effects of the substance

Number of Americans Identifying use or dependence on Illicit Substances (SAMHSA 2011)



Screening Tools & Resources

Despite the high prevalence of behavioral health and substance use problems, too many Americans go without treatment — in part because their disorders go undiagnosed. Regular screenings in primary care and other healthcare settings enables earlier identification of behavioral health and substance use disorders, which translates into earlier care. Screenings should be provided to people of all ages, even the young and the elderly.

SBIRT SBIRT is a comprehensive, integrated approach to help medical practitioners identify and provide early intervention to those patients who screen as at-risk for developing an SUD or long-term health issues related to their substance use. SBIRT includes a brief screen (the attached CAGE and AUDIT screening tools are examples) followed by a brief intervention, if appropriate, or referral for assessment and treatment. Please refer to your individual provider contract for information about whether SBIRT services are a covered benefit in your state. Additional training related to SBIRT, Substance Use Targeted Screening in Primary Care, and Brief Intervention Skills are available through http://www.coordinatedcarehealth.com or calling your local office.

CAGE AID is a commonly used, five-question tool used to screen for drug and alcohol use. It is a quick questionnaire to help determine if an alcohol assessment is needed. If a person answers yes to two or more questions, a complete assessment is advised.

AUDIT is a 10item questionnaire that screens for hazardous or harmful alcohol consumption. The AUDIT is particularly suitable for use in primary care settings and has been used with a variety of populations and cultural groups. It should be administered by a health professional or paraprofessional.

There is extensive research on the medical consequences and overall cost of substance use related illness and services. Substance Use can:

- Lead to unintentional injuries and violence
- Exacerbate medical conditions (e.g. Diabetes, hypertension)
- Exacerbate behavioral health conditions (e.g. depression, bi-polar)
- Affect the efficacy of prescribed meds
- Result in dependence, which may require multiple treatment service

Best Practices

Treatment must address the individual needs of the person seeking treatment and recovery. The current research-based best practices tend to merge the bio-psychosocial, theoretical perspective of addictive disorders. This includes supportive counseling, motivating client readiness for change, and coping-skills training techniques.

For additional information about substance use disorders or other behavioral health screening tools go to any of the following websites:

www.nami.org

www.nimh.nih.gov

www.iccmhc.org

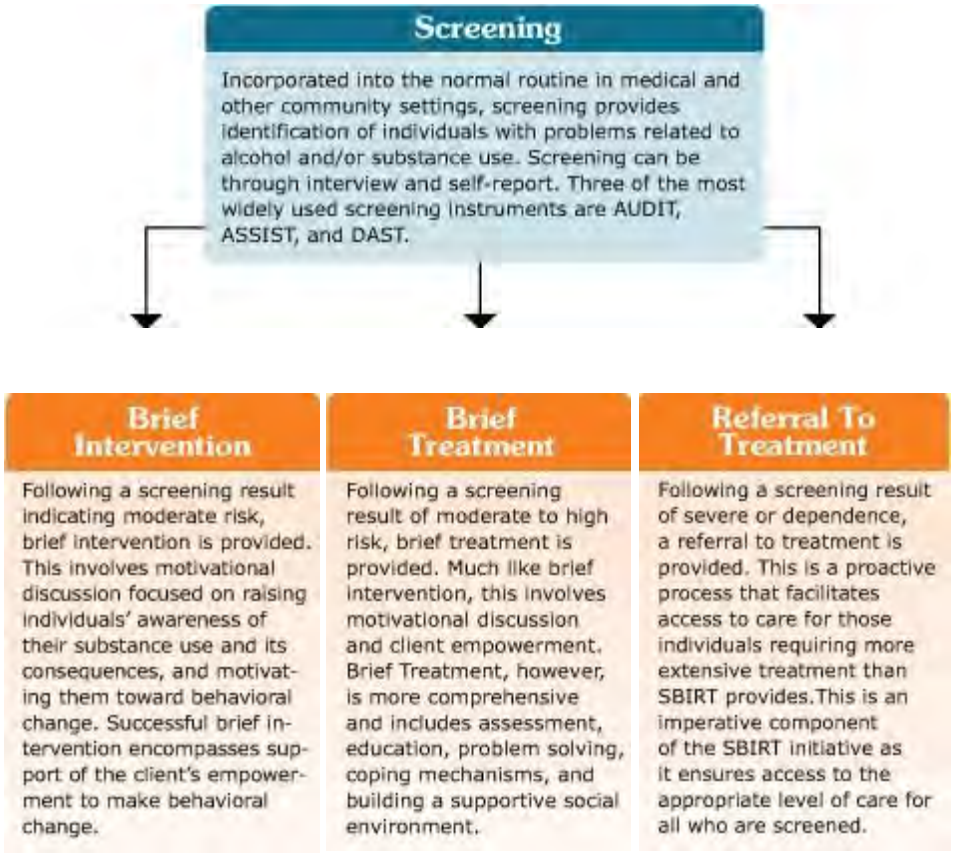
www.mentalhealth.samsha.gov

Brief Intervention and Treatment

What is it?

As defined by the Substance Abuse and Mental Health Services Administration, SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

- *Screening* quickly assesses for the presence of risky substance use, follows positive screens with further assessment of problem use, and identifies the appropriate level of treatment.
- *Brief intervention* focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- *Referral to treatment* provides those identified as needing more extensive treatment with access to specialty care. SAMHSA Treatment Locator: https://findtreatment.samhsa.gov/



Brief Intervention: Definition & Resources

Brief intervention comprises a single session, or sometimes multiple sessions, of motivational discussion focused on increasing insight and awareness regarding substance use and motivation toward behavioral change. Brief intervention can be used as a stand-alone treatment for those at-risk, as well as a vehicle for engaging those in need of more intensive specialized care.

- A practice to identify real or potential substance use problems and to motivate an individual to do something about it.
- Non-confrontational, short health counseling technique.
- Not a quick fix treatment.

Manuals and Training

1. Motivational Interviewing http://motivationalinterview.org/ **??**
2. (American College of Surgeons Committee on Trauma (COT): Screening and Brief Intervention Training for Trauma Care Providers: http://www.mayatech.com/cti/sbitrain07/ **??**
3. Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide https://www.facs.org/~/media/files/quality%20programs/trauma/publications/sbirtguide.ashx
4. Alcohol Screening and Brief Intervention Curriculum: http://www.bu.edu/act/mdalcoholtraining/index.html

Free web-based training curriculum geared toward generalist clinicians and developed by the Boston Medical Center.

5. Brief Counseling for Marijuana Dependence: A Manual for Treating Adults: https://www.integration.samhsa.gov/clinical-practice/sbirt/brief_counseling_for_marijuana_dependence.pdf
6. National Institute on Alcohol Abuse and Alcoholism Helping Patients Who Drink Too Much: A Clinician's Guide: https://www.niaaa.nih.gov/guide
7. Ensuring Solutions to Alcohol Problems SBI Implementation Guide for Hospitals: https://www.integration.samhsa.gov/clinical-practice/CDC-Screening_and_Brief_Interventions.pdf
8. BNI ART Institute https://www.bu.edu/bniart/

Referral to Treatment

Patients identified as needing more extensive treatment than what can be offered through an SBIRT program, referral to a specialized treatment provider may be necessary. Referral to treatment is an integral component of the SBIRT process and necessitates strong collaboration between the SBIRT team and substance abuse treatment providers in the community. Some useful links to treatment resources are provided below.

1. Florida Alcohol and Drug Abuse Association Treatment locator: https://www.fadaa.org/search/custom.asp?id=4865
2. Buprenorphine Physician/Treatment Locator: https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator
3. SAMHSA Treatment Locator: https://findtreatment.samhsa.gov/

A. WHO - ASSIST V3.0

INTERVIEWER ID		COUNTRY		CLINIC	
PATIENT ID			DATE		

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 ever used? *(NON-MEDICAL USSE 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, Serepax, 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 past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	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 past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	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

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC*) 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	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

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC*)?	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

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 eever 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 ever 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 ever 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** → **Brief Intervention including "risks associated with injecting" card**

More than once a week or **3 or more days in a row** → **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 + Q7cc**

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.

B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card – substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
i. Opioids (heroin, morphine, methadone, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

Once or twice: 1 to 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 days per week.

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

C. ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS

Name _____ Test Date _____

Specific Substance Involvement Scores

Substance	Score	Risk Level	
a. Tobacco products		0-3 4-26 27+	Low Moderate High
b. Alcoholic beverages		0-3 4-26 27+	Low Moderate High
c. Cannabis		0-3 4-26 27+	Low Moderate High
d. Cocaine		0-3 4-26 27+	Low Moderate High
e. Amphetamine type stimulants		0-3 4-26 27+	Low Moderate High
f. Inhalants		0-3 4-26 27+	Low Moderate High
g. Sedatives or Sleeping Pills		0-3 4-26 27+	Low Moderate High
h. Hallucinogens		0-3 4-26 27+	Low Moderate High
i. Opioids		0-3 4-26 27+	Low Moderate High
j. Other - specify:		0-3 4-26 27+	Low Moderate High

What do your scores mean?

Low:	You are at low risk of health and other problems from your current pattern of use.
Moderate:	You are at risk of health and other problems from your current pattern of substance use.
High:	You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent

Are you concerned about your substance use?

a. tobacco	Your risk of experiencing these harms is:……. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular tobacco smoking is associated with:**
	Premature aging, wrinkling of the skin
	Respiratory infections and asthma
	High blood pressure, diabetes
	Respiratory infections, allergies and asthma in children of smokers
	Miscarriage, premature labour and low birth weight babies for pregnant women
	Kidney disease
	Chronic obstructive airways disease
	Heart disease, stroke, vascular disease
	Cancers

b. alcohol	Your risk of experiencing these harms is:……. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular excessive alcohol use is associated with:**
	Hangovers, aggressive and violent behaviour, accidents and injury
	Reduced sexual performance, premature ageing
	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
	Anxiety and depression, relationship difficulties, financial and work problems
	Difficulty remembering things and solving problems
	Deformities and brain damage in babies of pregnant women
	Stroke, permanent brain injury, muscle and nerve damage
	Liver disease, pancreas disease
	Cancers, suicide

c. cannabis	Your risk of experiencing these harms is:……. **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of cannabis is associated with:**
	Problems with attention and motivation
	Anxiety, paranoia, panic, depression
	Decreased memory and problem solving ability
	High blood pressure
	Asthma, bronchitis
	Psychosis in those with a personal or family history of schizophrenia
	Heart disease and chronic obstructive airways disease
	Cancers

d. cocaine	Your risk of experiencing these harms is:.... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of cocaine is associated with:**
	Difficulty sleeping, heart racing, headaches, weight loss
	Numbness, tingling, clammy skin, skin scratching or picking
	Accidents and injury, financial problems
	Irrational thoughts
	Mood swings - anxiety, depression, mania
	Aggression and paranoia
	Intense craving, stress from the lifestyle
	Psychosis after repeated use of high doses
	Sudden death from heart problems

e. amphetamine type stimulants	Your risk of experiencing these harms is:..... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of amphetamine type stimulants is associated with:**
	Difficulty sleeping, loss of appetite and weight loss, dehydration
	jaw clenching, headaches, muscle pain
	Mood swings –anxiety, depression, agitation, mania, panic, paranoia
	Tremors, irregular heartbeat, shortness of breath
	Aggressive and violent behaviour
	Psychosis after repeated use of high doses
	Permanent damage to brain cells
	Liver damage, brain haemorrhage, sudden death (ecstasy) in rare situations

f. inhalants	Your risk of experiencing these harms is:..... **Low** ☐ **Moderate** ☐ **High** ☐ (tick one) **Regular use of inhalants is associated with:**
	Dizziness and hallucinations, drowsiness, disorientation, blurred vision
	Flu like symptoms, sinusitis, nosebleeds
	Indigestion, stomach ulcers
	Accidents and injury
	Memory loss, confusion, depression, aggression
	Coordination difficulties, slowed reactions, hypoxia
	Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)
	Death from heart failure

g. sedatives	Your risk of experiencing these harms is: Low ☐ Moderate ☐ High ☐ (tick one)
	Regular use of sedatives is associated with:
	Drowsiness, dizziness and confusion
	Difficulty concentrating and remembering things
	Nausea, headaches, unsteady gait
	Sleeping problems
	Anxiety and depression
	Tolerance and dependence after a short period of use.
	Severe withdrawal symptoms
	Overdose and death if used with alcohol, opioids or other depressant drugs.

h. hallucinogens	Your risk of experiencing these harms is:……. Low ☐ Moderate ☐ High ☐ (tick one)
	Regular use of hallucinogens is associated with:
	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory
	Difficulty sleeping
	Nausea and vomiting
	Increased heart rate and blood pressure
	Mood swings
	Anxiety, panic, paranoia
	Flash-backs
	Increase the effects of mental illnesses such as schizophrenia

i. opioids	Your risk of experiencing these harms is: Low ☐ Moderate ☐ High ☐ (tick one)
	Regular use of opioids is associated with:
	Itching, nausea and vomiting
	Drowsiness
	Constipation, tooth decay
	Difficulty concentrating and remembering things
	Reduced sexual desire and sexual performance
	Relationship difficulties
	Financial and work problems, violations of law
	Tolerance and dependence, withdrawal symptoms
	Overdose and death from respiratory failure

D. RISKS OF INJECTING CARD – INFORMATION FOR PATIENTS

Using substances by injection increases the risk of harm from substance use.

This harm can come from:

- **The substance**
  - If you inject any drug you are more likely to become dependent.
  - If you inject amphetamines or cocaine you are more likely to experience psychosis.
  - If you inject heroin or other sedatives you are more likely to overdose.
- **The injecting behavior**
  - If you inject you may damage your skin and veins and get infections.
  - You may cause scars, bruises, swelling, abscesses and ulcers.
  - Your veins might collapse.
  - If you inject into the neck you can cause a stroke.
- **Sharing of injecting equipment**
  - If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

❖ **It is safer not to inject**

❖ **If you do inject:**

- ✓ always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
- ✓ always use a new needle and syringe
- ✓ don't share equipment with other people
- ✓ clean the preparation area
- ✓ clean your hands
- ✓ clean the injecting site
- ✓ use a different injecting site each time
- ✓ inject slowly
- ✓ put your used needle and syringe in a hard container and dispose of it safely

❖ **If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis.**

- ✓ avoid injecting and smoking
- ✓ avoid using on a daily basis

❖ **If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose.**

- ✓ avoid using other drugs, especially sedatives or alcohol, on the same day
- ✓ use a small amount and always have a trial "taste" of a new batch
- ✓ have someone with you when you are using
- ✓ void injecting in places where no-one can get to you if you do overdose
- ✓ know the telephone numbers of the ambulance service

E. TRANSLATION AND ADAPTATION TO LOCAL LANGUAGES AND CULTURE: A RESOURCE FOR CLINICIANS AND RESEARCHERS

The ASSIST instrument, instructions, drug cards, response scales and resource manuals may need to be translated into local languages for use in particular countries or regions. Translation from English should be as direct as possible to maintain the integrity of the tools and documents. However, in some cultural settings and linguistic groups, aspects of the ASSIST and it's companion documents may not be able to be translated literally and there may be socio-cultural factors that will need to be taken into account in addition to semantic meaning. In particular, substance names may require adaptation to conform to local conditions, and it is also worth noting that the definition of a standard drink may vary from country to country.

Translation should be undertaken by a bi-lingual translator, preferably a health professional with experience in interviewing. For the ASSIST instrument itself, translations should be reviewed by a bi-lingual expert panel to ensure that the instrument is not ambiguous. Back translation into English should then be carried out by another independent translator whose main language is English to ensure that no meaning has been lost in the translation. This strict translation procedure is critical for the ASSIST instrument to ensure that comparable information is obtained wherever the ASSIST is used across the world.

Translation of this manual and companion documents may also be undertaken if required. These do not need to undergo the full procedure described above, but should include an expert bi-lingual panel.

Before attempting to translate the ASSIST and related documents into other languages, interested individuals should consult with the WHO about the procedures to be followed and the availability of other translations. Write to the Department of Mental Health and Substance Dependence, World Health Organization, 1211 Geneva 27, Switzerland.

SAMHSA

Opioid Overdose TOOLKIT:

Information for Prescribers

TABLE OF CONTENTS

Also see the other components of this Toolkit:

INFORMATION FOR PRESCRIBERS

Opioid overdose is a major public health problem, accounting for almost 17,000 deaths a year in the United States [1]. Overdose involves both males and females of all ages, ethnicities, and demographic and economic characteristics, and involves both illicit opioids such as heroin and, increasingly, prescription opioid analgesics such as oxycodone, hydrocodone, fentanyl and methadone [2].

Physicians and other health care providers can make a major contribution toward reducing the toll of opioid overdose through the care they take in prescribing opioid analgesics and monitoring patients' response, as well as their acuity in identifying and effectively addressing opioid overdose. Federally funded CME courses are available at no charge at www.OpioidPrescribing.com (five courses funded by the Substance Abuse and Mental Health Services Administration) and on MedScape (two courses funded by the National Institute on Drug Abuse).

OPIOID OVERDOSE

The risk of opioid overdose can be minimized through adherence to the following clinical practices, which are supported by a considerable body of evidence [3-6].

ASSESS THE PATIENT. Obtaining a history of the patient's past use of drugs (either illicit drugs or prescribed medications with abuse potential) is an essential first step in appropriate prescribing. Such a history should include very specific questions. For example:

- In the past 6 months, have you taken any medications to help you calm down, keep from getting nervous or upset, raise your spirits, make you feel better, and the like?
- Have you been taking any medications to help you sleep? Have you been using alcohol for this purpose?
- Have you ever taken a medication to help you with a drug or alcohol problem?
- Have you ever taken a medication for a nervous stomach?
- Have you taken a medication to give you more energy or to cut down on your appetite?

The patient history also should include questions about use of alcohol and over-the-counter (OTC) preparations. For example, the ingredients in many common cold preparations include alcohol and other central nervous system (CNS) depressants, so these products should not be used in combination with opioid analgesics.

Positive answers to any of these questions warrant furtherinvestigation.

TAKE SPECIAL PRECAUTIONS WITH NEW PATIENTS. Many experts recommend that additional precautions be taken in prescribing for new patients [5,6]. These might involve the following:

1. **Assessment:** In addition to the patient history and examination, the physician should determine who has been caring for the patient in the past, what medications have been prescribed and for what indications, and what substances (including alcohol, illicit drugs and OTC products) the patient has reported using. Medical records should be obtained (with the patient's consent).
2. **Emergencies:** In emergency situations, the physician should prescribe the smallest possible quantity, typically not exceeding a 3 days' supply of an opioid analgesic and arrange for a return visit the next day. At a minimum, the patient's identity should be verified by asking for proper identification.
3. **Limit quantities:** In non-emergency situations, only enough of an opioid analgesic should be prescribed to meet the patient's needs until the next appointment. The patient should be directed to *return to the office* for additional prescriptions, as telephone orders do not allow the physician to reassess the patient's continued need for the medication.

INFORMATION FOR PRESCRIBERS

STATE PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs) have emerged as a key strategy for addressing the misuse and abuse of prescription opioids and thus preventing opioid overdoses and deaths. Specifically, prescribers can check their state's PDMP database to determine whether a patient is filling the prescriptions provided and/or obtaining prescriptions for the same or similar drug from multiple physicians.

While many states now have operational PDMPs, the programs differ from state to state in terms of the exact information collected, how soon that information is available to physicians, and who may access the data. Therefore, information about the program in a particular state is best obtained directly from the PDMP or from the state board of medicine or pharmacy.

SELECT AN APPROPRIATE MEDICATION. Rational drug therapy demands that the efficacy and safety of all potentially useful medications be reviewed for their relevance to the patient's disease or disorder [3,6].

When an appropriate medication has been selected, the *dose*, *schedule*, and *formulation* should be determined. These choices often are just as important in optimizing pharmacotherapy as the choice of medication itself. Decisions involve (1) dose (based not only on age and weight of the patient, but also on severity of the disorder, possible loading-dose requirement, and the presence of potentially interacting drugs); (2) timing of administration (such as a bedtime dose to minimize problems associated with sedative or respiratory depressant effects); (3) route of administration (chosen to improve compliance/adherence as well as to attain peak drug concentrations rapidly); and (4) formulation (e.g., selecting a patch in preference to a tablet, or an extended-release product rather than an immediate-release formulation).

Additional safeguards are recommended before prescribing an opioid analgesic. For example, even when sound medical indications have been established, physicians typically consider three additional factors before deciding to prescribe [3,6]:

1. The **severity of symptoms**, in terms of the patient's ability to accommodate them. Relief of symptoms is a legitimate goal of medical practice, but using opioid analgesics requires caution.
2. The patient's **reliability in taking medications**, noted through observation and careful history-taking. The physician should assess a patient's history of and risk factors for drug abuse before prescribing any psychoactive drug and weigh the benefits against the risks. The likely development of physical dependence in patients on long-term opioid therapy should be monitored through periodic check-ups.
3. The **dependence-producing potential of the medication**. The physician should consider whether a product with less potential for abuse, or even a non-drug therapy, would provide equivalent benefits. Patients should be warned about possible adverse effects caused by interactions between opioids and other medications or illicit substances, including alcohol.

At the time a drug is prescribed, patients should be informed that it is illegal to sell, give away, or otherwise share their medication with others, including family members. The patient's obligation extends to keeping the medication in a locked cabinet or otherwise restricting access to it and to safely disposing of any unused supply (visit http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm for advice from the FDA on how to safely dispose of unused medications).

EDUCATE THE PATIENT AND OBTAIN INFORMED CONSENT. Obtaining informed consent involves informing the patient about the risks and benefits of the proposed therapy and of the ethical and legal obligations such therapy imposes on both the physician and patient [6]. Such informed consent can serve multiple purposes: (1) it provides the patient with information about the risks and benefits of opioid therapy; (2) it fosters adherence to the treatment plan; (3) it limits the potential for inadvertent drug misuse; and (4) it improves the efficacy of the treatment program.

Patient education and informed consent should specifically address the potential for physical dependence and cognitive impairment as side effects associated with

opioid analgesics. Other issues that should be addressed in the informed consent or treatment agreement include the following [6]:

- The agreement instructs the patient to stop taking all other pain medications, unless explicitly told to continue by the physician. Such a statement reinforces the need to adhere to a single treatment regimen.
- The patient agrees to obtain the prescribed medication from only one physician and, if possible, from one designated pharmacy.
- The patient agrees to take the medication only as prescribed (for some patients, it may be possible to offer latitude to adjust the dose as symptoms dictate).
- The agreement makes it clear that the patient is responsible for safeguarding the written prescription and the supply of medications, and arranging refills during regular office hours. This responsibility includes planning ahead so as not to run out of medication during weekends or vacation periods.
- The agreement specifies the consequences for failing to adhere to the treatment plan, which may include weaning and discontinuation of opioid therapy if the patient's actions compromise his or her safety.

Both patient and physician should sign the informed consent agreement, and a copy should be placed in the patient's medical record. It also is helpful to give the patient a copy of the agreement to carry with him or her, to document the source and reason for any controlled drugs in his or her possession. Some physicians provide a laminated card that identifies the individual as a patient of their practice. This is helpful to other physicians who may see the patient and in the event the patient is seen in an emergency department.

EXECUTE THE PRESCRIPTION ORDER. Careful execution of the prescription order can prevent manipulation by the patient or others intent on obtaining opioids for non-medical purposes. For example, federal law requires that prescription orders for controlled substances be signed and dated on the day they are issued. Also under federal law, every prescription order must include at least the following information:

Name and address of the patient
Name, address and DEA registration number of the physician
Signature of the physician
Name and quantity of the drug prescribed
Directions for use
Refill information
Effective date if other than the date on which the prescription was written

Many states impose additional requirements, which the physician can determine by consulting the state medical licensing board. In addition, there are special federal requirements for drugs in different schedules of the federal Controlled Substances Act (CSA), particularly those in Schedule II, where many opioid analgesics are classified.

Blank prescription pads, as well as information such as the names of physicians who recently retired, left the state, or died all can be used to forge prescriptions. Therefore, it is a sound practice to store blank prescriptions in a secure place rather than leaving them in examining rooms.

NOTE: The physician should immediately report the theft or loss of prescription blanks to the nearest field office of the federal Drug Enforcement Administration and to the state board of medicine or pharmacy.

MONITOR THE PATIENT'S RESPONSE TO TREATMENT. Proper prescription practices do not end when the patient receives a prescription. Plans to monitor for drug efficacy and safety, compliance, and potential development of tolerance must be documented and clearly communicated to the patient [3].

Subjective symptoms are important in monitoring, as are objective clinical signs (such as body weight, pulse rate, temperature, blood pressure, and levels of drug metabolites in the bloodstream). These can serve as early signs of therapeutic failure or unacceptable adverse drug reactions that require modification of the treatment plan.

Asking the patient to keep a log of signs and symptoms gives him or her a sense of participation in the treatment

program and facilitates the physician's review of therapeutic progress and adverse events.

Simply recognizing the potential for non-adherence, especially during prolonged treatment, is a significant step toward improving medication use [7]. Steps such as simplifying the drug regimen and offering patient education also improve adherence, as do phone calls to patients, home visits by nursing personnel, convenient packaging of medication, and periodic urine testing for the prescribed opioid as well as any other respiratory depressant.

Finally, the physician should convey to the patient through attitude and manner that any medication, no matter how helpful, is only part of an overall treatment plan.

When the physician is concerned about the behavior or clinical progress (or the lack thereof) of a patient being treated with an opioid analgesic, it usually is advisable to seek a consultation with an expert in the disorder for which the patient is being treated *and* an expert in addiction. Physicians place themselves at risk if they continue to prescribing opioids in the absence of such consultations [6].

CONSIDER PRESCRIBING NALOXONE ALONG WITH THE PATIENT'S INITIAL OPIOID PRESCRIPTION. With proper education, patients on long-term opioid therapy and others at risk for overdose may benefit from having a naloxone kit to use in the event of overdose [8].

Patients who are candidates for such kits include those who are:

- Taking high doses of opioids for long-term management of chronic malignant or non-malignant pain.
- Receiving rotating opioid medication regimens (and thus at risk for incomplete cross-tolerance).
- Discharged from emergency medical care following opioid intoxication or poisoning.
- At high risk for overdose because of a legitimate medical need for analgesia, coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids.
- Completing mandatory opioid detoxification or abstinence programs.
- Recently released from incarceration and a past user or abuser of opioids (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).

It also may be advisable to suggest that the at-risk patient create an "overdose plan" to share with friends, partners and/or caregivers. Such a plan would contain information on the signs of overdose and how to administer naloxone or otherwise provide emergency care (as by calling 911).

DECIDE WHETHER AND WHEN TO END OPIOID THERAPY. Certain situations may warrant immediate cessation of prescribing. These generally occur when out-of-control behaviors indicate that continued prescribing is unsafe or causing harm to the patient [3]. Examples include altering or selling prescriptions, accidental or intentional overdose, multiple episodes of running out early (due to excessive use), doctor shopping, or threatening behavior.

When such events arise, it is important to separate the patient as a person from the behaviors caused by the disease of addiction, as by demonstrating a positive regard for the person but no tolerance for the aberrant behaviors.

The essential steps are to (1) stop prescribing, (2) tell the patient that continued prescribing is not clinically supportable (and thus not possible), (3) urge the patient to accept a referral for assessment by an addiction specialist, (4) educate the patient about signs and symptoms of spontaneous withdrawal and urge the patient to go to the emergency department if symptoms occur, and (5) assure the patient that he or she will continue to receive care for the presenting symptoms or condition [6].

Identification of a patient who is abusing a prescribed controlled drug presents a major therapeutic opportunity. The physician should have a plan for managing such a patient, typically involving work with the patient and the patient's family, referral to an addiction expert for assessment and placement in a formal addiction treatment program, long-term participation in a 12-Step mutual help program such as Narcotics Anonymous, and follow-up of any associated medical or psychiatric comorbidities [3].

In all cases, patients should be given the benefit of the physician's concern and attention. It is important to remember that even drug-seeking patients often have very real medical problems that demand and deserve the same high-quality medical care offered to any patient [3,6].

TREATING OPIOID OVERDOSE

In the time it takes for an overdose to become fatal, it is possible to reverse the respiratory depression and other effects of opioids through respiratory support and administration of the opioid antagonist naloxone (Narcan) [9]. Naloxone is approved by the FDA and has been used for decades to reverse overdose and resuscitate individuals who have overdosed on opioids.

The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect [8,9]. If given to individuals who are not opioid-intoxicated or opioid-dependent, naloxone produces no clinical effects, even at high doses. Moreover, while rapid opioid withdrawal in tolerant patients may be unpleasant, it is not typically life-threatening.

Naloxone should be part of an overall approach to opioid overdose that incorporates the following steps.

RECOGNIZE THE SIGNS OF OVERDOSE. An opioid overdose requires rapid diagnosis. The most common signs of overdose include [3]:

- Pale and clammy face
- Limp body
- Fingernails or lips turning blue/purple
- Vomiting or gurgling noises
- Cannot be awakened from sleep or is unable to speak
- Very little or no breathing
- Very slow or no heartbeat

Signs of **OVERMEDICATION**, which may progress to overdose, include [3]:

- Unusual sleepiness or drowsiness
- Mental confusion, slurred speech, intoxicated behavior
- Slow or shallow breathing
- Pinpoint pupils
- Slow heartbeat, low blood pressure
- Difficulty waking the individual from sleep

Because opioids depress respiratory function and breathing, one telltale sign of an individual in a critical medical state is the "death rattle." Often mistaken for snoring, the "death rattle" is an exhaled breath with a very distinct, labored sound coming from the throat. It indicates that emergency resuscitation is needed immediately [8].

SUPPORT RESPIRATION. Supporting respiration is the single most important intervention for opioid overdose and may be life-saving on its own. Ideally, individuals who are experiencing opioid overdose should be ventilated with 100% oxygen before naloxone is administered to reduce the risk of acute lung injury [3, 8]. In situations where 100% oxygen is not available, rescue breathing can be very effective in supporting respiration [8]. Rescue breathing involves the following steps:

- Verify that the airway is clear.
- With one hand on the patient's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the patient's mouth to make a seal and give 2 slow breaths (the patient's chest should rise, but not the stomach).
- Follow up with one breath every 5 seconds.

INFORMATION FOR PRESCRIBERS

ADMINISTER NALOXONE. Naloxone (Narcan) should be given to any patient who presents with signs of opioid overdose, or when overdose is suspected [8]. Naloxone can be given by intramuscular or intravenous injection every 2 to 3 minutes [8-10].

The most rapid onset of action is achieved by intravenous administration, which is recommended in emergency situations [9]. Intravenous administration generally is used with patients who have no history of opioid dependence. Opioid-naive patients may be given starting doses of up to 2 mg without concern for triggering withdrawal symptoms [8].

The intramuscular route of administration may be more suitable for patients with a history of opioid dependence because it provides a slower onset of action and a prolonged duration of effect, which may minimize rapid onset of withdrawal symptoms [8].

Pregnant patients. Naloxone can safely be used to manage opioid overdose in pregnant women. The lowest dose to maintain spontaneous respiratory drive should be used to avoid triggering acute opioid withdrawal, which may cause fetal distress [8].

MONITOR THE PATIENT'S RESPONSE. Patients should be monitored for re-emergence of signs and symptoms of opioid toxicity for at least 4 hours following the last dose of naloxone (however, patients who have overdosed on long-acting opioids require more prolonged monitoring) [8].

Most patients respond to naloxone by returning to spontaneous breathing, with mild withdrawal symptoms [8]. The response generally occurs within 3 to 5 minutes of naloxone administration. (Rescue breathing should continue while waiting for the naloxone to take effect.)

The duration of effect of naloxone is 30 to 90 minutes. Patients should be observed after that time for re-emergence of overdose symptoms. The goal of naloxone therapy should be restoration of adequate spontaneous breathing, but not necessarily complete arousal [8-10].

More than one dose of naloxone may be required to revive the patient. Those who have taken longer-acting opioids may require further intravenous bolus doses or an infusion of naloxone [8]. Therefore, it is essential to get the person to an emergency department or other source of acute care as quickly as possible, even if he or she revives after the initial dose of naloxone and seems to feel better.

SIGNS OF OPIOID WITHDRAWAL: Withdrawal triggered by naloxone can feel unpleasant. As a result, some persons become agitated or combative when this happens and need help to remain calm.

The signs and symptoms of opioid withdrawal in an individual who is physically dependent on opioids may include, but are not limited to, the following: body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure [9]. Withdrawal syndromes may be precipitated by as little as 0.05 to 0.2 mg intravenous naloxone in a patient taking 24 mg per day of methadone.

In neonates, opioid withdrawal also may produce convulsions, excessive crying, and hyperactive reflexes [9].

NALOXONE-RESISTANT PATIENTS: If a patient does not respond to naloxone, an alternative explanation for the clinical symptoms should be considered. The most likely explanation is that the person is not overdosing on an opioid but rather some other substance or may even be experiencing a non-overdose medical emergency. A possible explanation to consider is whether the individual has overdosed on buprenorphine, a long-acting opioid partial agonist. Because buprenorphine has a higher affinity for the opioid receptors than do other opioids, naloxone may not be effective at reversing the effects of buprenorphine-induced opioid overdose [8].

In all cases, support of ventilation, oxygenation, and blood pressure should be sufficient to prevent the complications of opioid overdose and should be given the highest priority if the patient's response to naloxone is not prompt.

NOTE: All naloxone products have an expiration date. It is important to check the expiration date and obtain replacement naloxone as needed.

INFORMATION FOR PRESCRIBERS

LEGAL AND LIABILITY CONSIDERATIONS

Health care professionals who are concerned about legal risks associated with prescribing naloxone may be reassured by the fact that prescribing naloxone to manage opioid overdose is consistent with the drug's FDA-approved indication, resulting in no increased liability so long as the prescriber adheres to general rules of professional conduct. State laws and regulations generally prohibit physicians from prescribing a drug such as naloxone to a third party, such as a caregiver. (Illinois, Massachusetts, New York, and Washington State are the exceptions to this general principle.) More information on state policies is available at www.prescribetoprevent.org/ or from individual state medical boards.

CLAIMS CODING AND BILLING

Most private health insurance plans, Medicare, and Medicaid cover naloxone for the treatment of opioid overdose, but policies vary by state. The cost of take-home naloxone should not be a prohibitive factor. Not all community pharmacies stock naloxone routinely but can always order it. If you are caring for a large patient population likely to benefit from naloxone you may wish to notify the pharmacy when you implement naloxone prescribing as a routine practice.

The codes for Screening, Brief Intervention, and Referral to Treatment (SBIRT) can be used to bill time for counseling a patient about how to recognize overdose and how to administer naloxone. Billing codes for SBIRT are as follows:

Commercial Insurance: CPT 99408 (15 to 30 minutes)

Medicare: G0396 (15 to 30 minutes)

Medicaid: H0050 (per 15 minutes)

RESOURCES FOR PRESCRIBERS

Additional information on prescribing opioids for chronic pain is available at the following websites:

www.opioidprescribing.com. Sponsored by the Boston University School of Medicine, with support from SAMHSA, this site presents course modules on various aspects of prescribing opioids for chronic pain. To view the list of courses and to register, go to http://www.opioidprescribing.com/overview. CME credits are available at no charge.

www.pcss-o.org or www.pcssb.org. Sponsored by the American Academy of Addiction Psychiatry in collaboration with other specialty societies and with support from SAMHSA, the Prescriber's Clinical Support System offers multiple resources related to opioid prescribing and the diagnosis and management of opioid use disorders.

www.medscape.com. Two course modules sponsored by the National Institute on Drug Abuse and posted on MedScape can be accessed at http://www.medscape.org/viewarticle/770687 and http://www.medscape.org/viewarticle/770440. CME credits are available.

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Assessment and Diagnosis of Attention-Deficit/Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is defined by a persistent pattern of inattention (for example, difficulty keeping focus) and/or hyperactivity---impulsivity (for example, difficulty controlling behavior, excessive and inappropriate motor activity). Children with ADHD have difficulty performing well in school, interacting with other children, and following through on tasks. There are three sub---types of the disorder:

- Predominantly hyperactive/impulsive
- Predominantly inattentive
- Combined hyperactive/inattentive

The three overarching features of ADHD include inattention, hyperactivity, and impulsivity. Inattentive children may have trouble paying close attention to details, make careless mistakes in schoolwork, are easily distracted, have difficulty following through on tasks, such as homework assignments, or quickly become bored with a task. Hyperactivity may be defined by fidgeting or squirming, excessive talking, running about, or difficulty sitting still. Finally, impulsive children may be impatient, may blurt out answers to questions prematurely, have trouble waiting their turn, may frequently interrupt conversations, or intrude on others' activities.

The following clinical practice guidelines may be helpful in the assessment, diagnosis and treatment of ADHD:

- **American Academy of Pediatrics.** Clinical Practice Guideline: ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention---Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics 2011 Oct; 128:5 1007---1022; doi:10.1542/peds.2011---2654.
- https://pediatrics.aappublications.org/content/128/5/1007.full

American Academy of Pediatrics & American Academy of Child and Adolescent Psychiatry
Summary of Guidelines for ADHD: Diagnosis, Evaluation and Treatment

A. Consider Diagnosis in Patients who are:

Any child age 4-18 experiencing symptoms including the following which substantially interfere with healthy functioning and quality of life at home and school:

- Inattention
- Hyperactivity
- Impulsivity

B. Establishing Diagnostic Criteria:

Symptom criteria information should be obtained from parents and include information from teachers, caregivers and any school mental health clinicians, caregivers or other health providers regarding the child's behavior. Physicians should use the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to review criteria and conduct differential diagnosis. Helpful tools in pinpointing criteria are evidence-based behavior-rating scales.

Psychological and neuropsychological tests are not mandatory for the diagnosis of ADHD but should be performed if the patient's history suggests low general cognitive ability or low achievement in language or mathematics relative to the patient's intellectual ability. (AACAP, 2007)

Sources of Information for Diagnosis:

- Parent informant who has gathered information from teachers, school professionals, other health providers and caregivers.
- DSM-5
- Behavior-rating scales:
    a. Vanderbilt Assessment Scale (©2002 American Academy of Pediatrics and National Initiative for Children's Healthcare Quality)
        - https://chadd.org/for-professionals/clinical-practice-tools-quick-links/
        - Samples of parent and teacher scales provided at the end of this chapter
    b. Disruptive Behavior Disorder Rating Scale (RS-DBD)
        - https://www.nichq.org/sites/default/files/resource-file/NICHQ_Vanderbilt_Assessment_Scales.pdf
        - Sample of rating scale provided at the end of this chapter
    c. Conners 3 ADHD Index (Conners 3AI)
        - https://ecom.mhs.com/(S(hrenkp5520h10m55sddhd5zf))/product.aspx?gr=edu&prod=conners3ai&id=overview

C. Differential Diagnosis and Co-Morbid Disorders

As stated, physicians should work with a parent or guardian informant and use the DSM-5 to establish criteria and conduct differential diagnosis. Physicians must establish whether there are also criteria for co-morbid disorders. Differential diagnosis and co-morbid disorders to check for include:

- Anxiety
- Depression
- Oppositional---Defiant Disorder
- Conduct Disorder
- Learning Disorder
- Language Disorder
- Other Neurodevelopmental Disorder
- Physical disorders such as sleep apnea and tics
-

D. Age-Specific Treatment Summaries

1. Preschool-Age (4-5 years of age):

Evidence-based parent and/or teacher administered behavior interventions are the first line of treatment. Methylphenidate may be prescribed if these interventions are not followed by behavioral improvement or if the behavior continues to affect the child's functioning and quality of life at a moderate to severe level. If such interventions are not possible at the level of home and school, physicians contemplating prescribing medication must consider the risks of starting medication in a developing child against the risks of not treating.

2. Elementary and School-Age (6-11 years of age):

Prescribe US Food and Drug Administration-approved medication for ADHD AND/OR evidence-based interventions enacted by parents, teachers or both parents and teachers. The preferred treatment is BOTH medication AND evidence-based interventions enacted by parents AND teachers.

AAP ADHD CPG, 2011: "The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended---release clonidine (in that order)." (2011)

3. For Adolescents (12-18 years of age):

Physicians should prescribe Food and Drug-approved medications for ADHD with the assent of the adolescent. Behavior therapy may be prescribed involving evidence-based treatments enacted by parents, teachers or both. The preferred treatment is BOTH medication AND evidence-based interventions enacted by parents AND teachers. AAP ADHD CPG, 2011: "The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects."

E. Referral to a Specialist

The AAP acknowledges that some primary care clinicians might not be confident of their ability to successfully diagnose and treat ADHD in a child because of the child's age, coexisting conditions, or other concerns. At any point at which a clinician feels that he or she is not adequately trained or is uncertain about making a diagnosis or continuing with treatment, a referral to a pediatric or mental health subspecialist should be made.

DSM-5 Diagnostic Criteria

Complete diagnostic criteria for ADHD can be found under *Neurodevelopmental Disorders* in the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Attention-Deficit/Hyperactivity Disorder – 314.0x/F90.x (adapted from DSM-5)

Patients with ADHD show a persistent pattern of inattention and/or hyperactivity---impulsivity that interferes with functioning or development:

1. Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:
    - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
    - Often has trouble holding attention on tasks or play activities.
    - Often does not seem to listen when spoken to directly.
    - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side---tracked).
    - Often has trouble organizing tasks and activities.
    - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
    - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
    - Is often easily distracted
    - Is often forgetful in daily activities.

2. Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:
    - Often fidgets with or taps hands or feet, or squirms in seat.
    - Often leaves seat in situations when remaining seated is expected.
    - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
    - Often unable to play or take part in leisure activities quietly.
    - Is often "on the go" acting as if "driven by a motor".
    - Often talks excessively.
    - Often blurts out an answer before a question has been completed.
    - Often has trouble waiting his/her turn.
    - Often interrupts or intrudes on others (e.g., butts into conversations or games)

In addition, the following conditions must be met:

- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Educating Parents on Myths and Facts about ADHD

Knowing some of the myths parents often hear or believe can help physicians provide high---touch, quality care. Primary care providers can meet the myths with facts and provide parents the comfort and confidence of having correct information. The next section covers some of the most common myths and the facts to correct them.

ADHD is frequently discussed condition among parents, teachers and the community. The media, neighbors, friends and other outside influences can affect how parents interact with providers as they contemplate treatment about their child's behavior. This tool can help strengthen communication with parents in the exam room.

- *My child is too young to have ADHD*

  Signs and symptoms of ADHD can occur as early as the preschool years. Impulsive and active behavior can be normal characteristics in a young child, but it is important for a provider to evaluate these symptoms and ensure that they are not interfering with the child's life, development, self---esteem and general functioning

- *ADHD isn't a real medical condition.*

  ADHD is recognized as a medical condition by the Centers for Disease Control and Prevention, American Psychiatric Associate and American Academy of Pediatrics. It is important to treat it timely because it can impact a child's everyday life.

- *All children are active and just lose focus sometimes.*

  It is normal for children to act impulsive and inattentive sometimes. However, in a child with ADHD it can be extreme and impede day---to---day activity, as well as affect a child's ability to control activity or impulses. It is important to differentiate the functional disability from normal activity.

- *All children diagnosed with ADHD are hyperactive.*

  While hyperactivity is a common sign, a child can have ADHD without being hyperactive. Types of ADHD include: 1. Predominantly Inattentive – When he/she finds it hard to pay attention to detail or instructions. He/she easily forgets and gets distracted.

  2. Predominantly hyperactive---impulsive – When he/she fidgets a lot or can't sit still. He or she has a hard time waiting for his or her turn. It is also hard to listen to directions.
  3. Combined --- When he/she has symptoms of both Inattentive and Hyperactive---Impulsive.

- *ADHD is a result of poor parenting.*

  Raising a child with ADHD can be a challenge, but parental style does not cause a child to develop ADHD. However, a stressful home environment or inconsistent parenting practices can aggravate ADHD behaviors. It is important to maintain a clear set of limits and expectations to help reduce ADHD symptoms.

- *Children with ADHD will eventually outgrow the condition.*

  ADHD is a lifelong condition and can continue even through adult years. The symptoms may change as the child grows older but, if managed correctly, he/she can continue to live happy and productive lives.

Tools for Providers to Use in Educating Parents (*American Academy of Pediatrics* and the *National Initiative on Children's Healthcare Quality*)

Knowing What to Tell the Doctor

Parents may wonder what information to give a provider in the short span of time in the exam room. The next series of tools on the following pages, *Does My Child of ADHD?* provide clear answers to parents' questions. It also explains what types of behavior to monitor and who to talk to about their child's behavior prior to a doctor's appointment.

What to Look For with Medication and Behavior after Diagnosis

Behavior monitoring and medication adherence monitoring are an essential part of treating ADHD. A child's behavior and the household schedule can affect medication adherence and treatment outcome. For this reason, it is important for providers to offer parents medication adherence tips. By talking with parents about the child's experience with the medication, adverse side effects or other adherence challenges can be properly addressed. The following tools are provided for use in ongoing monitoring.

Many parents worry about this question. The answer comes from children, families, teachers, and doctors working together as a team. Watching your child's behavior at home and in the community is very important to help answer this question. Your doctor will ask you to fill out rating scales about your child. Watching your child's behavior and talking with other adults in the child's life will be important for filling out the forms.

Here are a few tips about what you can do to help answer the question:

Watch your child closely during activities where he or she should pay attention.

- ☐ Doing homework
- ☐ Doing chores
- ☐ During storytelling or reading

Watch your child when you expect him or her to sit for a while or think before acting.

- ☐ Sitting through a family meal
- ☐ During a religious service
- ☐ Crossing the street
- ☐ Being frustrated
- ☐ With brothers or sisters
- ☐ While you are on the phone

Pay attention to how the environment affects your child's behavior. Make changes at home to improve your child's behavior.

- ☐ Ensure that your child understands what is expected. Speak slowly to your child. Have your child repeat the instructions.
- ☐ Turn off the TV or computer games during meals and homework. Also, close the curtains if it will help your child pay attention to what he or she needs to be doing.
- ☐ Provide structure to home life, such as regular mealtimes and bedtime. Write down the schedule and put it where the entire family can see it. Stick to the schedule.
- ☐ Provide your child with planned breaks during long assignments.
- ☐ Give rewards for paying attention and sitting, not just for getting things right and finishing. Some rewards might be: dessert for sitting through a meal, outdoor play for finishing homework, and praise for talking through problems.
- ☐ Try to find out what things set off problem behaviors. See if you can eliminate the triggers.

If your child spends time in 2 households, compare observations.

- ☐ Consult your child's other parent about behavior in that home. Cooperation between parents in this area really helps the child.
- ☐ If the child behaves differently, consider differences in the environment that may explain the difference in behavior. Differences are common and not a mark of good or bad parenting.

Talk to your child's teacher.

- ☐ Learn about your child's behavior at school. Talk about how your child does during academic lessons and also during play with other children.
- ☐ Compare your child's behavior in subjects he or she likes and those in which he or she has trouble with the work.
- ☐ Determine how the environment at school affects your child's behavior. When does your child perform well? What events trigger problem behaviors?
- ☐ Consider with the teacher whether your child's learning abilities should be evaluated at school. If he or she has poor grades in all subjects or in just a few subjects or requires extra time and effort to learn material, then a learning evaluation may be valuable.

Gather impressions from other adult caregivers who know your child well.

- ☐ Scout leaders or religious instructors who see your child during structured activities and during play with other children
- ☐ Relatives or neighbors who spend time with your child
- ☐ Determine how other environments affect your child's behavior. When does your child perform well? What events trigger problem behaviors?

Make an appointment to see your child's doctor.

- ☐ Let the receptionist know you are concerned that your child might have ADHD.
- ☐ If possible, arrange a visit when both parents can attend.

Adapted from materials by Heidi Feldman, MD, PhD

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General Tips

1. Rules should be clear and brief. Your child should know exactly what you expect from him or her.
2. Give your child chores. This will give him or her a sense of responsibility and boost self-esteem.
3. Short lists of tasks are excellent to help a child remember.
4. Routines are extremely important for children with ADHD. Set up regular times for meals, homework, TV, getting up, and going to bed. Follow through on the schedule!
5. Identify what your child is good at doing (like art, math, computer skills) and build on it.
6. Tell your child that you love and support him or her unconditionally.
7. Catch your child being good and give immediate positive feedback.

Common Daily Problems

It is very hard to get my child ready for school in the morning.

- Create a consistent and predictable schedule for rising and getting ready in the morning.
- Set up a routine so that your child can predict the order of events. Put this routine in writing or in pictures on a poster for your child. Schedule example:

  Alarm goes off → Brush teeth → Wash face → Get dressed → Eat breakfast → Take medication → Get on school bus

- Reward and praise your child! This will motivate your child to succeed. Even if your child does not succeed in all parts of the "morning routine," use praise to reward your child when he or she is successful. Progress is often made in a series of small steps!
- If your child is on medication, try waking your child up 30 to 45 minutes before the usual wake time and give him or her the medication immediately. Then allow your child to "rest" in bed for the next 30 minutes. This rest period will allow the medication to begin working and your child will be better able to participate in the morning routine.

My child is very irritable in the late afternoon/early evening.
(Common side effect of stimulant medications)

- The late afternoon and evening is often a very stressful time for all children in all families because parents and children have had to "hold it all together" at work and at school.
- If your child is on medication, your child may also be experiencing "rebound"—the time when your child's medication is wearing off and ADHD symptoms may reappear.
- Adjust your child's dosing schedule so that the medication is not wearing off during a time of "high demand" (for example, when homework or chores are usually being done).
- Create a period of "downtime" when your child can do calm activities like listen to music, take a bath, read, etc.
- Alternatively, let your child "blow off extra energy and tension" by doing some physical exercise.
- Talk to you child's doctor about giving your child a smaller dose of medication in the late afternoon. This is called a "stepped down" dose and helps a child transition off of medication in the evening.

My child is losing weight or not eating enough.
(Common side effects of stimulant medication use)

- Encourage breakfast with calorie-dense foods.
- Give the morning dose of medication after your child has already eaten breakfast. Afternoon doses should also be given after lunch.
- Provide your child with nutritious after-school and bedtime snacks that are high in protein and in complex carbohydrates. Examples: Nutrition/protein bars, shakes/drinks made with protein powder, liquid meals.
- Get eating started with any highly preferred food before giving other foods.
- Consider shifting dinner to a time later in the evening when your child's medication has worn off. Alternatively, allow your child to "graze" in the evening on healthy snacks, as he or she may be hungriest right before bed.
- Follow your child's height and weight with careful measurements at your child's doctor's office and talk to your child's doctor.

Homework Tips

- Establish a routine and schedule for homework (a specific time and place.) Don't allow your child to wait until the evening to get started.
- Limit distractions in the home during homework hours (reducing unnecessary noise, activity, and phone calls, and turning off the TV).
- Praise and compliment your child when he or she puts forth good effort and completes tasks. In a supportive, noncritical manner, it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- It is not your responsibility to correct all of your child's errors on homework or make him or her complete and turn in a perfect paper.
- Remind your child to do homework and offer incentives: "When you finish your homework, you can watch TV or play a game."
- If your child struggles with reading, help by reading the material together or reading it to your son or daughter.
- Work a certain amount of time and then stop working on homework.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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- Many parents find it very difficult to help their own child with schoolwork. Find someone who can. Consider hiring a tutor! Often a junior or senior high school student is ideal, depending on the need and age of your child.

Discipline

- Be firm. Set rules and keep to them.
- Make sure your child understands the rules, so he or she does not feel uninformed.
- Use positive reinforcement. Praise and reward your child for good behavior.
- Change or rotate rewards frequently to maintain a high interest level.
- Punish behavior, not the child. If your child misbehaves, try alternatives like allowing natural consequences, withdrawing yourself from the conflict, or giving your child a choice.

Taking Care of Yourself

- Come to terms with your child's challenges and strengths.
- Seek support from family and friends or professional help such as counseling or support groups.
- Help other family members recognize and understand ADHD.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

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

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

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

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

Revised - 1102

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

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

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

Comments:

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

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

Total Symptom Score for questions 1–18: _____

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

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

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

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

Average Performance Score: _____

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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

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

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

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

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

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

Revised - 0303

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HE0351

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

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

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

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

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

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

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

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

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

Total Symptom Score for questions 1–18: _____

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

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

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

Average Performance Score: _____

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11-20/rev0303

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

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

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

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

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

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

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

Revised - 0303

American Academy of Pediatrics

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NICHQ

National Initiative for Children's Healthcare Quality

HE0352

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

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

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

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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NICHQ

National Initiative for Children's Healthcare Quality

11-21/rev0303

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

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

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

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

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

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

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

Revised - 0303

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HE0353

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

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

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

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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11-22/rev0303

Scoring Instructions for NICHQ Vanderbilt Assessment Scales

Baseline Assessment

The validation studies for the NICHQ Vanderbilt Assessment Scales were for the 6- to 12-year-old age group. However, to the extent that they collect information to establish *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* criteria, they are applicable to other groups, particularly preschoolers, where they have identified that *DSM-5* criteria are still appropriate.

These scales should *not* be used alone to make a diagnosis of ADHD without confirming and elaborating the information with interviews with at least the primary caregivers (usually parents) and patients. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for inattentive (items 1–9) and hyperactive (items 10–18) attention-deficit/hyperactivity disorder (ADHD).

Scoring for Diagnostic Purposes

To meet *DSM-5* criteria for the diagnosis, one must have at least 6 positive responses to the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment.

The initial scales have symptom screens for 3 other comorbidities: oppositional-defiant disorder, conduct disorder, and anxiety/depression. (The initial teacher scale also screens for learning disabilities.) These are screened by the number of positive responses in each of the segments. The specific item sets and numbers of positives required for each comorbid symptom screen set are detailed below and on the next page.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least 2 items of the performance set in which the child scores a 4, or 1 item of the performance set in which the child scores a 5; ie, there must be impairment, not just symptoms, to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s).

Scoring to Monitor Symptom and Performance Improvement

For the purposes of tracking symptoms and symptom severity, calculate the mean response for each subsegment of the ADHD symptom assessment screen items (inattentive 9 and hyperactive 9). To calculate the mean responses, first total the responses (0s, 1s, 2s, and 3s) from each item within the inattentive subsegment (items 1–9) and divide by the number of items that received a response. For example, if a parent only provided responses to 7 of the first 9 items, the responses would be totaled and divided by 7. Follow the same calculation instructions for the hyperactive subsegment (items 10–18).

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Predominantly Inattentive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
Predominantly Hyperactive/Impulsive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Predominantly Hyperactive/Impulsive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
ADHD Combined Inattention/Hyperactivity ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes	**ADHD Combined Inattention/Hyperactivity** ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes
Oppositional-Defiant Disorder ● Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Oppositional-Defiant/Conduct Disorder** ● Must score a 2 or 3 on 3 out of 10 items on questions 19–28. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
Conduct Disorder ● Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	

Parent Assessment Scale	Teacher Assessment Scale
Anxiety/Depression ● Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48–54.	**Anxiety/Depression** ● Must score a 2 or 3 on 3 out of 7 items on questions 29–35. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36–43.
	Learning Disabilities ● Must score a 4 on both, or 5 on 1, of questions 36 and 38.

Follow-up Assessment

Scoring for Diagnostic Purposes

The parent and teacher follow-up scales have the first 18 core ADHD symptoms and the comorbid symptoms oppositional-defiant (parent) and oppositional-defiant/conduct (teacher) disorders. The Performance section has the same performance items and impairment assessment as the initial scales; it is followed by a side-effect reporting scale that can be used to assess and monitor the presence of adverse reactions to prescribed medications, if any.

Scoring the follow-up scales involves tracking inattentive (items 1–9) and hyperactive (items 10–18) ADHD, as well as the aforementioned comorbidities, as measures of improvement over time with treatment.

Scoring to Monitor Symptom and Performance Improvement

To determine the score for follow-up, calculate the mean response for each of the ADHD subsegments. Compare the mean response from the follow-up inattentive subsegment (items 1–9) to the mean response from the inattentive subsegment that was calculated at baseline assessment. Conduct the same comparison for the mean responses for the hyperactive subsegment (items 10–18) taken at follow-up and baseline.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 27–33.	**Predominantly Inattentive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 1–9. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 29–36.
Predominantly Hyperactive/Impulsive subtype ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 27–33.	**Predominantly Hyperactive/Impulsive subtype** ● Must score a 2 or 3 on 6 out of 9 items on questions 10–18. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 29–36.
ADHD Combined Inattention/Hyperactivity ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes	**ADHD Combined Inattention/Hyperactivity** ● Requires the criteria on Inattentive AND Hyperactive/Impulsive subtypes
Oppositional-Defiant Disorder ● Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 27–33.	**Oppositional-Defiant/Conduct Disorder** ● Must score a 2 or 3 on 3 out of 10 items on questions 19–28. AND ● Score a 4 on at least 2, or 5 on at least 1, of the performance questions 29–36.

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QuIIN Quality Improvement Innovation Network
A program of the American Academy of Pediatrics

NICHQ National Initiative for Children's Healthcare Quality

Parent I Teacher DBD Rating Scale

Child's Name: _____ Form Completed by: _____

Grade: _____ Date of Birth: _____ Sex: _____ Date Completed: _____

Check the column that best describes your/this child. Please write DK next to any items for which you don't know the answer.

	Not at All	Just a Little	Pretty Much	Very Much
1. often interrupts or intrudes on others (e.g., butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
3. often argues with adults				
4. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talks excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)				
9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms in seat				
13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				
20. often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in the neighborhood)				
21. often shifts from one uncompleted activity to another				
22. often has difficulty playing or engaging in leisure activities quietly				
23. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
24. is often angry and resentful				
25. often leaves seat in classroom or in other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				
29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens, or intimidates others				
33. is often "on the go" or often acts as if "driven by a motor"				
34. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age 13 years				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)				
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42. often has difficulty organizing tasks and activities				
43. has broken into someone else's house, building, or car				
44. is often forgetful in daily activities				
45. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)				

SCORING INSTRUCTIONS FOR THE DISRUPTIVE BEHAVIOR DISORDER RATING SCALE

There are two ways to determine if a child meets the criteria for DSM IV diagnoses of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, or Conduct Disorder. The first method involves counting symptoms for each disorder using the Disruptive Behavior Disorders (DBD) rating scale. The second method involves comparing the target child's factor scores on the DBD Rating Scale to established norms. The factor scores method is preferable for diagnosis of females (e.g., using a 2 SD cutoff), as the symptom counting method often results in underdiagnosis of female children. Please note that items 10, 14, and 21 are from DSM-III-R and are not included in the scoring for a DSM-IV diagnosis.

Method 1: Counting Symptoms

To determine if a child meets the symptom criteria for DSM IV diagnoses of Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, or Conduct Disorder as measured by the DBD Parent / Teacher Rating Scale, count the number of symptoms that are endorsed "pretty much" or "very much" by either parent or teacher in each of the following categories: Note that impairment and other criteria must be evaluated in addition to symptom counts.

Attention-Deficit/Hyperactivity Disorder

_____ Attention-Deficit/Hyperactivity Disorder - Inattention Symptoms
(items 9, 18, 23, 27, 29, 34, 37, 42, 44)

6 or more items must be endorsed as "pretty much" or "very much" to meet criteria for **Attention-DeficitlHyperactivity Disorder, Predominantly Inattentive Type.** The six items may be endorsed on the teacher DBD, the parent DBD, or can be a combination of items from both rating scales (e.g., 4 symptoms endorsed on the teacher DBD and 2 separate symptoms endorsed on the parent DBD). The same symptom should **not** be counted twice if it appears on both versions (parent and teacher) of the rating scale.

_____ Attention-Deficit/Hyperactivity Disorder - Hyperactivity/Impulsivity Symptoms
(items 1, 7, 12, 19, 22, 25, 30, 33, 35)

6 or more items must be endorsed as "pretty much" or "very much" on the parent and/or the teacher DBD to meet criteria for **Attention-DeficitlHyperactivity Disorder, Predominantly Hyperactive-Impulsive Type.**

If 6 or more items are endorsed for Attention-Deficit/Hyperactivity Disorder - inattention and 6 or more items are endorsed for Attention-Deficit/Hyperactivity Disorder - hyperactivity/impulsivity, then criteria is met for **Attention-DeficitlHyperactivity Disorder, Combined Type.**

Some impairment from the symptoms must be present in two or more settings (e.g., school, home)

Oppositional Defiant Disorder

_____ Oppositional Defiant Disorder (items 3, 13, 15, 17, 24, 26, 28, 39)

A total of 4 or more items must be endorsed as "pretty much" or "very much" on either the parent or the teacher DBD to meet criteria for **Oppositional Defiant Disorder.**

Conduct Disorder

_____ Conduct Disorder - aggression to people and animals (items 6, 20, 31, 32, 36, 40, 45)
_____ Conduct Disorder - destruction of property (items 16, 41)
_____ Conduct Disorder - deceitfulness or theft (items 4, 8, 43)
_____ Conduct Disorder - serious violation of rules (items 2, 11, 38)

A total of 3 or more items in any category or any combination of categories must be endorsed as "pretty much" or "very much" on either the parent or the teacher DBD to meet criteria for **Conduct Disorder**

Method 2: Using Factor Scores

Factor scores for the two ADHD and ODD dimensions for teacher ratings on the DBD are reported in *Pelham, et al. (1992), Teacher ratings of DSM-III-R symptoms for the disruptive behavior disorders: Journal of the American Academy of Child and Adolescent Psychiatry, 31, 210-218*. The factor scores for DSM IV factors are the same as for the DSM III-R factors reported in that paper. To determine how a child's scores compare to normative data, compute the average rating for the items from each factor (listed below) using the following scoring: Not at all = 0, Just a little = 1, Pretty much = 2, Very much = 3. Then, using the information from the attached table of norms, determine where the child falls in relation to other children. A variety of cutoff scores can be used (e.g., 2 standard deviations above the mean).

Factors

Oppositional/Defiant	(items 3, 13, 15, 17, 24, 26, 28, 39)
Inattention	(items 9, 18, 23, 27, 29, 34, 37, 42, 44)
Impulsivity/Overactivity	(items 1, 7, 12, 19, 22, 25, 30, 33, 35)

Care Coordination with RightCare Case Managers

Through collaboration with other clinicians, PCP and community resources, RightCare case managers coordinate and facilitate a comprehensive, multi-disciplinary approach to promote member autonomy and enhance the continuity of care and the member's quality of life. By combining advocacy with open communications and resource management, the case manager will be able to promote cost-effective care interventions and outcomes. Case managers help patients with chronic illnesses, catastrophic illnesses, or injuries get the most out of their healthcare.

Case managers help transfer patients to specialized treatment facilities, ensuring their care needs are met. Patients, with support from their physician and family members, set goals that roadmap their recovery to a healthier status. The scope of services provided includes:

- Initial health assessment status
- Case Management Program education
- Member-specific care plan development
- Care plan progress reassessments and evaluation of adherence
- Regularly scheduled case manager contact, based on acuity
- Transition of care support between inpatient to other facilities or home
- Assistance in navigating and collaborating with providers and community resources

To request assistance from a RightCare case manager:

- Call RightCare Medical Management at (855) 691-SWHP, Option 1
- Complete the Case Management Referral Form at https://portal.swhp.org/#/referral