H. OBSESSIVE-COMPULSIVE DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

H1 In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (For example, the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting, or religious obsessions.)

(DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)

NO YES
↓
SKIP TO H4

H2 Did they keep coming back into your mind even when you tried to ignore or get rid of them?

NO YES
↓
SKIP TO H4

H3 Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?

NO YES
obsessions

H4 In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?

NO YES
compulsions

IS **H3** OR **H4** CODED YES?

➡
NO YES
➡

H5 Did you recognize that either these obsessive thoughts or these compulsive behaviors were excessive or unreasonable?

NO YES

H6 Did these obsessive thoughts and/or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour a day?

NO **YES**

O.C.D. CURRENT

I. POSTTRAUMATIC STRESS DISORDER (optional)

(➡ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

I1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER.	➡ NO	YES
I2	Did you respond with intense fear, helplessness or horror?	➡ NO	YES
I3	During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)?	➡ NO	YES

I4 **In the past month:**

a	Have you avoided thinking about or talking about the event ?	NO	YES
b	Have you avoided activities, places or people that remind you of the event?	NO	YES
c	Have you had trouble recalling some important part of what happened?	NO	YES
d	Have you become much less interested in hobbies or social activities?	NO	YES
e	Have you felt detached or estranged from others?	NO	YES
f	Have you noticed that your feelings are numbed?	NO	YES
g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
	ARE 3 OR MORE **I4** ANSWERS CODED **YES**?	➡ NO	YES

I5 **In the past month:**

a	Have you had difficulty sleeping?	NO	YES
b	Were you especially irritable or did you have outbursts of anger?	NO	YES
c	Have you had difficulty concentrating?	NO	YES
d	Were you nervous or constantly on your guard?	NO	YES
e	Were you easily startled?	NO	YES
	ARE 2 OR MORE **I5** ANSWERS CODED **YES**?	➡ NO	YES

I6 During the past month, have these problems significantly interfered with your work or social activities, or caused significant distress?

NO	YES
POSTTRAUMATIC STRESS DISORDER CURRENT	

~~J. ALCOHOL ABUSE AND DEPENDENCE~~ See DSM 5 Checklists

(➡ MEANS: GO TO DIAGNOSTIC BOXES, CIRCLE NO IN BOTH AND MOVE TO THE NEXT MODULE)

		➡ NO	YES
J1	**In the past 12 months**, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?		

J2 **In the past 12 months:**

a	Did you need to drink more in order to get the same effect that you got when you first started drinking?	NO	YES
b	When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms or to avoid being hungover, for example, "the shakes", sweating or agitation? IF YES TO EITHER, CODE YES.	NO	YES
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
d	Have you tried to reduce or stop drinking alcohol but failed?	NO	YES
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	NO	YES
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES
g	Have you continued to drink even though you knew that the drinking caused you health or mental problems?	NO	YES

ARE **3** OR MORE **J2** ANSWERS CODED **YES**?

* IF YES, SKIP J3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX AND MOVE TO THE NEXT DISORDER. DEPENDENCE PREEMPTS ABUSE.

NO **YES***

ALCOHOL DEPENDENCE
CURRENT

J3 **In the past 12 months:**

a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
b	Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
c	Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
d	Did you continue to drink even though your drinking caused problems with your family or other people?	NO	YES

ARE **1** OR MORE **J3** ANSWERS CODED **YES**?

NO **N/A** **YES**

ALCOHOL ABUSE
CURRENT

See DSM5 Checklist

K. ~~NON-ALCOHOL PSYCHOACTIVE SUBSTANCE USE DISORDERS~~

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

Now I am going to show you / read to you a list of street drugs or medicines.

K1 a **In the past 12 months**, did you take any of these drugs more than once, to get high, to feel better, or to change your mood? ➡ NO YES

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", "rush", Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, codeine, Percodan, Darvon, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, PCP ("angel dust", "peace pill"), psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA, or ketamine ("special K").

Inhalants: "glue", ethyl chloride, "rush", nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers").

Marijuana: hashish ("hash"), THC, "pot", "grass", "weed", "reefer".

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown, GHB, Roofinol, "Roofies".

Miscellaneous: steroids, nonprescription sleep or diet pills. Any others?

SPECIFY MOST USED DRUG(S): _____

CHECK ONE BOX

ONLY ONE DRUG / DRUG CLASS HAS BEEN USED ☐

ONLY THE MOST USED DRUG CLASS IS INVESTIGATED. ☐

EACH DRUG CLASS USED IS EXAMINED SEPARATELY (PHOTOCOPY K2 AND K3 AS NEEDED) ☐

b SPECIFY WHICH DRUG/DRUG CLASS WILL BE EXPLORED IN THE INTERVIEW BELOW IF THERE IS CONCURRENT OR SEQUENTIAL POLYSUBSTANCE USE: _____

K2 **Considering your use of (NAME THE DRUG / DRUG CLASS SELECTED), in the past 12 months:**

a Have you found that you needed to use more (NAME OF DRUG / DRUG CLASS SELECTED) to get the same effect that you did when you first started taking it? NO YES

b When you reduced or stopped using (NAME OF DRUG / DRUG CLASS SELECTED), did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed)? Did you use any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better? NO YES

IF YES TO EITHER, CODE YES.

c Have you often found that when you used (NAME OF DRUG / DRUG CLASS SELECTED), you ended up taking more than you thought you would? NO YES

d Have you tried to reduce or stop taking (NAME OF DRUG / DRUG CLASS SELECTED) but failed? NO YES

e On the days that you used (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time (>2 HOURS), obtaining, using or in recovering from the drug, or thinking about the drug? NO YES

f Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use? NO YES

g Have you continued to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it caused you health or mental problems? NO YES

ARE **3** OR MORE **K2** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

* IF YES, SKIP K3 QUESTIONS, CIRCLE N/A IN THE ABUSE BOX FOR THIS SUBSTANCE AND MOVE TO THE NEXT DISORDER.
DEPENDENCE PREEMPTS ABUSE.

NO **YES ***

SUBSTANCE DEPENDENCE
CURRENT

Considering your use of (NAME THE DRUG CLASS SELECTED), in the past 12 months:

K3 a Have you been intoxicated, high, or hungover from (NAME OF DRUG / DRUG CLASS SELECTED) more than once, when you had other responsibilities at school, at work, or at home? Did this cause any problem? NO YES

(CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)

b Have you been high or intoxicated from (NAME OF DRUG / DRUG CLASS SELECTED) more than once in any situation where you were physically at risk (for example, driving a car, riding a motorbike, using machinery, boating, etc.)? NO YES

c Did you have legal problems more than once because of your drug use, for example, an arrest or disorderly conduct? NO YES

d Did you continue to use (NAME OF DRUG / DRUG CLASS SELECTED), even though it caused problems with your family or other people? NO YES

ARE **1** OR MORE **K3** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

NO **N/A** **YES**

SUBSTANCE ABUSE
CURRENT

DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS CENTER OF EXCELLENCE

OPIOID USE DISORDER DIAGNOSTIC CRITERIA CHECKLIST

☐ 1. Opioids are 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 opioid use.

☐ 3. A great deal of time is spent in activities necessary to obtain the opioid, use of the opioid, or recover from its effects.

☐ 4. Craving, or a strong desire or urge to use opioids.

☐ 5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.

☐ 6. Continue opioid use despite having persistent and recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

☐ 7. Import social, occupational, or recreational activities are given up or reduced because of opioid use.

☐ 8. Recurrent opioid use in situations in which is it physically hazardous.

☐ 9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

☐ 10. Tolerance, as defined by either of the following:

a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.

b. A markedly diminished effect with continued use of the same amount of the opioid.

NOTE: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

☐ 11. Withdrawal, as manifested by either of the following:

a. The characteristic opioid withdrawal syndrome (refer to Criterion A and B of the criteria set for opioid withdrawal).

b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

NOTE: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

Total Number of Symptoms: _____

Please specify individual's current severity:

☐ Mild: Presence of 2-3 symptoms.

☐ Moderate: Presence of 4-5 symptoms.

☐ Severe: Presence of 6 or more symptoms.

Diagnosis: _____

Diagnostic Criteria taken from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (Copyright 2013).*

DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS CENTER OF EXCELLENCE

SUBSTANCE USE DISORDER DIAGNOSTIC CRITERIA CHECKLIST

☐ 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 the substance, use of the substance, or recover from its effects.

☐ 4. Craving, or a strong desire or urge to use the substance.

☐ 5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

☐ 6. Continue substance use despite having persistent and recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

☐ 7. Import social, occupational, or recreational activities are given up or reduced because of substance use.

☐ 8. Recurrent substance use in situations in which is it physically hazardous.

☐ 9. Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

☐ 10. Tolerance, as defined by either of the following:

a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

b. A markedly diminished effect with continued use of the same amount of the substance.

☐ 11. Withdrawal, as manifested by either of the following:

a. The characteristic withdrawal syndrome for the substance.

b. The substance is taken to relieve or avoid withdrawal symptoms.

Total Number of Symptoms: _____

Please specify individual's current severity:

☐ Mild: Presence of 2-3 symptoms.

☐ Moderate: Presence of 4-5 symptoms.

☐ Severe: Presence of 6 or more symptoms.

Diagnosis: _____

Diagnostic Criteria taken from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (Copyright 2013).*

L. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE YES ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS "BIZARRE".

DELUSIONS ARE "BIZARRE" IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.

HALLUCINATIONS ARE SCORED "BIZARRE" IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.

					BIZARRE
		Now I am going to ask you about unusual experiences that some people have.			
L1	a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? NOTE: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES →L6
L2	a	Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES →L6
L3	a	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES →L6
L4	a	Have you ever believed that you were being sent special messages through the TV, radio, or newspaper, or that a person you did not personally know was particularly interested in you?	NO	YES	YES
	b	**IF YES:** do you currently believe these things?	NO	YES	YES →L6
L5	a	Have your relatives or friends ever considered any of your beliefs strange or unusual? INTERVIEWER: ASK FOR EXAMPLES. ONLY CODE **YES** IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS L1 TO L4, FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITIUTION, ETC.	NO	YES	YES
	b	**IF YES:** do they currently consider your beliefs strange?	NO	YES	YES
L6	a	Have you ever heard things other people couldn't hear, such as voices? HALLUCINATIONS ARE SCORED "BIZARRE" ONLY IF PATIENT ANSWERS **YES** TO THE FOLLOWING:	NO	YES	
		IF YES: Did you hear a voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO		YES
	b	**IF YES:** have you heard these things in the past month?	NO	YES	YES →L8b

L7 a Have you ever had visions when you were awake or have you ever seen things other people couldn't see? NO YES

CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

b **IF YES:** have you seen these things in the past month? NO YES

CLINICIAN'S JUDGMENT

L8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS? NO YES

L9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR? NO YES

L10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW? NO YES

L11 a ARE 1 OR MORE « a » QUESTIONS FROM L1a TO L7a CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT OR RECURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**? NO →L13 YES

IF NO TO L11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO L13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

Were the beliefs and experiences you just described (SYMPTOMS CODED **YES** FROM **L1a** TO **L7a**) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER IS NO TO THIS DISORDER, ALSO CIRCLE NO TO L12 AND MOVE TO L13

NO **YES**

MOOD DISORDER WITH PSYCHOTIC FEATURES

LIFETIME

L12 a ARE 1 OR MORE « b » QUESTIONS FROM L1b TO L7b CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT) CODED **YES**?

IF THE ANSWER IS YES TO THIS DISORDER, CIRCLE NO TO L13 AND L14 AND MOVE TO THE NEXT MODULE

NO **YES**

MOOD DISORDER WITH PSYCHOTIC FEATURES

CURRENT

L13 ARE 1 OR MORE « b » QUESTIONS CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « b » QUESTIONS CODED **YES** (RATHER THAN **YES BIZARRE**)?

NO **YES**

PSYCHOTIC DISORDER
CURRENT

L14 IS **L13** CODED **YES**

OR

ARE 1 OR MORE « a » QUESTIONS FROM L1a TO L7a, CODED **YES BIZARRE**?

OR

ARE 2 OR MORE « a » QUESTIONS FROM L1a TO L7a, CODED **YES** (RATHER THAN **YES BIZARRE**)

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME TIME PERIOD?

NO **YES**

PSYCHOTIC DISORDER
LIFETIME

M. ANOREXIA NERVOSA

(➡ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

M1 a How tall are you? ☐☐ ft ☐☐ in. / ☐☐☐ cm.

b. What was your lowest weight in the past 3 months? ☐☐☐ lbs. / ☐☐☐ kgs.

c IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW) ➡ NO YES

In the past 3 months:

M2 In spite of this low weight, have you tried not to gain weight? ➡ NO YES

M3 Have you intensely feared gaining weight or becoming fat, even though you were underweight? ➡ NO YES

M4 a Have you considered yourself too big / fat or that part of your body was too big / fat? NO YES

b Has your body weight or shape greatly influenced how you felt about yourself? NO YES

c Have you thought that your current low body weight was normal or excessive? NO YES

M5 ARE 1 OR MORE ITEMS FROM **M4** CODED **YES**? ➡ NO YES

M6 FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)? ➡ NO YES

FOR WOMEN: ARE **M5 AND M6** CODED **YES**?

FOR MEN: IS **M5** CODED **YES**?

NO	YES
ANOREXIA NERVOSA CURRENT	

TABLE HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.5 KG/M²

Height/Weight														
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	81	84	87	89	92	96	99	102	105	108	112	115	118	122
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kgs	37	38	39	41	42	43	45	46	48	49	51	52	54	55

Height/Weight					
ft/in	5'11	6'0	6'1	6'2	6'3
lbs.	125	129	132	136	140
cm	180	183	185	188	191
kgs	57	59	60	62	64

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.5 kg/m² for the patient's height. This is the threshold guideline below which a person is deemed underweight by the DSM-IV and the ICD-10 Diagnostic Criteria for Research for Anorexia Nervosa.

N. BULIMIA NERVOSA

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

N1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	➡ NO YES
N2	In the last 3 months, did you have eating binges as often as twice a week?	➡ NO YES
N3	During these binges, did you feel that your eating was out of control?	➡ NO YES
N4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications?	➡ NO YES
N5	Does your body weight or shape greatly influence how you feel about yourself?	➡ NO YES
N6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO YES ↓ Skip to N8
N7	Do these binges occur only when you are under (_____lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO YES
N8	IS N5 CODED YES AND IS EITHER N6 OR N7 CODED NO?	**NO** **YES** ***BULIMIA NERVOSA*** **CURRENT**
	IS N7 CODED YES?	**NO** **YES** ***ANOREXIA NERVOSA*** *Binge Eating/Purging Type* **CURRENT**

O. GENERALIZED ANXIETY DISORDER

(➡ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

O1	a	Have you worried excessively or been anxious about several things over the past 6 months?	➡ NO	YES
	b	Are these worries present most days?	➡ NO	YES
		IS THE PATIENT'S ANXIETY RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	➡ NO	YES
O2		Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing?	➡ NO	YES
O3		FOR THE FOLLOWING, CODE NO IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT.		
		When you were anxious over the past 6 months, did you, most of the time:		
	a	Feel restless, keyed up or on edge?	NO	YES
	b	Feel tense?	NO	YES
	c	Feel tired, weak or exhausted easily?	NO	YES
	d	Have difficulty concentrating or find your mind going blank?	NO	YES
	e	Feel irritable?	NO	YES
	f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES

ARE **3** OR MORE **O3** ANSWERS CODED **YES**?

NO	YES

GENERALIZED ANXIETY DISORDER
CURRENT

P. ANTISOCIAL PERSONALITY DISORDER (optional)

(➡ MEANS : GO TO THE DIAGNOSTIC BOX AND CIRCLE NO.)

P1 **Before you were 15 years old, did you:**

a	repeatedly skip school or run away from home overnight?	NO	YES
b	repeatedly lie, cheat, "con" others, or steal?	NO	YES
c	start fights or bully, threaten, or intimidate others?	NO	YES
d	deliberately destroy things or start fires?	NO	YES
e	deliberately hurt animals or people?	NO	YES
f	force someone to have sex with you?	NO ➡	YES
	ARE 2 OR MORE **P1** ANSWERS CODED YES?	NO	YES

DO NOT CODE YES TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY POLITICALLY OR RELIGIOUSLY MOTIVATED.

P2 **Since you were 15 years old, have you:**

a	repeatedly behaved in a way that others would consider irresponsible, like failing to pay for things you owed, deliberately being impulsive or deliberately not working to support yourself?	NO	YES
b	done things that are illegal even if you didn't get caught (for example, destroying property, shoplifting, stealing, selling drugs, or committing a felony)?	NO	YES
c	been in physical fights repeatedly (including physical fights with your spouse or children)?	NO	YES
d	often lied or "conned" other people to get money or pleasure, or lied just for fun?	NO	YES
e	exposed others to danger without caring?	NO	YES
f	felt no guilt after hurting, mistreating, lying to, or stealing from others, or after damaging property?	NO	YES

ARE **3** OR MORE **P2** QUESTIONS CODED **YES**?

NO	YES
	ANTISOCIAL PERSONALITY DISORDER **LIFETIME**

THIS CONCLUDES THE INTERVIEW

REFERENCES

Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Janavs J, Weiller E, Bonara LI, Keskiner A, Schinka J, Knapp E, Sheehan MF, Dunbar GC. Reliability and Validity of the MINI International Neuropsychiatric Interview (M.I.N.I.): According to the SCID-P. European Psychiatry. 1997; 12:232-241.

Lecrubier Y, Sheehan D, Weiller E, Amorim P, Bonora I, Sheehan K, Janavs J, Dunbar G. The MINI International Neuropsychiatric Interview (M.I.N.I.) A Short Diagnostic Structured Interview: Reliability and Validity According to the CIDI. European Psychiatry. 1997; 12: 224-231.

Sheehan DV, Lecrubier Y, Harnett-Sheehan K, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar G: The Mini International Neuropsychiatric Interview (M.I.N.I.): The Development and Validation of a Structured Diagnostic Psychiatric Interview. J. Clin Psychiatry, 1998;59(suppl 20):22-33.

Amorim P, Lecrubier Y, Weiller E, Hergueta T, Sheehan D: DSM-III-R Psychotic Disorders: procedural validity of the Mini International Neuropsychiatric Interview (M.I.N.I.). Concordance and causes for discordance with the CIDI. European Psychiatry. 1998; 13:26-34.

Translations	M.I.N.I. 4.4 or earlier versions	M.I.N.I. 4.6/5.0, M.I.N.I. Plus 4.6/5.0 and M.I.N.I. Screen 5.0:
Afrikaans	R. Emsley	W. Maartens
Arabic		O. Osman, E. Al-Radi
Bengali		H. Banerjee, A. Banerjee
Brazilian Portuguese	P. Amorim	P. Amorim
Bulgarian	L.G.. Hranov	
Chinese		L. Carroll, Y-J. Lee, Y-S. Chen, C-C. Chen, C-Y. Liu, C-K. Wu, H-S. Tang, K-D. Juang, Yan-Ping Zheng.
Croatian		In preparation
Czech		P. Zvlosky
Danish	P. Bech	P. Bech, T. Schütze
Dutch/Flemish	E. Griez, K. Shruers, T. Overbeek, K. Demyttenaere	I. Van Vliet, H. Leroy, H. van Megen
English	D. Sheehan, J. Janavs, R. Baker, K. Harnett-Sheehan, E. Knapp, M. Sheehan	D. Sheehan, R. Baker, J. Janavs, K. Harnett-Sheehan, M. Sheehan
Estonian		J. Shlik, A. Aluoja, E. Khil
Farsi/Persian		K. Khooshabi, A. Zomorodi
Finnish	M. Heikkinen, M. Lijeström, O. Tuominen	M. Heikkinen, M. Lijeström, O. Tuominen
French	Y. Lecrubier, E. Weiller, I. Bonora, P. Amorim, J.P. Lepine	Y. Lecrubier, E. Weiller, P. Amorim, T. Hergueta
German	I. v. Denffer, M. Ackenheil, R. Dietz-Bauer	G. Stotz, R. Dietz-Bauer, M. Ackenheil
Greek	S. Beratis	T. Calligas, S. Beratis
Gujarati		M. Patel, B. Patel
Hebrew	J. Zohar, Y. Sasson	R. Barda, I. Levinson, A. Aviv
Hindi		C. Mittal, K. Batra, S. Gambhir
Hungarian	I. Bitter, J. Balazs	I. Bitter, J. Balazs
Icelandic		J.G. Stefansson
Italian	I. Bonora, L. Conti, M. Piccinelli, M. Tansella, G. Cassano, Y. Lecrubier, P. Donda, E. Weiller	L. Conti, A. Rossi, P. Donda
Japanese		T. Otsubo, H. Watanabe, H. Miyaoka, K. Kamijima, J.Shinoda, K.Tanaka, Y. Okajima
Korean		In preparation, Anxiety Disorder Association of Korea
Latvian	V. Janavs, J. Janavs, I. Nagobads	V. Janavs, J. Janavs
Lithuanian		A. Bacevicius
Norwegian	G. Pedersen, S. Blomhoff	K.A. Leiknes , U. Malt, E. Malt, S. Leganger
Polish	M. Masiak, E. Jasiak	M. Masiak, E. Jasiak
Portuguese	P. Amorim	P. Amorim, T. Guterres
Punjabi		A. Gahunia, S. Gambhir
Romanian		O. Driga
Russian		A. Bystritsky, E. Selivra, M. Bystritsky
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Setswana		K. Ketlogetswe
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Urdu		A. Taj, S. Gambhir

A validation study of this instrument was made possible, in part, by grants from SmithKline Beecham and the European Commission.
The authors are grateful to Dr. Pauline Powers for her advice on the modules on Anorexia Nervosa and Bulimia.

STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.

COE - 013

SUBSECTION EFFECTIVE DATE

2/10/17

POLICY/PROCEDURE

The Drug Abuse Screening Test (DAST)

AMENDMENT / REVISION HISTORY
Approved:
Amended:

POLICY

Each new patient to the COE will complete a DAST to assist with determining the presence of substance use disorders and treatment needs.

PROCEDURE

Description

1. As part of the intake evaluation, patients will be asked to complete the DAST which will be scored by a staff member and results used in consideration of the severity of substance use problems being experienced by the patient.

LIST OTHER SUPPORTING DOCUMENTS/RESOURCES

1. *Addiction Research Foundation Detailed Review of the Drug Abuse Screening Test (DAST). In: Addiction Research Foundation (1993). Directory of client outcome measures for addiction treatment programs. (Ontario. Addiction Research Foundation).*

Substance Abuse Screening Instrument (O4/05)

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol.

The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

		YES	NO
1.	Have you used drugs other than those required for medical reasons?	___	___
2.	Have you abused prescription drugs?	___	___
3.	Do you abuse more than one drug at a time?	___	___
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	___	___
5.	Are you always able to stop using drugs when you want to?	___	___
6.	Do you abuse drugs on a continuous basis?	___	___
7.	Do you try to limit your drug use to certain situations?	___	___
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	___	___
9.	Do you ever feel bad about your drug abuse?	___	___
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	___	___
11.	Do your friends or relatives know or suspect you abuse drugs?	___	___
12.	Has drug abuse ever created problems between you and your spouse?	___	___
13.	Has any family member ever sought help for problems related to your drug use?	___	___
14.	Have you ever lost friends because of your use of drugs?	___	___
15.	Have you ever neglected your family or missed work because of your use of drugs?	___	___
16.	Have you ever been in trouble at work because of drug abuse?	___	___
17.	Have you ever lost a job because of drug abuse?	___	___
18.	Have you gotten into fights when under the influence of drugs?	___	___
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	___	___
20.	Have you ever been arrested for driving while under the influence of drugs?	___	___
21.	Have you engaged in illegal activities in order to obtain drug?	___	___
22.	Have you ever been arrested for possession of illegal drugs?	___	___
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	___	___
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	___	___
25.	Have you ever gone to anyone for help for a drug problem?	___	___
26.	Have you ever been in a hospital for medical problems related to your drug use?	___	___
27.	Have you ever been involved in a treatment program specifically related to drug use?	___	___
28.	Have you been treated as an outpatient for problems related to drug abuse?	___	___

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.

STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.
COE – 013A

SUBSECTION EFFECTIVE DATE

02/10/2017

POLICY/PROCEDURE

Naloxone Education

AMENDMENT / REVISION HISTORY
Approved:
Amended:

POLICY

Every patient with opioid use disorder or found to be at risk for opioid overdose will be offered education on naloxone use as an antidote to opioid overdose and will be offered a naloxone kit.

PROCEDURE

All patients will be educated by their Counselor/Case Manager or Peer Specialist on risk for opioid overdose, recognition of opioid overdose, providing emergency care for someone experiencing an overdose, naloxone and its pharmacology, and how to use naloxone to reverse opioid overdose. The SAMHSA Opioid Overdose Prevention Toolkit will be used as an educational tool. Family members or significant others will also be offered education with the patient's permission.

SAMHSA
Opioid Overdose Prevention TOOLKIT:

Facts for Community Members

Five Essential Steps for First Responders

Information for Prescribers

Safety Advice for Patients & Family Members

Recovering From Opioid Overdose

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

TABLE OF CONTENTS

SAMHSA Opioid Overdose Prevention Toolkit

FACTS FOR COMMUNITY MEMBERS

SCOPE OF THE PROBLEM

Opioid overdose continues to be a major public health problem in the United States. It has contributed significantly to accidental deaths among those who use or misuse illicit and prescription opioids. In fact, U.S. overdose deaths involving prescription opioid analgesics increased to about 19,000 deaths in 2014[1,2] more than three times the number in 2001.[1] According to Centers for Disease Control and Prevention (CDC) data, health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.[3-4]

WHAT ARE OPIOIDS? Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (OxyContin®, Percodan®, Percocet®), hydrocodone (Vicodin®, Lortab®, Norco®), fentanyl (Duragesic®, Fentora®), hydromorphone (Dilaudid®, Exalgo®), and buprenorphine (Subutex®, Suboxone®).

Opioids work by binding to specific receptors in the brain, spinal cord, and gastrointestinal tract. In doing so, they minimize the body's perception of pain. However, stimulating the opioid receptors or "reward centers" in the brain can also trigger other systems of the body, such as those responsible for regulating mood, breathing, and blood pressure.

HOW DOES OVERDOSE OCCUR? A variety of effects can occur after a person takes opioids, ranging from pleasure to nausea, vomiting, severe allergic reactions (anaphylaxis), and overdose, in which breathing and heartbeat slow or even stop.

Opioid overdose can occur when a patient deliberately misuses a prescription opioid or an illicit drug such as heroin. It can also occur when a patient takes an opioid as directed, but the prescriber miscalculated the opioid dose or an error was made by the dispensing pharmacist or the patient misunderstood the directions for use.

Also at risk are individuals who misuse opioids and combine them with sedative hypnotic agents resulting in sedation and respiratory depression.[5,6]

WHO IS AT RISK? Anyone who uses opioids for long-term management of chronic cancer or non-cancer pain is at risk for opioid overdose, as are persons who use heroin.[7] Others at risk include persons who are:

- Receiving rotating opioid medication regimens (and thus are 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 substance use disorder, or non-medical use of prescription or illicit opioids.
- Completing mandatory opioid detoxification or abstinent for a period of time (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).
- Recently released from incarceration and who have a history of opioid use disorder (and presumably have reduced opioid tolerance and high risk of relapse to opioid use).

Tolerance develops when someone uses an opioid drug regularly, so that their body becomes accustomed to the drug and needs a larger or more frequent dose to continue to experience the same effect.

Loss of tolerance occurs when someone stops taking an opioid after long-term use. When someone loses tolerance and then takes the opioid drug again, they can experience serious adverse effects, including overdose, even if they take an amount that caused them no problem in the past.

STRATEGIES TO PREVENT OVERDOSE DEATHS

STRATEGY 1: Encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose. Providers should be encouraged to keep their knowledge current about evidence-based practices for the use of opioid analgesics to manage pain, as well as specific steps to prevent and manage opioid overdose.

Federally funded Continuing Medical Education courses are available to providers at no charge at http://www.OpioidPrescribing.com (a series of courses funded by the Substance Abuse and Mental Health Services Administration [SAMHSA]).

Helpful information for laypersons on how to prevent and manage overdose is available from Project Lazarus at http://www.projectlazarus.org or from the Massachusetts Health Promotion Clearinghouse at http://www.maclearinghouse.org.

Encourage providers and others to learn about preventing and managing opioid overdose

STRATEGY 2: Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders. Effective treatment of substance use disorders can reduce the risk of overdose and help overdose survivors attain a healthier life. Medication-assisted treatment, as well as counseling and other supportive services, can be obtained at SAMHSA-certified and Drug Enforcement Administration (DEA)-registered opioid treatment programs (OTPs), as well as from physicians who are trained to provide care in office-based settings with medications such as buprenorphine and naltrexone.

Information on treatment services available in or near your community can be obtained from your state health department, your state alcohol and drug agency, or SAMHSA (see page 4).

Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders.

STRATEGY 3: Ensure ready access to naloxone. Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths.[7]

On the other hand, naloxone is not effective in treating overdoses of benzodiazepines (such as Valium®, Xanax®, or Klonopin®), barbiturates (Seconal® or Fiorinal®), clonidine, Elavil®, GHB, ketamine, or synthetics. It is also not effective in overdoses with stimulants, such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful.

Naloxone injection has been approved by the United States Food and Drug Administration (FDA) and used for more than 40 years by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate persons who otherwise might have died in the absence of treatment.[8]

FACTS FOR COMMUNITY MEMBERS

Naloxone does not have the potential for abuse. It reverses the effects of opioid overdose.[9] Injectable naloxone is relatively inexpensive. It typically is supplied as a kit with two syringes[10] These kits require training on how to administer naloxone using a syringe. The FDA has also approved an intranasal naloxone product, called Narcan® Nasal Spray, and a naloxone auto-injector, called Evzio®. The intranasal spray is a pre-filled, needle-free device that requires no assembly. The auto-injector can deliver a dose of naloxone through clothing, if necessary, when placed on the outer thigh.

Prior to 2012, just six states had any laws that expanded access to naloxone or limited criminal liability.[11] Today, 42 states and the District of Columbia have statutes that provide criminal liability protections to laypersons or first responders who administer naloxone. Thirty-nine states and the District of Columbia have statutes that provide civil liability protections to laypersons or first responders who administer naloxone. Thirty-eight states have statutes that offer criminal liability protections for prescribing or distributing naloxone. Thirty-three states have statutes that offer civil liability protections for prescribing or distributing naloxone. And 42 states have statutes that allow naloxone distribution to third parties or first responders via direct prescription or standing order. To find states that have adopted relevant laws, visit the White House website at https://www.whitehouse.gov/sites/default/files/ondcp/Blog/naloxonecirclechart_january2016.pdf.

STRATEGY 4: Encourage the public to call 911. An individual who is experiencing opioid overdose needs immediate medical attention. An essential first step is to get help from someone with medical expertise as quickly as possible.[12-13] Therefore, members of the public should be encouraged to call 911. All they have to say is "Someone is not breathing" and give a clear address and location. Thirty-two states and the District of Columbia have "Good Samaritan" statutes that prevent arrest, charge, or prosecution for possession of a controlled substance or paraphernalia if emergency assistance is sought for someone who is experiencing an opioid-induced overdose.

STRATEGY 5: Encourage prescribers to use state Prescription Drug Monitoring Programs. State Prescription Drug Monitoring Programs (PDMPs) have emerged as a key strategy for addressing the misuse 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 a similar drug from multiple prescribers.

While nearly all 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 prescribers, and who may access the data. Therefore, information about the program in a particular state is best obtained directly from the state PDMP or from the board of medicine or pharmacy.

Encourage the public to call 911.

Encourage prescribers to use state Prescription Drug Monitoring Programs.

RESOURCES FOR COMMUNITIES

Resources that may be useful to local communities and organizations are found at:

Substance Abuse and Mental Health Services Administration (SAMHSA)

- National Helpline:
  1-800-662-HELP (4357) or 1-800-487-4889 (TDD — for hearing impaired)
- Behavioral Health Treatment Locator:
  https://findtreatment.samhsa.gov to search by address, city, or zip code
- Buprenorphine Treatment Physician Locator:
  http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- State Substance Abuse Agencies:
  https://findtreatment.samhsa.gov/TreatmentLocator/faces/about.jspx
- Center for Behavioral Health Statistics and Quality (CBHSQ):
  http://www.samhsa.gov/data
- SAMHSA Publications: http://store.samhsa.gov
  1-877-SAMHSA (1-877-726-4727)

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/drugoverdose/epidemic
http://www.cdc.gov/homeandrecreationalsafety/poisoning

White House Office of National Drug Control Policy (ONDCP)
State and Local Information: http://www.whitehouse.gov/ondcp/state-map

Association of State and Territorial Health Officials
(ASTHO) ASTHO 214 Policy Inventory: State Action to Prevent and Treat Prescription Drug Abuse: http://www.astho.org/rx/profiles/Rx-Survey-Highlights

National Association of State Alcohol and Drug Abuse Directors (NASADAD)
Overview of State Legislation to Increase Access to Treatment for Opioid Overdose:
http://nasadad.org/wp-content/uploads/2015/09/Opioid-Overdose-Policy-Brief-2015-Update-FINAL1.pdf

American Association for the Treatment of Opioid Dependence (AATOD)
Prevalence of Prescription Opioid Abuse:
http://www.aatod.org/projectseducational-training/prevalance-of-prescription-opioid-abuse

Resources that may be useful to local communities and organizations ...

FIVE ESSENTIAL STEPS FOR FIRST RESPONDERS

Overdose is common among persons who use illicit opioids such as heroin and among those who misuse medications prescribed for pain, such as oxycodone, hydrocodone, and morphine. The incidence of opioid overdose is rising nationwide. In 2014, 28,647 of drug overdose deaths involved some type of opioid, including heroin.[14] U.S. overdose deaths involving prescription opioid analgesics increased to about 19,000 deaths in 2014[1,2] more than three times the number in 2001.[1]

To address the problem, emergency medical personnel, health care professionals, and patients increasingly are being trained in the use of the opioid antagonist naloxone hydrochloride (naloxone), which is the treatment of choice to reverse the potentially fatal respiratory depression caused by opioid overdose. (Note that naloxone has no effect on non-opioid overdoses, such as those involving cocaine, benzodiazepines, or alcohol.)[15]

The steps outlined below are recommended to reduce the number of deaths resulting from opioid overdoses[2,6,10,16,17,18,19,20]

STEP 1: CALL FOR HELP (DIAL 911)

AN OPIOID OVERDOSE NEEDS IMMEDIATE MEDICAL ATTENTION. An essential step is to get someone with medical expertise to see the patient as soon as possible, so if no emergency medical services (EMS) or other trained personnel are on the scene, dial 911 immediately. All you have to say is "Someone is not breathing." Be sure to give a clear address and/or description of your location.

STEP 2: CHECK FOR SIGNS OF OPIOID OVERDOSE

Signs of **OVERDOSE**, which often results in death if not treated, include[15]:

- Extreme sleepiness, inability to awaken verbally or upon sternal rub.
- Breathing problems that can range from slow to shallow breathing in a patient that cannot be awakened.
- Fingernails or lips turning blue/purple.
- Extremely small "pinpoint" pupils.
- Slow heartbeat and/or low blood pressure.

Signs of **OVERMEDICATION**, which may progress to overdose, include:[15]

- Unusual sleepiness, drowsiness, or difficulty staying awake despite loud verbal stimulus or vigorous sternal rub.
- Mental confusion, slurred speech, intoxicated behavior.
- Slow or shallow breathing.
- Extremely small "pinpoint" pupils, although normal size pupils do not exclude opioid overdose.
- Slow heartbeat, low blood pressure.
- Difficulty waking the person from sleep.

Because opioids depress respiratory function and breathing, one telltale sign of a person in a critical medical state is the "death rattle." If a person emits a "death rattle"—an exhaled breath with a very distinct, labored sound coming from the throat—emergency resuscitation will be necessary immediately, as such a sound almost always is a sign that the individual is near death.[17]

STEP 3: SUPPORT THE PERSON'S BREATHING

Ventilatory support is an important intervention and may be life-saving on its own. Patients should be ventilated with oxygen prior to administration of naloxone.[2,6] In situations where oxygen is not available, rescue breathing can be very effective in supporting respiration.[2] Rescue breathing for adults involves the following steps:

- Be sure the person's airway is clear (check that nothing inside the person's mouth or throat is blocking the airway).
- Place one hand on the person's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the person's mouth to make a seal and give 2 slow breaths.
- The person's chest should rise (but not the stomach).
- Follow up with one breath every 5 seconds.

STEP 4: ADMINISTER NALOXONE

Any patient who presents with signs of opioid overdose, or when this is suspected, should be administered naloxone. Naloxone injection is approved by the FDA and has been used for decades by EMS personnel to reverse opioid overdose and resuscitate individuals who have overdosed on opioids.

Naloxone can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.[17-19] The most rapid onset of action is achieved by intravenous administration, which is recommended in emergency situations.[17] The dose should be titrated to the smallest effective dose that maintains spontaneous normal respiratory drive.

Opioid-naive patients may be given starting doses of up to 2 mg without concern for triggering withdrawal symptoms depending on the route of administration.[2,9,18]

The intramuscular route of administration for naloxone may be suitable for patients with suspected opioid use disorder because it provides a slower onset of action and a prolonged duration of effect, which may minimize rapid onset of withdrawal symptoms.[2,5,10]

DURATION OF EFFECT. The duration of effect of naloxone is 20 to 90 minutes depending on dose and route of administration[6], and overdose symptoms.[5,17,18] The goal of naloxone therapy should be to restore adequate spontaneous breathing, but not necessarily complete arousal.[5]

More than one dose of naloxone may be needed to revive someone who is overdosing. Patients who have taken longer-acting opioids may require further intravenous bolus doses or an infusion of naloxone.[21]

Comfort the person being treated, as 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.

SAFETY OF NALOXONE. The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect.[2,9,17,22] When given to individuals who are not opioid-intoxicated or opioid-dependent, naloxone produces no clinical effects, even at high doses. Moreover, although rapid opioid withdrawal in tolerant patients may be unpleasant, it is not life-threatening.

Naloxone can be used in life-threatening opioid overdose circumstances in pregnant women.[23]

The FDA has approved injectable naloxone, intranasal naloxone (called Narcan® Nasal Spray), and a naloxone auto-injector (called Evzio®[1]). The currently available naloxone kits that include a syringe and naloxone ampules or vials or a prefilled naloxone

[1] http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm391465.htm

syringe and a mucosal atomizer device to enable intranasal delivery require the user to be trained on how to assemble all of the materials and administer the naloxone to the victim. The Narcan Nasal Spray is a pre-filled, needle-free device that requires no assembly, which can deliver a single dose into one nostril. The Evzio auto-injector is injected into the outer thigh to deliver naloxone to the muscle (intramuscular) or under the skin (subcutaneous). Once turned on, the device provides verbal instruction to the user describing how to deliver the medication, similar to automated defibrillators. Both Narcan Nasal Spray and Evzio are packaged in a carton containing two doses, to allow for repeat dosing if needed.

STEP 5: MONITOR THE PERSON'S RESPONSE

All patients should be monitored for recurrence of signs and symptoms of opioid toxicity for at least 4 hours from the last dose of naloxone or discontinuation of the naloxone infusion. Patients who have overdoses on long-acting opioids should have more prolonged monitoring.[2,10]

Most patients respond by returning to spontaneous breathing. The response generally occurs within 3 to 5 minutes of naloxone administration. (Continue rescue breathing while waiting for the naloxone to take effect.)[2,5,10]

Naloxone will continue to work for 30 to 90 minutes, but after that time, overdose symptoms may return.[17,18]Therefore, it is essential to get the person to an emergency department or other source of medical 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. 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. In the neonate, opioid withdrawal may also include convulsions, excessive crying, and hyperactive reflexes.[17]

NALOXONE NON-RESPONDERS. 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 that 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.[18]

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

SUMMARY

Do's and Don'ts in Responding to Opioid Overdose

- DO support the person's breathing by administering oxygen or performing rescue breathing.
- DO administer naloxone.
- DO put the person in the "recovery position" on the side, if he or she is breathing independently.
- DO stay with the person and keep him/her warm.
- DON'T slap or try to forcefully stimulate the person—it will only cause further injury. If you are unable to wake the person by shouting, rubbing your knuckles on the sternum (center of the chest or rib cage), or light pinching, he or she may be unconscious.
- DON'T put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock.
- DON'T inject the person with any substance (saltwater, milk, "speed," heroin, etc.). The only safe and appropriate treatment is naloxone.
- DON'T try to make the person vomit drugs that he or she may have swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

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

INFORMATION FOR PRESCRIBERS

Opioid overdose is a major public health problem. In 2014, 28,647 of drug overdose deaths involved some type of opioid, including heroin.[14,19] Overdose involves both men and women 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.[4]

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 through their acuity in identifying and effectively addressing opioid overdose. Federally funded Continuing Medical Education (CME) courses are available at no charge at http://www.OpioidPrescribing.com (a series of courses funded by the Substance Abuse and Mental Health Services Administration [SAMHSA])[2].

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. [2,10,22,24]

ASSESS THE PATIENT. Obtaining a history of the patient's past use of drugs (either illicit drugs or prescribed medications with misuse 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?"
- "Have you ever been treated for a possible or suspected opioid overdose?"

The patient history should also 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 further investigation.

TAKE SPECIAL PRECAUTIONS WITH NEW PATIENTS. Many experts recommend that additional precautions be taken in prescribing opioid analgesics for new patients.[22] These might involve the following:

1. Assessment: In addition to doing 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, what substances (including alcohol, illicit drugs, and OTC products) the patient has reported using, and when and what amount was last used and by what route. 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 3 days' supply, and arrange for a

[2] For additional educational material for extended-release and long-acting opioid analgesics, see http://www.er-la-opioidrems.com/IwgUI/rems/faq.action and the FDA Blueprint for Prescriber Education for Extended- Release and Long-Acting Opioid Analgesics, http://www.accessdata.fda.gov/drugsatfda_docs/rems/ERLA_opioids_2015-10-23_FDA_Blueprint.pdf.

return visit the next day. In addition, consider prescribing naloxone to help mitigate risk associated with these emergent situations. At a minimum, the patient's identity should be verified by asking for proper identification.

3. Non-emergencies: 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.

STATE PRESCRIPTION DRUG MONITORING PROGRAMS. State Prescription Drug Monitoring Programs (PDMPs) have emerged as a key strategy for addressing the misuse 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 drugs from multiple physicians.

While nearly all 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.[2,22]

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).

Even when sound medical indications have been established, physicians typically consider three additional factors before deciding to prescribe an opioid analgesic[2,22]:

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 substance use disorders 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 checkups.
3. The dependence-producing potential of the medication. The physician should consider whether a product with less potential for misuse, or even a non-drug therapy, would provide equivalent benefits. Patients should be warned about possible adverse effects caused by inter- actions between opioids and other medications or 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/Consumer-Updates/ucm101653.htm for advice from the United States Food and Drug Administration (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 physician and patient.[22] 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; 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 of opioid analgesics.[3]

Other issues that should be addressed in the informed consent or treatment agreement include the following[22]:

- 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.
- The agreement specifies the consequences for failing to adhere to the treatment plan, which may include discontinuation of opioid therapy if the patient's actions compromise his or her safety.

Both patient and physician should sign the informed con- sent 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 or der must include at least the following information:

- Name and address of the patient
- Name, address, and DEA registration number of the physician

[3] An important source of patient information is the FDA package insert. The medication guides that accompany all extended-release or long-acting as well as oral solution opioids should be reviewed as part of the FDA Risk Evaluation and Management Strategy (REMS). For links to medication guides, please visit http://www.er-la-opioidrems.com/IwgUI/rems/products.action.

For a general patient counseling document on opioid analgesics, available in English or Spanish, please visit: http://www.er-la-opioidrems.com/IwgUI/rems/pcd.action.

- 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.[2]

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[25]. 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 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 prescribe opioids in the absence of such consultations.[22]

CONSIDER PRESCRIBING NALOXONE ALONG WITH THE PATIENT'S INITIAL OPIOID PRESCRIPTION. Naloxone competitively binds opioid receptors and is the antidote to acute opioid toxicity. With proper education, patients on long-term opioid therapy and others at risk for overdose may benefit from being prescribed (1) a naloxone kit containing naloxone, syringes, and needles; (2) Narcan® Nasal Spray, which delivers a single dose of naloxone into one nostril via a pre-filled intranasal spray; or (3)

Evzio®,[4] which delivers a single dose of naloxone to the outer thigh via a hand-held auto-injector. [5,9]

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 are 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 use disorder or non-medical use of prescription or illicit opioids.
- On certain opioid preparations that may increase risk for opioid overdose such as extended release/long-acting preparations.
- Completing mandatory opioid detoxification or abstinence programs.
- Recently released from incarceration and with a history of opioid use disorder (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).

It may also 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.[2] Examples include altering or selling prescriptions, accidental or intentional overdose, multiple episodes of running out early (due to excessive use), doctor shopping, or engaging in 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.

In such a situation, 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 withdrawal symptoms occur, (5) retrain on the risks and the signs of opioid overdose and on the use of naloxone and consider prescribing naloxone if deemed appropriate, and (6) assure the patient that he or she will continue to receive care for the presenting symptoms or condition.[22]

Identification of a patient who is misusing a prescribed opioid 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.[2]

Providing training on use of naloxone and prescribing a naloxone kit or FDA-approved naloxone should be considered.

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

[4] For further information about Evzio® visit http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm.

very real medical problems that demand and deserve the same high-quality medical care offered to any patient.[2,22]

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. [17] Naloxone is approved by the FDA and has been used for decades to reverse overdose and resuscitate individuals who have overdosed on opioids. The routes of administration for naloxone are intravenous, intranasal, intramuscular, and subcutaneous.

The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect.[6,17] 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 known or suspected opioid overdose that incorporates the steps below.

RECOGNIZE THE SIGNS OF OVERDOSE. An opioid overdose requires rapid diagnosis. The most common signs of overdose include[2]:

- Extreme sleepiness, inability to awaken verbally or upon sternal rub.
- Breathing problems that can range from slow to shallow breathing in a patient who cannot be awakened.
- Fingernails or lips turning blue/purple.
- Extremely small "pinpoint" pupils.
- Slow heartbeat and/or low blood pressure.

Signs of **OVERMEDICATION**, which may progress to overdose, include[2]:

- Unusual sleepiness, drowsiness, or difficulty staying awake despite loud verbal stimulus or vigorous sternal rub.
- Mental confusion, slurred speech, intoxicated behavior.
- Slow or shallow breathing.
- Pinpoint (small) pupils; normal size pupils does not exclude opioid overdose.
- Slow heartbeat, low blood pressure.
- Difficulty waking the person from sleep.

Because opioids depress respiratory function and breathing, one telltale sign of an individual in a critical medical state is the "death rattle." This is an exhaled breath with a very distinct, labored sound coming from the throat. It indicates that emergency resuscitation is needed immediately.[26]

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 oxygen before naloxone is administered to reduce the risk of acute lung injury.[2,6] In situations where oxygen is not available, rescue breathing can be very effective in supporting respiration until naloxone becomes available.[27] 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 1 breath every 5 seconds.

ADMINISTER NALOXONE. Naloxone competitively binds opioid receptors and is the antagonist of choice for the reversal of acute opioid toxicity. Any patient who presents with signs of opioid overdose, or when

this is suspected, should be administered naloxone.[9] Naloxone can be given intranasally intramuscularly, subcutaneously, or by intravenous injection.[9,17,18]

PREGNANT PATIENTS. Naloxone can be used in life-threatening opioid overdose circumstances in pregnant women.[9]

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).[6]

Most patients respond to naloxone by returning to spontaneous breathing, with mild withdrawal symptoms.[6] The response generally occurs within 3 to 5 minutes of naloxone administration. (Continue rescue breathing while waiting for the naloxone to take effect.)

The duration of effect of naloxone is 20 to 90 minutes depending on dose and route of administration. 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.[18,19]

More than one dose of naloxone may be required to revive the patient. Those who have taken longer-acting opioids or opioid partial agonists may require further doses or may require further intravenous bolus doses or an infusion of naloxone.[22] 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.[17] 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 may also produce convulsions, excessive crying, and hyperactive reflexes.[17] Additionally, in neonates, opiate withdrawal may be life- threatening if not recognized and properly treated.

NALOXONE NON-RESPONDERS. 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 over- dosing on an opioid but rather some other substance or may even be experiencing a non-overdose medical emergency. Another possible explanation to consider is that 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[5].

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.

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. Many state laws and regulations now permit physicians to prescribe naloxone to a third party, such as a caregiver.[11] More information on state policies is available at http://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 they can always order it. If you are caring for a large population of patients who are 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)

For counseling and instruction on the safe use of opioids, including the use of naloxone outside of the context of SBIRT services, the provider should document the time spent in medication education and use the E&M code that accurately captures the time and complexity. For example, for new patients deemed appropriate for opioid pharmacotherapy and when a substantial and appropriate amount of additional time is used to provide a separate service such as behavioral counseling (e.g., opioid overdose risk assessment and naloxone administration training), consider using modifier–25 in addition to the E&M code.

In addition, when using an evidence-based opioid use disorder or overdose risk factor assessment tool/screening instrument, CPT Code 99420 (Administration and interpretation of health risk assessment instrument) can be used for patients with commercial insurance.

RESOURCES FOR PRESCRIBERS

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

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

http://www.er-la-opioidrems.com/IwgUI/rems/home.action. As required by the FDA under a risk management program for extended-release and long-acting opioid analgesics, this website provides physician training and patient education on the use of such medications.

http://www.medscape.com. One course module sponsored by SAMHSA on Screening, Brief Intervention, and Referral to Treatment (SBIRT) can be accessed at http://www.medscape.org/viewarticle/830331. CME/CE credits are available at no charge.

http://prescribetoprevent.org. Compiled by prescribers, pharmacists, public health workers, lawyers, and researchers working on overdose prevention and naloxone access, this privately funded site provides resources to help health care providers educate their patients to reduce overdose risk and provide naloxone rescue kits to patients.

SAFETY ADVICE FOR PATIENTS & FAMILY MEMBERS

WHAT ARE OPIOIDS?

Opioids include illicit drugs such as heroin and prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine.

Opioids work by binding to specific receptors in the brain, spinal cord, and gastrointestinal tract. In doing so, they minimize the body's perception of pain. However, stimulating the opioid receptors or "reward centers" in the brain can also trigger other systems of the body, such as those responsible for regulating mood, breathing, and blood pressure.

A variety of effects can occur after a person takes opioids, ranging from pleasure to nausea and vomiting, from severe allergic reactions (anaphylaxis) to overdose, in which breathing and heartbeat slow or even stop.

Opioid overdose can occur when a patient misunderstands the directions for use, accidentally takes an extra dose, or deliberately misuses a prescription opioid or an illicit drug such as heroin.

Also at risk is the person who takes opioid medications pre- scribed for someone else, as is the individual who combines opioids—prescribed or illicit—with alcohol, certain other medications, and even some over-the-counter products that depress breathing, heart rate, and other functions of the central nervous system[5].

PREVENTING OVERDOSE

If you are concerned about your own use of opioids, don't wait! Talk with the health care professional(s) who prescribed the medications for you. If you are concerned about a family member or friend, urge him or her to talk to whoever prescribed the medication.

Effective treatment of opioid use disorder can reduce the risk of overdose and help a person who is misusing or addicted to opioid medications attain a healthier life. An evidence-based practice for treating opioid addiction is the use of United States Food and Drug Administration (FDA)-approved medications, along with counseling and other supportive services. These services are available at SAMHSA-certified and DEA-registered opioid treatment programs (OTPs).[28,29] In addition, physicians who are trained to provide treatment for opioid addiction in office-based and other settings with medications such as buprenorphine/naloxone and naltrexone may be available in your community.[30]

IF YOU SUSPECT AN OVERDOSE

An opioid overdose requires immediate medical attention. An essential first step is to get help from some- one with medical expertise as soon as possible. *Call 911 immediately* if you or someone you know exhibits any of the symptoms listed below. All you have to say: "Some- one is unresponsive and not breathing." Give a clear address and/or description of your location.

Signs of OVERDOSE, which is a life-threatening emergency, include the following:

- The face is extremely pale and/or clammy to the touch.
- The body is limp.
- Fingernails or lips have a blue or purple cast.
- The person is vomiting or making gurgling noises.
- He or she cannot be awakened from sleep or is unable to speak.
- Breathing is very slow or stopped.
- The heartbeat is very slow or stopped.

Signs of OVERMEDICATION, which may progress to overdose, include:

- Unusual sleepiness or drowsiness.
- Mental confusion, slurred speech, or intoxicated behavior.
- Slow or shallow breathing.
- Extremely small "pinpoint" pupils.
- Slow heartbeat or low blood pressure.
- Difficulty in being awakened from sleep.

SAFETY ADVICE FOR PATIENTS & FAMILY MEMBERS

WHAT IS NALOXONE?

Naloxone is an antidote to opioid overdose. It is an opioid antagonist that is used to reverse the effects of opioids. Naloxone works by blocking opiate receptor sites. It is not effective in treating overdoses of benzodiazepines (such as Valium®, Xanax®, or Klonopin®), barbiturates (Seconal® or Fiorinal®), clonidine, Elavil®, GHB, or ketamine. It is also not effective in treating overdoses of stimulants such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful.

IMPORTANT SAFETY INFORMATION. Naloxone may cause dizziness, drowsiness, or fainting.
These effects may be worse if it is taken with alcohol or certain medicines. For more information, see http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm472923.htm.

REPORT ANY SIDE EFFECTS

Get emergency medical help if you or someone has any signs of an allergic reaction after taking naloxone, such as hives, difficulty breathing, or swelling of your face, lips, tongue, or throat.

Call your doctor or 911 at once if you have a serious side effect such as:

- Chest pain, or fast or irregular heartbeats.
- Dry cough, wheezing, or feeling short of breath.
- Sweating, severe nausea, or vomiting.
- Severe headache, agitation, anxiety, confusion, or ringing in your ears.
- Seizures (convulsions).
- Feeling that you might pass out.
- Slow heart rate, weak pulse, fainting, or slowed breathing.

If you are being treated for opioid use disorder (either an illicit drug like heroin or a medication prescribed for pain), you may experience the following symptoms of opioid withdrawal after taking naloxone:

- Feeling nervous, restless, or irritable.
- Body aches.
- Dizziness or weakness.
- Diarrhea, stomach pain, or mild nausea.
- Fever, chills, or goosebumps.
- Sneezing or runny nose in the absence of a cold.

This is not a complete list of side effects, and others may occur. Talk to your doctor about side effects and how to deal with them.

STORE NALOXONE IN A SAFE PLACE

Naloxone is usually handled and stored by a health care provider.

If you are using naloxone at home, store it in a locked cabinet or other space that is out of the reach of children or pets.

SUMMARY: HOW TO AVOID OPIOID OVERDOSE

1. Take medicine only if it has been prescribed to you by your doctor.
2. Do not take more medicine or take it more often than instructed.
3. Call a doctor if your pain gets worse.
4. Never mix pain medicines with alcohol, sleeping pills, or any illicit substance.
5. Store your medicine in a safe place where children or pets can- not reach it.
6. Learn the signs of overdose and how to use naloxone to keep it from becoming fatal.
7. Teach your family and friends how to respond to an overdose.
8. Dispose of unused medication properly.

READ MORE AT
http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm472923.htm.

RESOURCES FOR OVERDOSE SURVIVORS AND FAMILY MEMBERS

Survivors of opioid overdose have experienced a life- changing and traumatic event. They have had to deal with the emotional consequences of overdosing, which can involve embarrassment, guilt, anger, and gratitude, all accompanied by the discomfort of opioid withdrawal. Most need the support of family and friends to take the next steps toward recovery.

While many factors can contribute to opioid overdose, it is almost always an accident. Moreover, the underlying problem that led to opioid use—most often pain or substance use disorder—still exists and continues to require attention.[2]

Moreover, the individual who has experienced an overdose is not the only one who has endured a traumatic event. Family members often feel judged or inadequate because they could not prevent the overdose. It is important for family members to work together to help the overdose survivor obtain the help that he or she needs.

FINDING A NETWORK OF SUPPORT

As with any disease, it is not a sign of weakness to admit that a person or a family cannot deal with the trauma of overdose with- out help. It takes real courage to reach out to others for support and to connect with members of the community to get help.

Health care providers, including those who specialize in treating substance use disorders, can provide structured, therapeutic support and feedback.

If the survivor's underlying problem is pain, referral to a pain specialist may be in order. If it is addiction, the patient should be referred to an addiction specialist for assessment and treatment, either by a physician specializing in the treatment of opioid addiction, in a residential treatment program, or in a federally certified Opioid Treatment Program (OTP). In each case, counseling can help the individual manage his or her problems in a healthier way. Choosing the path to recovery can be a dynamic and challenging process, but there are ways to help.

In addition to receiving support from family and friends, overdose survivors can access a variety of community-based organizations and institutions, such as:

- Health care and behavioral health providers.
- Peer-to-peer recovery support groups such as Narcotics Anonymous.
- Faith-based organizations.
- Educational institutions.
- Neighborhood groups.
- Government agencies.
- Family and community support programs.

RESOURCES

Information on opioid overdose and helpful advice for overdose survivors and their families can be found at:

Substance Abuse and Mental Health Services Administration (SAMHSA)

- National Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD—for hearing impaired)
- Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov to search by address, city, or zip code
- Buprenorphine Treatment Physician Locator: http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- State Substance Abuse Agencies: https://findtreatment.samhsa.gov/TreatmentLocator/faces/about.jspx

Centers for Disease Control and Prevention (CDC):
http://www.cdc.gov/drugoverdose/epidemic

National Institutes of Health (NIH), National Center for Biotechnical Information:
http://www.ncbi.nlm.nih.gov

Partnership for Drug-Free Kids:
http://www.drugfree.org/join-together/opioid-overdose-antidote-being-more-widely-distributed-to-those-who-use-drugs

Project Lazarus:
http://www.projectlazarus.org

Harm Reduction Coalition:
http://www.harmreduction.org

Overdose Prevention Alliance:
http://www.overdosepreventionalliance.org

Toward the Heart:
http://www.towardtheheart.com/naloxne

REFERENCES

[1] Number and age-adjusted rates of drug-poisoning deaths involving opioid analgesics and heroin: United States, 2000–2014. Centers for Disease Control and Prevention Website. http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf. Accessed January 11, 2016.

[2] Beletsky LB, Rich JD, Walley AY. Prevention of fatal opioid overdose. *JAMA*. 2012;308(18):1863-1864.

[3] Centers for Disease Control and Prevention. CDC Vital Signs: Opioid painkiller prescribing—where you live makes a difference. http://www.cdc.gov/vitalsigns/opioid-prescribing. Published July 1, 2014. Accessed January 11, 2016.

[4] Harvard Medical School. Painkillers fuel growth in drug addiction: opioid overdoses now kill more people than cocaine or heroin. *Harvard Ment Hlth Let*. 2011;27(7):4-5.

[5] Brunton L, Chabner B, Knollman B. *Goodman and Gilman's The Pharmacological Basis of Therapeutics*. 12th ed. New York: McGraw-Hill; 2011.

[6] Boyer EW. Management of opioid analgesic overdose. *N Engl J Med*. 2012;367(2):146-155.

[7] Enteen L, Bauer J, McLean R, Wheeler E, Huriaux E, Kral AH, Bamberger JD. Overdose prevention and naloxone prescription for opioid users in San Francisco. *J Urban Health*. 2010;87(6):931-941.

[8] Seal KH, Thawley R, Gee L, et al. Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: a pilot intervention study. *J Urban Health*. 2005;82(2):303-311.

[9] Bazazi AR, Zaller ND, Fu JJ, Rich JD. Preventing opiate overdose deaths: examining objections to take-home naloxone. *J Health Care Poor Underserved*. 2010;21(4):108–1113. doi:10.1353/hpu.2010.0935

[10] Coffin PO, Sullivan SD. Cost effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intl Med*. 2013;158(1):1-9.

[11] Davis C. Legal interventions to reduce overdose mortality: naloxone access and overdose Good Samaritan laws. https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf. Updated September 2015. Accessed January 11, 2016.

[12] Strang J, Manning V, Mayet S, et al. Overdose training and take-home naloxone for opiate users: prospective cohort study of impact on knowledge and attitudes and subsequent management of overdoses. *Addiction*. 2008;103(10):1648-1657.

[13] Green TC, Heimer R, Grau LE. Distinguishing signs of opioid overdose and indication for naloxone: an evaluation of six overdose training and naloxone distribution programs in the United States. *Addiction*. 2008;103(6):979-998.

[14] Centers for Disease Control and Prevention. Increases in drug and opioid overdose deaths — United States, 2000-2014. *MMWR Morb Mortal Wkly Rep*. 2016;64(50):1378-1382.

[15] Yaksh TL, Wallace MS. Opioids, analgesia, and pain management. In: Brunton L, Chabner B, Knollman B, eds. *Goodman and Gilman's The Pharmacologic Basis of Therapeutics*. 12th ed. New York, NY: McGraw-Hill; 2011, 481-526.

REFERENCES

[16] Centers for Disease Control and Prevention. Community-based opioid overdose prevention programs providing naloxone—United States, 2010. *MMWR Morb Mortal Wkly Rep.* 2012;261(6):101-105.

[17] Rx List. http://www.rxlist.com. Accessed March 24, 2013.

[18] Drugs.com. http://www.drugs.com. Accessed March 24, 2013.

[19] FDA moves quickly to approve easy-to-use nasal spray to treat opioid overdose. Food and Drug Administration Website:.http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm473505.htm. Published November 18, 2015. Updated November 19, 2016. Accessed January 11, 2016.

[20] Sporer KA. Acute heroin overdose. *Ann Intern Med.* 1999;130(7):584-590.

[21] LoVecchio F, Pizone A, Riley B, Sami, A, D'Incognito C. Onset of symptoms after methadone overdose. *Am J Emerg Med.* 2007;25(1):57-59.

[22] Isaacson JH, Hopper JA, Alford DP, Parran T. Prescription drug use and abuse. Risk factors, red flags, and prevention strategies. *Postgrad Med.* 2005;118:19.

[23] Kampman, K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the use of medications in the treatment of addiction involving opioid use. *J Addict Med.* 2015;9(5):358-67. doi:10.1097/ADM.0000000000000166

[24] Centers for Disease Control and Prevention. CDC grand rounds: prescription drug overdoses—a U.S. epidemic. *MMWR Morb Mortal Wkly Rep.* 2012;61(1):10-13.

[25] Finch JW, Parran TV Jr, Wilford BB, Wyatt SA. Clinical, ethical, and legal considerations in prescribing drugs with abuse potential. In: Ries RK, Fiellin DA, Miller SC, Saitz R, eds. *Principles of Addiction Medicine.* 5th ed. Philadelphia, PA: Wolters Kluwer; 2014:1703-1710.

[26] Clary PL, Lawson P. Pharmacologic pearls for end-of-life care. *Am Fam Physician.* 2009;79(12):1059-1065.

[27] Lavonas J, Drennan IR, Gabrielli A, Heffner AC, Hoyte CO, Orkin AM, Sawyer KN, Donnino MW. Part 10: Special circumstances of resuscitation. In: *American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.* Dallas, TX: American Heart Association; 2015.

[28] Michna E, Ross EL, Hynes WL, et al. Predicting aberrant drug behavior in patients treated for chronic pain: importance of abuse history. *J Pain Symptom Manage.* 2004;28(3):250-258.

[29] SAMHSA's National Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD for hearing impaired).

[30] Behavioral Health Treatment Services Locator: https://findtreatment.samhsa.gov to search by address, city, or zip code.

ACKNOWLEDGMENTS

Acknowledgments

This publication was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Association of State and Territorial Health Officials, in cooperation with Public Health Research Solutions, under contract number 10-233-00100 with SAMHSA, U.S. Department of Health and Human Services (HHS). LCDR Brandon Johnson, M.B.A., served as the Government Project Officer.

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Recommended Citation

Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 16-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

Originating Office

Division of Pharmacologic Therapies, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.
HHS Publication No. (SMA) 16-4742. First printed 2013. Revised 2014, 2016.

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

HHS Publication No. (SMA) 16-4742. First printed 2013. Revised 2014, 2016

STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTH CARE

UNIT **Center of Excellence**

POLICY/PROCEDURE NO.

COE - 014

SUBSECTION EFFECTIVE DATE

08/08/2016

POLICY/PROCEDURE

The Alcohol Use Disorders Identification Tool (AUDIT)

AMENDMENT / REVISION HISTORY
Approved:
Amended:

POLICY

The AUDIT is to be given to each patient to complete at the time of intake evaluation to assist with determination of whether hazardous alcohol use or a possible diagnosis of Alcohol Use Disorder is present.

PROCEDURE

Description

As part of the intake evaluation, patients will be asked to complete the AUDIT which will be scored by a staff member and results used in consideration of the severity of substance use problems being experienced by the patient.

LIST OTHER SUPPORTING DOCUMENTS/RESOURCES

This tool was developed by the World Health Organization to assess alcohol consumption, behavior related to drinking, and alcohol related problems.

1. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG: AUDIT: Alcohol use disorders identification test for use in primary care populations, second edition, World Health Organization, Department of Mental Health and Substance Dependence; http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf accessed online April 5, 2008

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

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

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

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

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

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

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

Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

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

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

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

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

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

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

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

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

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

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

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

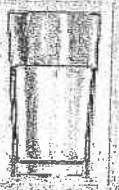
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

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

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  ~5% alcohol	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  ~7% alcohol	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  ~12% alcohol	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  ~40% alcohol	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

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