Dear Healthcare Professional

NYS is in a period of transformation on how healthcare is delivered and received with a greater emphasis on prevention and a whole patient approach. Reimbursements are being structured on value rather than fee for service.

The Staten Island PPS is working to build provider capacity in incorporating behavioral health services in Primary Care in order to prepare for these changes and provide the highest level of care and achieve the triple aim of improving health, enhancing the patient care experience which encompasses access, quality, and reliability, and reduce or control the cost of care. As you are aware, Staten Island is in the middle of a substance abuse epidemic, these issues along with depression and anxiety can play an important role in the etiology, course and outcomes associated with chronic diseases. Primary care physicians can effectively screen for and manage these issues with multiple resource support.

Because people with co-occurring disorders are everywhere in our communities, every point of entry into the health care system is an opportunity for out-reach, education, and connection to needed services. The primary care setting is ideal for identification of people with behavioral health issues.

In order to better serve your patients we strongly recommend the following:

- **Universal screening for substance use and mental health issues such as depression and anxiety**
- **Create systems to link your patients to behavioral health resources in the community**
- **Refer your Medicaid patients to SI CARES**

This Toolkit provides valuable resources for clinicians on how these issues impact wellness. Included in your toolkit is a referral grid for services focusing on Mental Health and Substance use as well as patient education material. We will be following up with you soon to explore how the Staten Island PPS can better support you in the behavioral health integration efforts.

In the meantime please visit the Staten Island PPS web site for more information and resources.
http://www.statenislandpps.org/home

Sincerely,

Nadeen Makhlouf Pharm D., MPH
Sr. Coordinator Clinical Outreach & Education
Staten Island Partnership for Community Wellness (SIPCW)

Sincerely,

Salvatore Volpe, MD
Chief Medical Officer
Staten Island PPS

Use this guide as a quick referral tool. It has mental health providers on Staten Island and the services they offer

STATEN ISLAND MENTAL HEALTH PROVIDERS

	Outpatient Treatment Clinic	Inpatient Services	Peer Services	Family Support	Respite Services	Housing	Vocational Services	Care Management	Club House
Bridge Back to Life 718-447-5700	* Youth & Adults								
Brightpoint Health Staten Island - Addiction Treatment Program 718-808-1439	* Youth & Adults								
Camelot of Staten Island 718-981-8117	* Youth & Adults								
CHASI Health Homes & SI Cares 718-808-1433								18+	
Freedom From Fear 718-331-1717	Anxiety Only								
Jewish Board of Family & Children's Services 718-727-3303								Youth & Adults	
Jewish Board of Family & Children's Services 718-761-9800	Youth & Adults		Youth & Adults	Ages 0-24	Ages 5-18	Ages 8-18			
National Alliance on Mental Illness (NAMI) 718-477-1700			Youth & Adults	Youth & Adults					
Project Hospitality 718-273-8409	* 18+					Ages 21+			
Project Hospitality Care Management 718-420-1475								Youth & Adults	
RUMC-Inpatient Unit 718-818-1234		Youth & Adults							
RUMC-Mental Illness, Chemical Abuse (MICA) Clinic 718-818-5777	* 18+								
RUMC Partial Hospital Program 718-818-6132	18+		18+						
RUMC-Saint George Clinic 718-818-6132	18+								
RUMC-West Brighton Clinic 718-818-6132	* 18+								
St. Joseph's Medical Center 718-985-4740	18+					* 18+			
St. Joseph's Medical Center 718-876-2810					18+				
St. Joseph's Medical Center 718-983-2300				18+	18+				
Samaritan Daytop 718-981-3136	Youth & Adults								
Silver Lake Behavioral Health 718-815-3155	18+			18+					
SIMHS Safety.net 718-984-6218			Ages 16-23				Ages 16-23		
SIUH-South- Inpatient Psychiatric Program 718-226-2800		18+	18+	18+		18+		18+	
SIUH-North - Outpatient Mental Health Clinic 718-226-8910/8911	18+			18+				18+	
SIUH- North - Partial Hospital Program 718-226-6552	18+			18+			18+	18+	
SIUH- On Track NY ***(for onset of psychosis)*** 718-226-3943	Ages 16-30		Ages 16-30	Ages 16-30			Ages 16-30	Ages 16-30	
SIUH- South - Outpatient Mental Health Clinic 718-226-2274/2275	18+			18+				18+	
South Beach Psychiatric Center 718-667-2300	Youth & Adults	Youth & Adults	18+			Youth & Adults			
Staten Island Behavioral Network 718-351-5530						18+		18+	
Staten Island Mental Health Society 718-442-2225	Youth & Adults			Youth & Adults			Ages 16-24	Ages 0-18	
Venture House 718-658-7821			18+				18+		18+
YMCA North Shore Center 718-981-4382	Youth & Adults								
YMCA South Shore Center 718-948-3232	Youth & Adults								

Chart Key

Youth & Adults

Adults Only
18+

***Co-occurring Disorders:** have substance use and mental health disorder. For these agencies the individuals must have a primary diagnosis of substance use.

For mental health emergencies:

CPEP
355 Bard Ave
SI. NY 10310
718-818-6443

For crisis situations, call NYC Well to dispatch a Mobile Crisis Team

1-888-NYC-WELL
(1-888-692-9355)
or Text
WELL to 65173

Staten Island Partnership for Community Wellness

Staten Island
Performing Provider System

SERVICE DEFINITIONS

MENTAL HEALTH SERVICES

Outpatient Treatment Clinic: Facility that provides comprehensive assessment, screening, and treatment services as well as psychiatric services, family, individual, and group counseling, and referral services.

Inpatient Services: A 24 hours per day hospital based program which includes psychiatric , medical, nursing, and social services, which are required for the assessment and/or treatment of a person with a primary diagnosis of mental illness who can not be adequately serve in the community.

Crisis/Emgercency Services: Activities aimed at stabilizing occurrences of individual/family crisis where it arises. Services include are screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs. This can also be in a hospital setting: A hospital based program which offers access to crisis outreach, interventions, and residential services and/or provides beds for the extended observation (up to 72 hours) to adults who need emergency mental health services.

Peer Services: Persons with lived experience trained to work with people.

Family Support: Training and counseling services for the families of individuals served. Family is defined as the persons who live with or provide care to a person served, and may include a parent, spouse, children, relatives, foster family, or in-laws.

Respite Services: Short-term relief to individuals who are caring for family members who might need more support outside of the home. There are various models for providing respite care depending on how much support is needed. (NAMI).

Vocational Services: Services that help overcome barriers to access, maintaining or returning to employment or other occupations.

Care Management: Care coordination, health education and management support, transition services, direct social service support, individual and family support via New York State Health Home or the Staten Island CARES program services.

Use this guide as a quick referral tool. It has all the substance use treatment providers on Staten Island and the services they offer.

STATEN ISLAND SUBSTANCE USE TREATMENT PROVIDERS

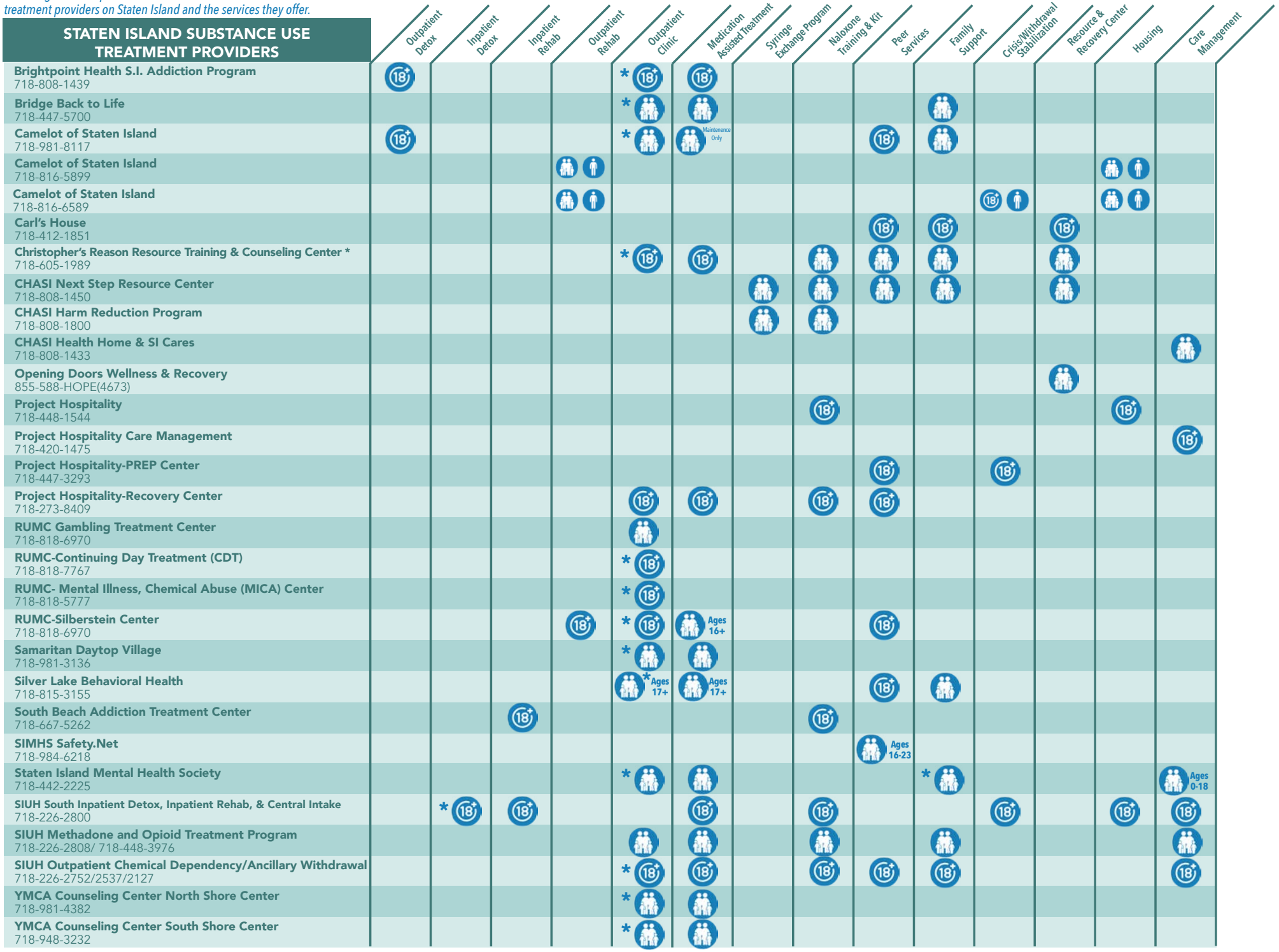


Chart Key

Youth & Adults

Adults Only 18+

Male Only

* **Co-occurring Disorders:** have substance use and mental health disorder. For these agencies the individuals must have a primary diagnosis of substance use.

SERVICE DEFINITIONS

SUBSTANCE USE SERVICES

Detoxification (Detox): Medical treatment conducted under the supervision of a physician to systematically reduce the amount of the addictive substance in a patient's body. There is some level of monitoring of the withdrawal symptoms. This can be in an inpatient or outpatient setting. Patients must meet criteria to be admitted into inpatient detox.

Rehabilition (Rehab): A facility for ongoing treatment after the patient has been detoxed. Usually the patient stays overnight (inpatient), but it can be an outpatient setting.

Outpatient Detox (a.k.a. Ambulatory Detox or Ancillary Withdrawal): A facility for safe withdrawal of substances and ongoing treatment, however the patient does not stay overnight. This may include Medication Assisted Treatment (MAT).

Inpatient Detox: 24 hour per day monitored medical acute care services in hospital or residential setting for safe withdrawal and transition to ongoing treatment.

Inpatient Rehab: 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility staffed with physicians, nurses, and clinical staff 24/7. The patient stays in this facility overnight.

Outpatient Clinic: Clinics that provide treatment services to individuals who suffer from substance use disorders and their family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the patient. The patient does not stay overnight at the clinic.

Medication Assisted Treatment: The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

Syringe Exchange Program: Programs that provide free sterile syringes and collect used syringes from injection-drug users to reduce transmission of blood borne pathogens, including HIV, Hepatitis B, Hepatitis C.

Naloxone Training and Kit: Programs target people who are at risk of opioid overdose and/or likely to be bystanders during an overdose to educate them on how to prevent an overdose from occurring, and to prevent opioid related over intoxication from progressing to a fatal overdose by seeking help, rescue breathing and administering naloxone.

Peer Services: Persons with lived experience trained to work with people.

Family Support: Services that provide education, counseling, and other assistance to family/friend of a person with substance use issues.

Resource and Recovery Centers: Centers where a person can get information on many types of treatment, recovery, and support options including peer support.

Crisis / Withdrawal Stabilization: Activities aimed at stabilizing occurrences of individual/family crisis where it arises. Services include are screening, assessment, stabilization, triage, and/or referral to an appropriate program or programs.

Care Management: Care coordination, health education and management support, transition services, direct social service support, individual and family support via New York State Health Home or the Staten Island CARES program services.

Collaborative Care: Integrating Behavioral Health into Primary care

Program Name	Delivered by	Description & Link	Delivery Mode	Cost
Primary Care Psychiatric Consultation Training Series.	Aims Center; Division of University of Washington	Training modules on Collaborative Care & support for implementing a Collaborative Care consultation program in primary care settings https://aims.uw.edu/resource-library/primary-care-psychiatric-consultation-training-series	Online	FREE
Psychiatry Residents Training in Collaborative Care	Aims Center; Division of University of Washington	Clinical curriculum that introduces a senior resident to the role of psychiatric consultant in Collaborative Care Team https://aims.uw.edu/resource-library/psychiatry-resident-training-collaborative-care	Online	FREE
The PCP Role Training Module	Aims Center; Division of University of Washington	Training module for the role of PCP as part of a Collaborative Care team https://aims.uw.edu/resource-library/pcp-role-training-module	Online	FREE
Staten Island PPS Education forum series	SI PPS, SIPCW, & Borough Hall	Collaborative effort between SI PPS, Borough Hall, and SIPCW to bring a series of presentations for medical and behavioral health providers across the island. CME event http://www.statenislandpps.org/home	In person	FREE For more information contact Nadeen@sipcw.org
Shared Decision Making	Dartmouth-Hitchcock & Mayo Clinic	Allows patients & providers to make decisions concerning the patient's health (i.e. medication, treatment). Patient centered care and better management of patients health Shared Decision Making http://med.dartmouth-hitchcock.org/csdm_toolkits.html	Online	FREE

		Mayo Clinic: http://shareddecisions.mayoclinic.org/		
NYC REACH Membership	NYC REACH	Assists New York City-based practices, independently owned community health centers, and hospital ambulatory sites with adopting and implementing health information systems, quality improvement, and practice transformation initiatives http://nycreach.org/	Online	FREE
EHR Support	NYC DOHMH	Provides support in adopting & implementing an EHR. Can also get quality improvement support on using & customizing HER & process billing http://www1.nyc.gov/site/doh/providers/electronic-records.page	Contact NYC DOHMH for more information	FREE
Mental Health Service Corps	NYC DOHMH	A program that hires and pays for mental health professionals up to 3 years to be placed in primary care settings. Professionals will help manage patients with mental health disorders by assessing, treating, and referring patients.	Contact ecarrol@health.nyc.gov	Free for those who are eligible; application Process

Screening and brief interventions For Behavioral Health

Program Name	Delivered by	Description	Delivery Mode	Cost
Children and Adolescents Psychiatry for Primary Care (CAP PC)	**Project TEACH** In NYC Columbia University Medical Center/NYS Psychiatric Institute & Hofstra North well School of Medicine	Component of Project TEACH. Builds the capacity of pediatric PCPs to assess & manage children & adolescents (up to age 21) with mild to moderate mental health disorders. PCPs have access to adolescent psychiatrists via phone consultation 5 days a week (M-Th 8am-7pm, F 8am-5pm), a	If interested or want more information contact Dr. David Kaye, the Project Director for	If interested or want more information contact Dr. David Kaye, the Project Director for

	provide project TEACH services	Liaison Coordinator to help with referrals to children mental health services and to educational programs through REACH Institute	Region 3 (518) 474-8394	Region 3 (518) 474-8394
Screening, Brief Intervention, and Referral to Treatment (SBIRT) SI PPS/SIUH: SI PPS is working with SIUH to offer SBIRT training for medical professionals 2 Modules: Model A1: 4 hour online module for licensed professionals Model C: 4 hour online module + 8 hour in-person training for non-licensed professional OASAS SBIRT services: OASAS will dedicate a person to train SBIRT in pediatric settings	SI PPS/SIUH	An evidence based model that helps identify, reduce, and prevent problematic use, abuse, and dependence of substances https://www.oasas.ny.gov/admed/sbirt/index.cfm	Online and in-person	FREE
Motivational Interviewing	More information to follow	A method that works on facilitating and engaging intrinsic motivation within the client in order to change behavior http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing#resources	Online	FREE
Alcohol Use Disorder Identification Test (AUDIT)	SAMHSA	A 10-item questionnaire that screen for harmful alcohol consumption. The shorter version is the AUDIT-C, which is a 3 item questionnaire http://www.integration.samhsa.gov/clinical-practice/screening-tools	Online	FREE
Drug Abuse Screen Test (DAST)	SAMHSA	A 10 item questionnaire that screen for drug use http://www.integration.samhsa.gov/clinical-practice/screening-tools	Online	FREE

Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)	SAMHSA	A 6 item questionnaire that screen for substance use for children & adolescents (under age 21) http://www.integration.samhsa.gov/clinical-practice/screening-tools	Online	FREE
CAGE AID	SAMHSA	A questionnaire that screen for alcohol and drug use http://www.integration.samhsa.gov/clinical-practice/screening-tools	Online	FREE
Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)	SAMHSA	A questionnaire that screen for alcohol and drug use http://www.integration.samhsa.gov/clinical-practice/screening-tools	Online	FREE
Michigan Alcoholism Screening Test (MAST)	SAMHSA	A screening tool for alcohol. The shorter version is the MAST 10, which is a 10 item questionnaire http://www.integration.samhsa.gov/clinical-practice/screening-tools	Online	FREE
P4	TBD	A screening tool to evaluate potential suicide risk	Online	FREE
Columbia Suicide Severity Rating Scale (C-SSRS)	The Columbia Light House Project	A questionnaire that used for suicide assessment http://cssrs.columbia.edu/training/training-options/	Online or in person	FREE
PHQ - 9	AAFP American Family Physician	A screening tool used to identify depression disorder http://www.aafp.org/afp/2012/0115/p139.html	Online	FREE

Judicious pain management

Program Name	Delivered by	Description	Delivery Mode	Cost
(COPE-REMS)	Aims Center; Division of University of Washington	Interactive online training for opioid prescribing providers. Focuses on care & management of chronic pain. Physicians can **earn free CME credits** http://www.coperems.org/about-page/	Online	FREE
Medical Patients with Psychiatric Illness	Aims Center; Division of University of Washington	Presentation on chronic illness & behavioral health. Tips to identify and treat common medical co-morbidities, chronic pain & pain management strategies into treatment plans. Power Point presentation found on https://aims.uw.edu/resource-library/medical-patients-psychiatric-illness	Online power point	FREE

Opiate disorder treatment

Program Name	Delivered by	Description	Delivery Mode	Cost
Medication Assisted Treatment	Niatx	A toolkit to help start with MAT http://www.niatx.net/PDF/NIATx-MAT-Toolkit.pdf	Online	FREE
Buprenorphine Course for Office-Based Treatment of Opioid Use Disorder The American Society of Addiction Medicine http://www.samhsa.gov/medica	SAMHSA		Online	FREE

tion-assisted-treatment/training-resources/buprenorphine-physician-training OR http://www.asam.org/education/live-online-cme/buprenorphine-course NYC DOHMH (Buprenorphine waiver training & technical assistance for physicians practicing in NYC)	ASAM NYC DOHMH	Mat training for physicians, NP's & PA's; allows professionals to obtain their waiver to prescribe Buprenorphine 8-hour training course on buprenorphine prescribing	Online In person	FREE For information & dates of upcoming trainings, please email: buprenorphine@health.nyc.gov
Providers' Clinical Support System for MAT http://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training OR http://pcssmat.org/	SAMHSA	Webinars/online sessions trainings for MAT & T Stigma	Online	FREE
PCIP (Primary Care Information Project	PCIP	http://www1.nyc.gov/site/doh/providers/electronic-records.page Any practice not in PHIP (and not getting PPS paid PCMH TA) can get free technical assistance from PCIP to become an "Advanced Primary Care" recognized site		FREE

Care Management

Program/Provider	Delivered by	Description	Delivery Mode	Cost
CHASI 56 Bay street, 6th floor 718-808-1439	Community Health Action Of Staten Island (CHASI)	Care coordination, health education and management support, transition services, direct social service support, individual and family support via Staten Island CARES and NYS Health Home Program services. Ages 18+ www.Chasiny.org	In person	Contact CHASI For more details
Coordinated Behavioral Care, in 358 St. marks place 718-556-7340	Coordinated Behavioral Care, inc	Care coordination, health education and management support, transition services, direct social service support, individual and family support via Staten Island CARES and NYS Health Home Program services. Ages 0+ www.cbcare.org	In person	Contact for more details
Jewish Board of Family & Children Services 358 St. Marks Place 718-727-3303	Jewish Board of Family & Children Services	Care coordination, health education and management support, transition services, direct social service support, individual and family support via Staten Island CARES and NYS Health Home Program services. Ages 0+ www.jewishboard.org	In person	Contact for more details
Northwell Health Solutions 1-888-680-6501	Northwell Health Solutions	Care coordination, health education and management support, transition services, direct social service support, individual and family support via Staten Island CARES and NYS Health Home Program services. Ages 18+	In person	Contact for more Details
Project Hospitality 100 Park Avenue	Project Hospitality	Care coordination, health education and management support, transition services, direct social service support, individual and	In person	Contact for more Details

718-448-1544		family support via Staten Island CARES and NYS Health Home Program services. Ages 18+ www.projecthospitality.org		
Saint Joseph's Medical Center 1216 Bay St 718-982-4772	Saint Joseph's Medical Center	Care coordination, health education and management support, transition services, direct social service support, individual and family support via Staten Island CARES and NYS Health Home Program services. Ages 18+	In person	Contact for more details
Staten Island Behavioral Network 4434 Amboy Road, 2nd Floor 718-351-5530	Staten Island Behavioral Network	Care coordination, health education and management support, transition services, direct social service support, individual and family support via Staten Island CARES and NYS Health Home Program services. Ages 18+ www.sibehavioralnetwork.org	In person	Contact for more Details
Staten Island Mental Health Society 669 Castleton Avenue 718-442-2225 www.simhs.org	Staten Island Mental Health Society	Care coordination, health education and management support, transition services, direct social service support, individual and family support via Staten Island CARES and NYS Health Home Program services. Ages 0-18	In person	Contact for more details

Smoking Cessation

Program Name	Delivered by	Description	Delivery Mode	Cost
Public Health Action Kits for Smoking Cessation	NYC DOHMH	**Clinical Tools:** includes**;** Pregnancy smoking cessation guide for Primary Care providers, Helping your patients quit smoking coaching guide, Smoking Cessation medication prescribing chart **https://www1.nyc.gov/site/doh/providers/resources/public action-kits-smoking-cessation.page**	**Printable**	**FREE**

New York State's Smokers QUIT LINE	**NYC DOHMH**	The New York State Smokers' Quitline provides free quit-smoking services to New York State residents interested in quitting tobacco use. The Quitline also supports providers who want to help their patients quit smoking. qunity.nysmokefree.com https://www1.nyc.gov/assets/doh/downloads/pdf/csi/nys-s quitline.pdf	**Online & Via Phone**	**FREE**
Public Health Action Kits for Smoking Cessation Created by: NYC DOHMH	**NYC DOHMH**	**Provider resources:** E-cigarettes know the facts, NYS Tobacco cessation Counseling information & billing Codes, Treating tobacco use online learning module, Tobacco quit kit resources, https://www1.nyc.gov/site/doh/providers/resources/public action-kits-smoking-cessation.page	**Online PDF**	**FREE**
Public Health Action Kits for Smoking Cessation Created by: NYC DOHMH	**NYC DOHMH**	**Patient Education Material:** How to make your home Smoke free, Medicaid Fact card, Medicaid poster, Quit to save brochure, still smoking brochure, tobacco Quit kit poster, tobacco quit kit palm card https://www1.nyc.gov/site/doh/providers/resources/public action-kits-smoking-cessation.page	**PDF**	**FREE**
FREE CME on Treating Tobacco Use	**NYC DOHMH**	**Online Training FREE CME:** Provides 5a's on treating Tobacco use, pharmacologic therapy as well as its Contraindications and indications, identify which Medications can be combined for treatment, New York state benefits for smoking cessation Treatment https://www1.nyc.gov/assets/doh/media/tobacco/player.ht	**Online Training**	**FREE**

UPDATED
OCTOBER 2016
WITH REIMBURSEMENT CHANGES

City Health Information

Volume 35 (2016) The New York City Department of Health and Mental Hygiene No. 1; 1-12

Detecting and Treating Depression in Adults

- **Many patients with depression seek medical care for other concerns, but depression remains undiagnosed.**
- **Primary care physicians can effectively detect and manage depression.**
- **Routinely screen adults for depression using a simple 2-question tool (PHQ-2).**
- **Engage patients in treatment planning and provide pharmacotherapy when appropriate (see page 3).**

INSIDE THIS ISSUE

Depression is a major cause of morbidity and mortality that often goes untreated. Nearly 1 in 6 adults in the United States suffer from depression during their lifetimes.[1] Based on a population-based survey that included a clinical interview, only 55% of adults in New York City (NYC) with depression had ever been told by a provider that they have the illness and only 36% said they had recently been treated for depression.[2]

Certain groups, including people with certain medical conditions, people living in poverty, and postpartum women, are more at risk for depression (**Box 1**).[3-8] In NYC, people living at the highest level of poverty are more likely to have suffered from depression than those at higher income levels (18% vs 11%).[3] Estimates of the prevalence of depression range from 13% to 19% among postpartum women.[4]

Depression can be treated. Primary care is an ideal setting to identify and offer treatment for depression because most patients see a primary care physician (PCP), but don't access mental health services. In one national study, 78% of people with depression saw a PCP, while only 18% saw a mental health specialist.[9] A review of older patients who committed suicide showed that 58% had visited their PCP within the previous month and 77% had done so within the previous year.[10]

Barriers to screening may include inadequate physician training in diagnosing and managing mental health conditions and inadequate health plans. But underdiagnosis deprives patients of access to effective treatment.

New national guidelines recommend asking adults, including pregnant women and postpartum women, about depression.[11] Screen for depression using a simple 2-question tool, the Patient Health Questionnaire-2 (PHQ-2), at least annually or when clinically indicated. Work with the patient to develop the treatment plan—which may include both nonpharmacologic and pharmacologic approaches.

BE AWARE OF SIGNS AND SYMPTOMS OF DEPRESSION

There is a bidirectional relationship between depression and many medical conditions (**Box 2**)[12-18]; the health behaviors and physiological changes associated with depression increase the risk for chronic medical disorders, and biological changes and complications associated with chronic medical disorders may precipitate depressive episodes.[19,20]

When seeing a patient, especially patients with chronic or severe physical illnesses[12]:

- Be attentive to clues suggesting depression. These can include multiple (>5) medical visits per year, multiple unexplained symptoms, dampened affect, weight gain or loss, sleep disturbance, fatigue; complaints about memory/cognition, stress, or mood disturbance.
- Be aware that cultural experiences can affect patients' views of symptoms, diagnoses, and treatments.[12,21]
- Use an interpreter or interpretation service to overcome linguistic barriers.[12,21]

BOX 1. GROUPS AT HIGHER RISK FOR DEPRESSION[3-8]

- People living in poverty
- People in short-term financial distress
- Postpartum women
- People with chronic medical conditions and risk behaviors (**Box 2**)
- LGBT individuals
- People who have
  - a family history of depression
  - a history of neglect or exposure to trauma

IDENTIFY DEPRESSION

Routinely screen adults for depression[11] using the PHQ-2 (**Box 3**[22]), at least annually or when clinically indicated. Explain that routine screening is now recommended because depression is very common and effective treatment is available, and offer to perform the screen.

If the patient answers "yes" to either item on the PHQ-2, evaluate further with the Patient Health Questionnaire (PHQ-9) (**Boxes 4**[23] and **6**[12,24]). The PHQ-9 is available in multiple languages (**Resources**).

When reviewing the responses to the PHQ-9 with the patient, ask about

- Other symptoms and history, including history of and treatment for depression and suicide attempts.
- Other mental health conditions (eg, anxiety).
- Medical conditions and medications that can cause or worsen depression.
- Alcohol and drug use (**Box 5**[25,26]).
- Family history of depression (including suicide attempts and treatment).

If the patient gives a positive response to question 9 of the PHQ-9 or if you suspect suicidal thinking, assess and manage suicide risk (see page 5).

BOX 2. SELECTED CONDITIONS AND BEHAVIORS ASSOCIATED WITH DEPRESSION[12-18]

- Substance use (including alcohol)
- Anxiety
- Diabetes
- Rheumatoid arthritis
- Hypertension
- Cardiovascular disease
- Coronary artery disease
- Cancer
- Sleep disorders
- Chronic pain
- Smoking
- COPD
- HIV
- Asthma
- Obesity
- Stroke
- Alzheimer's disease
- Myocardial infarction
- PTSD
- Eating disorder

BOX 3. PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)[22]

Over the past 2 weeks, have you been bothered by:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?

If "yes" to either question, screen with the Patient Health Questionnaire (PHQ-9) (see page 3).

BACK TO PAGE 1

BOX 4. PATIENT HEALTH QUESTIONNAIRE (PHQ-9)[23]

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	add columns:		+	+
(Health care professional: For interpretation of TOTAL, please refer to **Box 6** on page 4.)	**TOTAL:**			
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____	Somewhat difficult _____	Very difficult _____	Extremely difficult _____

Source: www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf.
Note: For patients who give a positive response to question 9, assess and manage suicide risk (see page 5).

BOX 5. SCREENING FOR ALCOHOL AND DRUG USE[25,26]

Alcohol use[25]

1. Prescreen: "Do you sometimes drink alcoholic beverages?" If yes: "How many times in the past year have you had X or more drinks in a day?" (X=5 for men and <65 years, 4 for all women and for men aged 65+)
2. If the response is ≥1, screen with AUDIT. See *City Health Information:* Brief Intervention for Excessive Drinking for more information.

Drug use[26]

1. Ask "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"
2. If ≥1, screen with a clinical tool such as NIDA-ASSIST. See *City Health Information:* Improving the Health of People Who Use Drugs for more information.

If a patient has co-occurring depression and substance use disorder or other mental health condition (eg, anxiety), refer to or co-manage with a mental health provider.[12]

ASSESS AND MANAGE SUICIDE RISK

Depression is a risk factor for suicide (**Box 7**)[27]; the prevalence of suicide ideation among people who suffered from major depression in the past year is 26%, as opposed to 2% among adults who did not suffer from major depression in the past year.[28] Knowing how to detect suicidal risk and when and how to intervene can be life-saving. Asking a patient about suicidal thoughts or plans does not initiate such ideas or foster action.

A positive response to item 9 on the PHQ-9 is associated with a higher risk of suicide attempts.[29] Conduct a suicide assessment (**Box 9**[30,31]) on any patient who answers "yes" to question 9, or whom you judge to be at possible risk, and intervene according to responses. See Intermountain Healthcare. Management of Depression—2015 update and Suicide Risk Assessment Tools (**Resources**) for detailed guidance.

ENGAGE THE PATIENT IN TREATMENT PLANNING

Successful care of depression requires active engagement of patients and their families, beginning at diagnosis[12,19,32-35] (**Boxes 8**[30,31] and **10**[12,35]). Collaborate with patients in developing

(Continued on page 5)

BACK TO PAGE 1

BOX 6. PHQ-9 SCORES TRANSLATED INTO DSM-5 DIAGNOSES AND PRACTICE[12a,24]

PHQ-9 Symptoms and Impairment	PHQ-9 Scores	Intensity	Initial Management	Next Steps
• 1-4 symptoms • Minimal functional impairment	5-9	Subclinical*	• Instruct the patient to call if he or she feels worse • Prescribe physical activity • Educate patient to schedule daily pleasurable activities	If no improvement in 1 month, consider referral to behavioral health for evaluation
• 2 symptoms • Score 2+ on Question 1 or 2 • Functional impairment	10-14	Mild Major Depression	All actions for Subclinical Depression, plus • Psychotherapy, pharmacotherapy, or both	Consider weekly contact initially to ensure adequate engagement, then at least monthly
• ≥3 symptoms • Score 2+ on Question 1 or 2 • Functional impairment	15-19	Moderate Major Depression	All actions for Mild Major Depression	Initially consider weekly contact to ensure adequate engagement, then minimum every 2-4 weeks (unless in mental health treatment elsewhere)
• ≥4 symptoms • Score 2+ on Question 1 or 2 • Marked functional impairment • Motor agitation	≥20	Severe Major Depression	All actions for Mild Major Depression: pharmacotherapy necessary; psychotherapy when patient is able to participate	Weekly contact until less severe (unless in mental health treatment elsewhere)

* Consider for persistent depressive disorder. Persistent depressive disorder is defined as low-level depression most of the day for more days than not for at least 2 years. Must include presence of at least 2 of the listed DSM-5 criteria affecting appetite, sleep, fatigue, self-esteem, concentration/decision-making, or hopelessness.[24] Initiate pharmacotherapy or refer to mental health specialty clinician for evaluation, or both.

Note: This table is designed to translate the PHQ-9 scores into DSM-5 categories; it does not directly correspond to the PHQ-9 Scoring Guide at www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf.

Adapted from Mitchell J, Trangle M, Degnan B, et al; Institute for Clinical Systems Improvement. *Adult Depression in Primary Care*. Updated September 2013. Bloomington, MN: Institute for Clinical Systems Improvement; 2013.

BOX 7. SUICIDE RISK AND PROTECTIVE FACTORS[27]

Risk Factors

- Prior suicide attempts or self-injurious behavior
- Family history of suicide, suicide attempts, or psychiatric diagnoses, especially those requiring hospitalization
- Current/past psychiatric disorders, especially depression, bipolar disorder, psychotic disorders, alcohol/substance abuse, traumatic brain injury, posttraumatic stress disorder, personality disorders (co-occurring disorders and recent onset of illness increase risk)
- Inability to feel pleasure, impulsivity, command hallucinations, intoxication
- Events leading to humiliation, shame, or despair (eg, loss of relationship, health, or financial status—real or anticipated)
- Recent loss through death, divorce, or separation[12]
- Chronic medical illness (**Box 2**)
- Past or current abuse or neglect

Protective Factors

- Internal: ability to cope with stress; religious beliefs; frustration tolerance
- External: responsibility to children or pets; positive therapeutic relationships; social supports

BOX 8. WHAT TO TELL PATIENTS ABOUT DEPRESSION[30,31]

- Depression is a common medical illness.
- Don't feel ashamed or embarrassed about depression.
- Treating depression works for many patients—it may take up to several months to a year.
- Treatment for depression may improve your overall health.
- The aim of treatment is remission—that means being mostly free of symptoms.
- You and I will decide together what treatment to try.
- Relapse is common; stick with the treatment plan even after you feel better. Treatment involves staying well, not just getting well.
- Support from family and friends can help you follow the treatment plan and feel better.
- Let me know right away if you begin to feel worse, or feel that you want to hurt yourself, especially if the thoughts are frequent or more intense.
- If you are in crisis and need immediate help, call 800-273-TALK (8255) or 800-LIFENET (543-3638).
- If your life or someone else's is in immediate danger, call 911.

BACK TO PAGE 1

BOX 9. SUICIDE RISK ASSESSMENT AND INTERVENTION[30,31]

If a patient responds positively to item 9 on the PHQ-9 or you suspect the patient has suicidal thoughts, screen for suicide risk using the Columbia-Suicide Severity Rating Scale (C-SSRS) Quick Screen.

Questions	Answers	Risk Level	Actions based on positive responses (respond based on highest level of risk)
1. Have you wished you were dead or wished you could go to sleep and not wake up? 2. Have you actually had any thoughts of killing yourself?	Yes to 1 and no to 2	**Low**	• Consider referral to mental health or behavioral health provider • Consider patient education (see **page 3** and **Resources for Patients**) • Ask question 6 (response may increase risk category)
If No to 1 and Yes to 2 or Yes to both, ask 3-6			
3. Have you been thinking about how you might want to kill yourself?	Yes	**Moderate**	• Access risk factors and facilitate evaluation for inpatient admission, or complete safety plan with follow-up within 24-48 hours • Educate patient
4. Have you had these thoughts and had some intention of acting on them? 5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	Yes to 4 and/ or 5	**High**	• Facilitate immediate evaluation by psychiatrist or psychiatric nurse practitioner • Educate patient
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	If in the past 4 weeks	**High**	• Facilitate immediate evaluation for inpatient care • Educate patient
	If 1-12 months ago	**Moderate**	• Assess risk factors and refer to mental health or behavioral health provider and educate patient, emphasizing importance of reporting suicidal thinking
	If ≥1 year ago	**Low**	• Consider referral to mental or behavioral health provider and consider patient education

Adapted from Intermountain Health Care. Management of Depression—2015 Update. https://intermountainhealthcare.org/ext/Dcmnt?ncid=51061767.

BOX 10. ENGAGING PATIENTS IN TREATMENT PLANNING[12,35]

- Involve patients in deciding which form of treatment, ie, psychotherapy, pharmacotherapy, or both, to pursue.[12]
- Suggest learning and using self-management skills such as journal writing and self-monitoring.[12]
- Encourage use of support networks of family and friends for crisis intervention and relapse prevention.[35]
- Encourage family or friends to attend appointments when appropriate.[12]
- Schedule follow-up appointments and phone calls for the first 12 months of care.[12]
- Establish a way to reach out if the patient drops out of care.[12]

(Continued from page 3)

or modifying the treatment plan[12,35] and educate them about diagnosis, prognosis, and treatment options. Explain costs, duration, side effects, and expected benefits of any medication. Also, determine whether psychotherapy is available and whether the patient prefers it.[12]

NONPHARMACOLOGIC APPROACHES

Nonpharmacologic therapies for depression include self-management strategies and psychotherapy.

Self-management strategies

Physical activity[36]: Strongly recommend 30 minutes of moderate-intensity aerobic physical activity, 3 to 5 days a week,[12] and follow up at each visit. Examples of moderate-intensity physical activity include walking briskly (3 miles per hour or faster, but not race-walking), water aerobics, bicycling, tennis (doubles), ballroom dancing, and gardening.[37] See **Resources for Patients** for information on exercise programs.

Behavioral changes[12]: While patients with depression struggle with an inability to feel pleasure, encourage those with

BACK TO PAGE 1

mild to moderate depression to schedule daily activities such as outings or getting together with friends. This approach (behavioral activation) can help reduce depressive symptoms,[12,38,39] and for some patients the effect is comparable to pharmacotherapy after 4 months of treatment.[40]

Healthy sleep and nutrition: Recommend that patients get enough sleep on a regular basis, eat a healthy diet, and avoid alcohol to help reduce symptoms of depression.[6]

Self-management documentation: Self-monitoring such as journal-writing can improve outcomes.[12] Encourage patients to share their self-management documentation with you to maintain engagement.

Psychotherapy[12]

Several psychotherapy modalities have proven benefits in treating depression:

- Cognitive behavioral therapy concentrates on identifying negative thought patterns and replacing them with positive thought patterns and rewarding activities.
- Interpersonal psychotherapy focuses on current problems and relationships.
- Psychodynamic psychotherapy/psychoanalysis is based on psychoanalytic theory and methods.[41] Treatment can be short- or long-term.[12]
- Problem-solving treatment teaches adaptive problem-solving attitudes and skills.[42]

PHARMACOLOGIC THERAPY

Several classes of medication are effective in treating depression[35,43-45] (**Table 1**[12,30,46-61]). In general, it is best to select initial treatment based on the patient's symptoms and the medication's side-effect profile (eg, sedating antidepressant for someone with insomnia). Also consider the patient's history of response to antidepressant medications, medication tolerability, cost, and medication interactions (see **Resources for Providers—Pharmacotherapy**).[35,43,45,62] If prescribing pharmacotherapy, remember that effectiveness of the trial depends on duration, adherence, and dosage[35] (**Table 2**[30,46-60]) and let the patient know what to expect when beginning the trial, including discussing potential side effects (**Box 11**[12,46-60]).

MONITOR RESPONSE AND ADJUST TREATMENT

Establish and maintain follow-up office, phone, or other contact (see **Box 6**) to monitor and reassure the patient.

The goal of treatment is remission, or a score of <5 on the PHQ-9.[12] Full remission is defined as a 2-month period without major depressive signs or symptoms.[12] At each follow-up visit, use the PHQ-9 to assess response to treatment. To save time, the patient can complete the PHQ-9 before the visit. See **Resources for Providers—Pharmacotherapy** for guidance on switching medications.

BOX 11. WHAT TO TELL PATIENTS ABOUT PHARMACOTHERAPY FOR DEPRESSION[12,46-60]

- You may start to feel better after 4-8 weeks, but it usually takes 6-12 months to feel the full benefits.
- You may feel side effects before your symptoms improve. Expect some discomfort before you feel the benefit of the medicine.
- Some side effects may go away with time and some can be managed by changing the dosing or schedule.
- We may have to adjust the dosage or try different medications to find the treatment that will give you the best response with the fewest side effects. It's important that you don't get discouraged.
- Take the medication as prescribed, even after you feel better, to reduce the chance of relapse.
- Do not stop taking your medicine suddenly. We need to reduce the dosage gradually in order to avoid or minimize withdrawal symptoms, especially if you've been taking the medication for 6 weeks or more.

Be aware that improvement with psychotherapy may be slower than with pharmacotherapy. It may take 8 to 10 weeks before response can be evaluated.[12] If improvement is not adequate after initial treatment and the patient has been seen at least once a week, consider switching to another psychotherapeutic approach and/or adding pharmacotherapy.[12]

PREVENT RELAPSE

To prevent relapse, continue pharmacotherapy after remission is achieved, based on the patient's history of major depression.[12]

- First episode: continue for 4-9 months.
- Second episode: Continue for 2 years and discuss with the patient the possibility of withdrawing gradually.
- Persistent depressive disorder: Continue medication treatment indefinitely.

See **Resources for Providers—Depression Management** for further guidance.

(Continued on page 9)

COLLABORATIVE CARE FOR DEPRESSION

In the collaborative care model, primary care providers, care managers, and mental health providers work together to help patients with depression.

Collaborative care for depression

- Improves depression symptoms, adherence to treatment, and remission and recovery[63,64]
- Improves treatment engagement among underserved racial and ethnic groups[65]
- Significantly improves co-morbid depression and diabetes measures[66,67]

The best models involve care coordination and case management; regular/proactive monitoring and treatment; and regular psychiatric reviews and consultation for patients who do not show clinical improvement.[68]

BACK TO PAGE 1

TABLE 1. FIRST-LINE ANTIDEPRESSANTS FOR ADULTS[12,30,46-61]

Class/Drug	Clinical Considerations (see product prescribing information for details)
Selective Serotonin Reuptake Inhibitors (SSRIs)	
Citalopram (Celexa®)*,[a] Escitalopram (Lexapro®) Fluoxetine (Prozac®) Paroxetine (Pexeva®, Paxil CR®) Sertraline (Zoloft®)	• Common side effects: headache, somnolence, insomnia, nausea, diarrhea, dry mouth, fatigue, sexual dysfunction, nervousness, agitation, restlessness, weight gain • Taper to reduce risk of discontinuation syndrome, particularly with paroxetine and sertraline (not necessary with fluoxetine) • Potentially lethal interaction with monoamine oxidase inhibitors (MAOIs). If MAOI treatment is considered, consult a drug information reference or psychiatrist for dosing, wash-out period, monitoring, and drug-drug and drug-food interactions
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	
Duloxetine (Cymbalta®)[b] Levomilnacipran (Fetzima®)[c] Venlafaxine (Effexor XR®) Desvenlafaxine (Pristiq®) **Generic not available**	• Common side effects: nausea, dry mouth, headache, constipation, diarrhea, dizziness, drowsiness, insomnia, activation, dose-related increases in blood pressure, sexual dysfunction, weight gain • Increased risk of liver damage for patients with substantial alcohol use or preexisting liver disease • Do not use with an MAOI or within 14 days of stopping an MAOI. Allow 7 days after stopping the SNRI before starting an MAOI • Monitor blood pressure during dose titration and throughout treatment • Taper to reduce risk of discontinuation syndrome • May increase risk of bleeding events
Other Agents	
Bupropion HCl (Wellbutrin SR® or XL®),[c] dopamine-norepinephrine reuptake inhibitor	• Common side effects: agitation, dry mouth, constipation, headache/migraine, nausea/vomiting, dizziness, excessive sweating, tremor, insomnia, blurred vision, tachycardia, confusion, rash, hostility, cardiac arrhythmias, and auditory disturbance • May improve sexual desire • No weight gain and may help with weight loss • Useful as a smoking cessation agent
Mirtazapine (Remeron®), norepinephrine-serotonin release enhancer	• Common side effects: somnolence, weight gain, dizziness, dry mouth, increased appetite, constipation, weight gain • Minimal sexual dysfunction • Do not use with an MAOI or within 14 days of stopping an MAOI
Vilazodone (Viibryd®), SSRI, 5HT1A receptor partial agonist **Generic not available**	• Common side effects: diarrhea, nausea, vomiting, insomnia • May increase risk of bleeding events • Taper to reduce risk of discontinuation syndrome • Do not use with an MAOI or within 14 days of stopping an MAOI
Vortioxetine (Brintellix®), SSRI, 5HT3 receptor antagonist, 5HT1A agonist **Generic not available**	• Common side effects: nausea, constipation, vomiting • Generally not used first-line • May increase risk of bleeding events • May be decreased to 5 mg/day if patients are intolerant to higher doses • May be discontinued abruptly if needed; taper recommended • Do not use with an MAOI or within 14 days of stopping an MAOI

CR, controlled release; XR, extended release; SR, sustained release; XL, extended release.

* Use of brand names is for informational purposes only and does not imply endorsement by the New York City Department of Health and Mental Hygiene.

[a] Avoid doses greater than 40 mg daily due to dose-dependent increased risk for QTc prolongation. Obtain ECG at baseline in patients with history of CHF, bradyarrhythmias, or concurrent administration of other QTc-prolonging medications. Check potassium and magnesium levels at baseline for patients at risk of electrolyte abnormalities.

[b] Hepatic function test at baseline.

[c] Bupropion IR is not recommended due to seizure risk and poor tolerability. Bupropion is contraindicated in patients with a history of seizure disorder or eating disorder (IR is highest risk).

Note: Angle-closure glaucoma has occurred in patients with untreated anatomically narrow angles treated with antidepressants.

BACK TO PAGE 1

TABLE 2. ANTIDEPRESSANT AGENTS: DOSING RANGES AND GUIDELINES FOR MAJOR DEPRESSIVE DISORDER[30,46-60]

	Dose (once daily unless noted)			
Agent	**Start**	**Maintenance**	**Maximum**	**Comments**
Bupropion HCl (Wellbutrin SR®)	100 mg (not at nighttime)	100 mg, 2-3x/day	150 mg, 3x/day	Increase dose gradually to reduce seizure risk Caution with co-morbid anxiety
Bupropion HCl (Wellbutrin XL®)	150 mg (morning)	150-300 mg	450 mg	Increase dose gradually to reduce seizure risk Caution with co-morbid anxiety
Citalopram (Celexa®)[a]	10 mg/day for first 7 days	20-40 mg	40 mg	Dose 10 mg/day for 7 days, then increase to 20 mg Dose-dependent increased risk for QTc prolongation
Duloxetine (Cymbalta®)	30-60 mg	30-60 mg	120 mg	
Escitalopram (Lexapro®)	10 mg	10-20 mg	20 mg	Allow at least ≥3 weeks at 10 mg/day before increasing
Fluoxetine (Prozac®)	10 mg/day for first 7 days (morning)	20-60 mg 1x/day (morning) or 2x/day (morning; noon)	80 mg	Dose 10 mg/day for first 7 days, then increase to 20 mg (morning) Also in once-weekly 90-mg capsule
Levomilnacipran (Fetzima®)	20 mg for first 2 days	40-120 mg	120 mg	Dose 20 mg for 2 days, then increase to 40 mg daily May increase by 40 mg every 2 days
Mirtazapine (Remeron®)	15 mg	15-45 mg, 1x/day	45 mg	Take at bedtime Titrate to effect and tolerability in intervals of 1-2 weeks Minimal sedating effect beyond 15 mg
Paroxetine (Paxil®)	20 mg (IR) OR 25 mg (CR)	20-50 mg once daily (IR) OR 25-62.5 mg once daily (CR)	50 mg (IR) OR 62.5 mg (CR)	IR: 10 mg/day increments, intervals at least 1 week CR: 12.5-mg/day increments, 1- to 2-week intervals
Desvenlafaxine (Pristiq®)	50 mg, 1x/day	50 mg once daily	50 mg, 1x/day	**Generic not available.** Taper down with 25-mg dose when discontinuing
Sertraline (Zoloft®)	25 mg/day for first 7 days	50-200 mg once daily	200 mg, 1x/day	Dose at 25 mg/day for 7 days, then increase to 50 mg/day
Venlafaxine (Effexor XR®)	37.5 mg/day for first 7 days	75-225 mg once daily	225 mg, 1x/day	Dose 37.5 mg/day for first 7 days, then increase to 75 mg, 1x/day Take with food. Taper down 75 mg/week to discontinue
Vilazodone (Viibryd®)	10 mg, 1x/day	40 mg, 1x/day	40 mg, 1x/day	**Generic not available**
Vortioxetine (Brintellix®)	10 mg, 1x/day	10-20 mg once daily	20 mg, 1x/day	**Generic not available** In patients taking 15-20 mg/day, decrease to 10 mg/day for 1 week, then discontinue

SR, sustained release; XL, extended release; CR, controlled release; IR, immediate release; XR, extended release.

[a] Obtain ECG at baseline in patients with history of CHF, bradyarrhythmias, or concurrent administration of other QTc-prolonging medications. Check potassium and magnesium levels at baseline for patients at risk of electrolyte abnormalities.

BACK TO PAGE 1

(Continued from page 6)

SPECIAL CONSIDERATIONS

Pregnancy and breastfeeding

- Depression during or after pregnancy is very common.
- In addition to common signs and symptoms of depression, the mother may
  - fear that something bad will happen to the baby,
  - have thoughts that she may harm the baby herself,
  - have trouble feeling connected with the baby.
- Postpartum depression can impact maternal care-taking behaviors, as well as the behavior, cognitive development, and physical health of the child.[4]
- If a patient is pregnant, planning to breastfeed, or is breastfeeding, stay current with research on risks and benefits of psychotropic medications or consult with an expert.[69]
- Help pregnant and breastfeeding patients assess the negative effects of depression on themselves and their families, as well as the risks and benefits of pharmacotherapy and other treatment options,[12] or refer to a specialized provider.

Older adults

- Older adults may be taking several medications, so interactions are an important consideration.
- Be aware that older patients may have to be treated longer to achieve remission.[12]

Children, adolescents, and adults aged 18 to 24

- **Antidepressants carry an FDA-issued black box warning about increased risks of suicidal thinking and behaviors during initial treatment (generally first 1 or 2 months) of patients aged 24 and younger.**[70]
- If antidepressant medication is indicated in a young patient, start with a low dose and increase slowly, carefully monitoring the patient for new or worsening suicidal thoughts or behaviors.[70,71]

Some patients (**Box 12**[12]) may benefit from a referral to a mental health clinician who can consider additional strategies, such as psychotherapy, auxiliary medication, hospitalization, electroconvulsive treatment (ECT), or light therapy. Consider co-managing with the specialist if possible.

BOX 12. WHEN TO INVOLVE A MENTAL HEALTH SPECIALIST[12]

Refer to or co-manage with a mental health specialty clinician when needed[12]:

- High suicide risk
- Patient preference
- Signs and symptoms continue to interfere with work, school, family care, or other basic needs and relationships
- Other psychiatric disorders such as bipolar or substance abuse
- Complex psychosocial needs

SUMMARY

Depression is a common and debilitating illness that can affect a patient's overall health. Be alert to risk factors for depression and use standardized tools to screen and diagnose. Engage the patient in developing the treatment plan, which may include a variety of modalities, and closely monitor response. ◆

HOW TO DETECT AND TREAT DEPRESSION IN PRIMARY CARE

- Screen with the PHQ-2.
- If the PHQ-2 is positive, assess further with the PHQ-9.
- Engage the patient in treatment planning.
- Closely monitor progress.
- Refer to or co-manage with a mental health specialist when necessary.

REIMBURSEMENT FOR DEPRESSION-RELATED SERVICES

Depression (ICD-10: Z13.89)	Codes	Comments
Medicare	HCPCS: G0444	Annual depression screening, 15 min
Medicaid Fee For Service Medicaid Managed Care	HCPCS: G8431	Documented positive screen and follow-up plan
Aetna Commercial	HCPCS: G8510	Documented negative screen; no follow-up plan required
Emblem Commercial	CPT: 96127	Annual depression screening, 15 min, patients aged ≥12 years
Postpartum Depression Screening[a] (ICD-10: O90.6)		
Medicaid Fee for Service[b]	HCPCS: G8431 (HD)	Documented positive screen and follow-up plan
Medicaid Managed Care[c]	HCPCS: G8510 (HD)	Documented negative screen; no follow-up plan required
Prenatal Depression Screening	HCPCS: H1000, H1005	

[a] Postpartum maternal depression screening with a validated screening tool may be reimbursed up to 3 times in the first year of the infant's life. If screening is performed on the same day as the infant's primary care visit (E&M) by the infant's health care provider, one claim can be submitted for both services using the appropriate maternal "G" series code under the infant's Medicaid identification number. Alternatively, providers, **including pediatricians**, may bill this service separately under the mother's Medicaid identification number.
[b] Effective September 1, 2016.
[c] Effective November 1, 2016.

BACK TO PAGE 1

RESOURCES FOR PROVIDERS

Depression Management

- American Psychiatric Association. Treating Major Depressive Disorder: A Quick Reference Guide: psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd-guide.pdf
- Institute for Clinical Systems Improvement. Depression, Adult in Primary Care Guideline: www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/
- Intermountain Health Care. Management of Depression—2015 Update: https://intermountainhealthcare.org/ext/Dcmnt?ncid=51061767

Depression Screening Tool

- Patient Health Questionnaire (PHQ-9): http://www.phqscreeners.com/select-screener/36

Perinatal Depression Guidelines

- Nassau County Best Practices Task Force: http://ny2aap.org/pdf/NCPerinatalResourceGuideDec11.pdf

Suicide Risk Assessment Tools and Other Materials

- Western Interstate Commission and Suicide Prevention Resource Center. Suicide Prevention Toolkit for Rural Primary Care Practices: www.sprc.org/sites/sprc.org/files/pctoolkit.pdf
- Intermountain Healthcare. Suicide Prevention: https://intermountainhealthcare.org/ext/Dcmnt?ncid=526742474

Pharmacotherapy Resources

- Interactions Checkers
  - The Physician's Desk Reference: http://www.pdr.net
  - Epocrates: https://online.epocrates.com/interaction-check (registration required)
- Choosing Antidepressants for Adults: http://effectivehealthcare.ahrq.gov/repFiles/AntidepressantsClinicianGuide.pdf
- Switching Medications
  - Health Alliance: https://www.healthalliance.org/media/Generics_antidepressants_comparison_chart.pdf (see page 2)
  - Switching Antidepressants: http://wiki.psychiatrienet.nl/index.php/SwitchAntidepressants

Mental Health Referrals

- LIFENET (24 hours a day/7 days a week)
  In English: 800-LIFENET (800-543-3638)
  In Spanish: 800-AYUDESE (877-298-3373)
  In Korean and Chinese (Mandarin and Cantonese dialects): 800-ASIAN LIFENET (877-990-8585)
  For other languages, call 800-LIFENET or 311 and ask for an interpreter.
  For TTY (hard of hearing), call 212-982-5284
  www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-lifenet.page
- Anxiety and Depression Association of America: treatment.adaa.org

RESOURCES FOR PATIENTS

Patient Education Materials

- New York City Department of Health and Mental Hygiene
  - Common Symptoms of Depression Fact Sheet: www1.nyc.gov/assets/doh/downloads/pdf/csi/depressionkit-pt-symptoms-fact.pdf
  - *Health Bulletin #34, Feeling Better: Depression:* www1.nyc.gov/assets/doh/downloads/pdf/public/dohmhnews10-04.pdf
- Agency for Health Care Research and Quality. Mental Health: www.ahrq.gov/patients-consumers/treatmentoptions/consumer-mental-health.html
  Brochures on treatment choices, and pharmacotherapy and its side effects
- National Institute of Mental Health. Depression: www.nimh.nih.gov/health/topics/depression/index.shtml
- National Alliance on Mental Illness. Depression: www.nami.org/Learn-More/Mental-Health-Conditions/Depression
- American Psychiatric Association. Help With Depression: www.psychiatry.org/patients-families/depression

Organizations and Support Groups

- Depression and Bipolar Support Alliance: www.dbsalliance.org
  Education, wellness, and peer support services to patients, family members, and clinicians
- Mood Disorders Support Group New York: www.mdsg.org
  Free, peer-run support groups in Manhattan
- Mental Health America: www.mentalhealthamerica.net/conditions/depression
- Suicide Prevention Resource Center: www.sprc.org/
- National Alliance on Mental Illness-New York: www.naminycmetro.org/

Crisis Hotlines

- LIFENET (24 hours a day/7 days a week)
  In English: 800-LIFENET (800-543-3638)
  In Spanish: 800-AYUDESE (877-298-3373)
  In Korean and Chinese (Mandarin and Cantonese dialects): 800-ASIAN LIFENET (877-990-8585)
  For other languages, call 800-LIFENET or 311 and ask for an interpreter.
  For TTY (hard of hearing), call 212-982-5284
  www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-lifenet.page
- National Suicide Prevention Lifeline (24 hours a day/7 days a week): 800-273-TALK (800-273-8255)

Physical Activity

- NYC Health Department. Physical Activity: www1.nyc.gov/site/doh/health/health-topics/physical-activity.page
  - Make NYC Your Gym
  - Bicycling in New York City
- New York City Office of the Mayor. Shape Up NYC: www1.nyc.gov/nyc-resources/service/2441/shape-up-nyc
  Find a free fitness class

Postpartum Depression

- NYC Health Department: www1.nyc.gov/site/doh/health/health-topics/post-partum-depression.page
- Medline Plus (in 14 languages): www.nlm.nih.gov/medlineplus/languages/postpartumdepression.html

Depression in Older Adults

- NYC Department for the Aging: nyc.gov/html/dfta/html/health/mental.shtml

BACK TO PAGE 1

REFERENCES

1. Reeves WC, Strine TW, Pratt LA, et al. Mental illness surveillance among adults in the United States. *MMWR Morb Mortal Wkly Rep.* 2011;60(03):1-32. www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm. Accessed September 22, 2015.
2. Gwynn RC, McQuistion HL, McVeigh KH, Garg RK, Frieden TR, Thorpe LE. Prevalence, diagnosis, and treatment of depression and generalized anxiety disorder in a diverse urban community. *Psychiatr Serv.* 2008; 59(6):641-647.
3. New York City Department of Health and Mental Hygiene. EpiQuery. New York City Community Health Survey, 2013. a816-healthpsi.nyc.gov/epiquery/CHS/CHSXIndex.html. Accessed September 30, 2015.
4. O'Hara MW, McCabe JE. Postpartum depression: current status & future directions. *Annu Rev Clin Psychol.* 2013;9:379-407.
5. Center for Excellence for Transgender Health. *Primary Care Protocol for Transgender Patient Care.* April 2011. Transgender Health Program. transhealth.ucsf.edu/trans?page=protocol-00-00. Accessed October 8, 2015.
6. American Psychiatric Association. What is depression? http://www.psychiatry.org/patients-families/depression/what-is-depression. Accessed March 1, 2016.
7. Lorant V, Croux C, Weich S, Deliège D, Mackenbach J, Ansseau M. Depression and socio-economic risk factors: 7-year longitudinal population study. *Br J Psychiatry.* 2007;190:293-298.
8. Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: what we know and what needs to be done. *Am J Public Health.* 2008;98(6):989-995.
9. Young AS, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the United States. *Arch Gen Psychiatry.* 2001;58(1):55-61.
10. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry.* 2002;159(6):909-916.
11. Siu AL, US Preventive Services Task Force (USPSTF), Bibbins-Domingo K, et al. Screening for depression in adults: US Preventive Services Task Force Recommendation Statement. *JAMA.* 2016;(4):380-387.
12. Trangle M, Gursky J, Haight R, et al; Institute for Clinical Systems Improvement. *Adult Depression in Primary Care.* Updated March 2016. www.icsi.org/_asset/fnhdm3/Depr.pdf. Accessed April 5, 2016.

12a. Mitchell J, Trangle M, Degnan B, et al; Institute for Clinical Systems Improvement. *Adult Depression in Primary Care.* Updated September 2013. Bloomington, MN: Institute for Clinical Systems Improvement; 2013.

13. Kessler RC. The costs of depression. *Psychiatr Clin North Am.* 2012;35(1):1-14.
14. Massie MJ. Prevalence of depression in patients with cancer. *J Natl Cancer Inst Monogr.* 2004;(32):57-71.
15. Puccio F, Fuller-Tyszkiewicz M, Ong D, Krug I. A systematic review and meta-analysis on the longitudinal relationship between eating pathology and depression. *Int J Eat Disord.* 2016. doi:10.1002/eat.22506. [Epub ahead of print]
16. Franzen PL, Buysse DJ. Sleep disturbances and depression: risk relationships for subsequent depression and therapeutic implications. *Dialogues Clin Neurosci.* 2008;10(4):473-481.
17. Shalev Y, Freedman S, Peri T, et al. Prospective study of posttraumatic stress disorder and depression following trauma. *Am J Psychiatry.* 1998;155(5):630-637.
18. Centers for Disease Control and Prevention, National Center for Health Statistics. Depression and smoking in the U.S. household population aged 20 and over, 2005-2008. *NCHS Data Brief.* 2010;(34):1-8. www.cdc.gov/nchs/data/databriefs/db34.pdf. Accessed October 6, 2015.
19. Katon W. Epidemiology and treatment of depression in patients with chronic medical illness. *Dialogues Clin Neurosci.* 2011;13(1):7-23.
20. Centers for Disease Control and Prevention. Depression. www.cdc.gov/nchs/fastats/depression.htm. Accessed September 22, 2015.
21. US Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity.* Rockville, MD: US Department of Health and Human Services; 2001.
22. Kroenke K, Spitzer RL, Williams JB. The patient health questionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41(11):1284-1292.
23. Kroenke K, Spitzer RL. The PHQ-9: a new depression and severity measure. *Psychiatr Ann.* 2002;32(9):509-521.
24. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th ed (DSM-5).* Arlington, VA: American Psychiatric Association Publishing; 2013.
25. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. Primary care validation of a single-question alcohol screening test. *J Gen Intern Med.* 2009;24(7):783-788.
26. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. *Arch Intern Med.* 2010;170(13):1155-1160.
27. Western Interstate Commission for Higher Education (WICHE) and *Suicide Prevention Resource Center (SPRC). Suicide Prevention Toolkit for Rural Primary Care. A Primer for Primary Care Providers.* Boulder, CO: Western Interstate Commission for Higher Education; 2009. www.sprc.org/sites/sprc.org/files/pctoolkit.pdf. Accessed March 7, 2016.
28. Han B, Gfroerer J, McKeon R. Suicidal ideation among community-dwelling adults in the United States. *Am J Public Health.* 2014;104(3):488-497.
29. Simon GE, Rutter CM, Peterson D, et al. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? *Psychiatr Serv.* 2013;64(12):1195-1202.
30. Intermountain Healthcare. *Management of Depression—2015 Update.* https://intermountainhealthcare.org/ext/Dcmnt?ncid=51061767. Accessed March 1, 2016.
31. Intermountain Healthcare. *Suicide Prevention.* December 2014. https://intermountainhealthcare.org/ext/Dcmnt?ncid=526742474. Accessed March 23, 2016.
32. Simmons LA, Wolever RQ, Bechard EM, Snyderman R. Patient engagement as a risk factor in personalized health care: a systematic review of the literature on chronic disease. *Genome Med.* 2014;26;6(2):16. doi: 10.1186/gm533.
33. Voinov B, Richie WD, Bailey RK. Depression and chronic diseases: it's time for a synergistic mental health and primary care approach. *Prim Care Companion CNS Disord.* 2013;15(2). doi:10.4088/PCC.12r01468.
34. Bachman J, Swenson S, Reardon ME, Miller D. Patient self-management in the primary care treatment of depression. *Adm Policy Ment Health.* 2006;33(1):76-85.
35. American Psychiatric Association. *Practice Guideline for the Treatment of Patients with Major Depressive Disorder.* 3rd ed. http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf. Accessed December 15, 2015.
36. Mura G, Moro MF, Patten SB, Carta MG. Exercise as an add-on strategy for the treatment of major depressive disorder: a systematic review. *CNS Spectr.* 2014;19(6):496-508.
37. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *2008 Physical Activity Guidelines for Americans.* www.health.gov/paguidelines. Accessed April 5, 2016.
38. Carek PJ, Laibstain SE, Carek SM. Exercise for the treatment of depression and anxiety. *Int J Psychiatry Med.* 2011;41(1):15-28.
39. Cooney GM, Dwan K, Greig CA, et al. Exercise for depression. *Cochrane Database Syst Rev.* 2013;9:CD004366.
40. Blumenthal JA, Babyak MA, Doraiswamy PM, et al. Exercise and pharmacotherapy in the treatment of major depressive disorder. *Psychosom Med.* 2007;69(7):587-596.
41. Shedler J. The efficacy of psychodynamic psychotherapy. *Am Psychol.* 2010;65(2):98-109.
42. Bell AC., D'Zurilla TJ Problem-solving therapy for depression: a meta-analysis. *Clin Psychol Rev.* 2009;29(4):348-353.
43. Bentley SM, Pagalilauan GL, Simpson SA. Major depression. *Med Clin North Am.* 2014;98(5):981-1005.
44. Dupuy JM, Ostacher MJ, Huffman J, Perlis RH, Nierenberg AA. A critical review of pharmacotherapy for major depressive disorder. *Int J Neuropsychopharmacol.* 2011;14(10):1417-1431.
45. Lin SY, Stevens MB. The symptom cluster-based approach to individualize patient-centered treatment for major depression. *J Am Board Fam Med.* 2014;27(1):151-159.
46. Brintellix [package insert]. Deerfield, IL: Takeda Pharmaceuticals America, Inc.; 2014. http://general.takedapharm.com/content/file.aspx?applicationcode=396066C6-E50F-4113-ABAD-54FE9525BF7E&filetypecode=BRINTELLIXPI&cacheRandomizer=7d4abb9d-1e2a-4cd1-bfb4-1faf5cdc9be1. Accessed March 7, 2016.

(Continued on next page)

BACK TO PAGE 1

City Health Information

NYC Health
nyc.gov/health

Volume 35 (2016) The New York City Department of Health and Mental Hygiene No. 1; 1-12

42-09 28th Street, Long Island City, NY 11101 (347) 396-2914

ASK CHI
Have questions or comments about Depression?
E-mail
AskCHI@health.nyc.gov

New York City Department of Health and Mental Hygiene. Detecting and treating depression in adults. *City Health Information.* 2016;35(1):1-12.

(Continued from previous page)

47. Celexa [package insert]. St Louis, MO: Forest Pharmaceuticals, Inc.; 2014. http://pi.actavis.com/data_stream.asp?product_group=1906&p=pi&language=E. Accessed January 4, 2016.
48. Cymbalta [package insert]. Indianapolis, IN: Lilly USA, LLC; 2015. http://pi.lilly.com/us/cymbalta-pi.pdf. Accessed January 4, 2016.
49. Effexor XR [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals Inc.; 2015. http://labeling.pfizer.com/ShowLabeling.aspx?id=100. Accessed January 5, 2016.
50. Fetzima [package insert]. St Louis, MO: Forest Pharmaceuticals, Inc.; 2014. http://pi.actavis.com/data_stream.asp?product_group=1903&p=pi&language=E#page=1. Accessed January 4, 2016.
51. Lexapro [package insert]. St Louis, MO: Forest Pharmaceuticals, Inc.; 2014. http://pi.actavis.com/data_stream.asp?product_group=1907&p=pi&language=E. Accessed January 4, 2016.
52. Paxil CR [package insert.] Research Triangle Park, NC: GlaxoSmithKline; 2014. http://www.accessdata.fda.gov/drugsatfda_docs/label/2014/020936s049lbl.pdf. Accessed January 5, 2016.
53. Pexeva [package insert]. Noven Pharmaceuticals, Inc.: Miami, FL; 2014. http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=6c4d4603-190a-496f-a40f-bc09853b9820. Accessed March 7, 2016.
54. Pristiq [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals Inc.; 2014. http://labeling.pfizer.com/showlabeling.aspx?id=497. Accessed January 5, 2016.
55. Prozac [package insert]. Indianapolis, IN: Lilly USA, LLC; 2014. http://pi.lilly.com/us/prozac.pdf. Accessed January 4, 2016.
56. Remeron [package insert]. Whitehouse Station, NJ: Merck USA; 2012. http://www.merck.com/product/usa/pi_circulars/r/remeron/remeron_tablets_pi.pdf. Accessed January 4, 2016.
57. Wellbutrin XL [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; 2014. http://www.wellbutrinxl.com/. Accessed January 4, 2016.
58. Wellbutrin SR [package insert]. Research Triangle Park, NC: GlaxoSmithKline; 2014. https://www.gsksource.com/pharma/content/dam/GlaxoSmithKline/US/en/Prescribing_Information/Wellbutrin_SR/pdf/WELLBUTRIN-SR-PI-MG.PDF. Accessed April 15, 2016.
59. Viibryd [package insert]. Parsippany, NJ: Activis, Inc.; 2015. http://pi.actavis.com/data_stream.asp?product_group=1905&p=pi&language=E. Accessed January 5, 2016.
60. Zoloft [package insert]. New York, NY: Pfizer Inc; 2014. http://labeling.pfizer.com/ShowLabeling.aspx?id=517#page=1. Accessed January 5, 2016.
61. Hirsch M, Birnbaum RJ. Selective serotonin reuptake inhibitors: pharmacology, administration, and side effects. UpToDate. http://www.uptodate.com/contents/selective-serotonin-reuptake-inhibitors-pharmacology-dministration-and-side-effects. Accessed February 26, 2016.
62. Cameron C, Habert J, Anand L, Furtado M. Optimizing the management of depression: primary care experience. *Psychiatry Res.* 2014;220(Suppl 1):S45-S57.
63. Community Preventive Services Task Force. Recommendations from the Community Preventive Services Task Force for use of collaborative care for the management of depressive disorders. *Am J Prev Med.* 2012;42(5):521-524.
64. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev.* 2012;10:CD006525.
65. Interian A, Lewis-Fernandez R, Dixon L. Improving treatment engagement of underserved U.S. racial-ethnic groups: a review of recent interventions. *Psychiatr Serv.* 2013;64(3):212-222.
66. Atlantis E, Fahey P, Foster J. Collaborative care for comorbid depression and diabetes: a systematic review and meta-analysis. *BMJ Open.* 2014;4(4):e004706. doi:10.1136/bmjopen-2013-004706.
67. Huang Y, Wei X, Wu T, Chen R, Guo A. Collaborative care for patients with depression and diabetes mellitus: a systematic review and meta-analysis. *BMC Psychiatry.* 2013;13:260.
68. Unutzer J, Harbin H, Schoenbaum M. Collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. Health Home Information Resource Center. May 2013. www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf. Accessed October 5, 2015.
69. Ng RC, Hirata CK, Yeung W, Haller E, Finley PR. Pharmacologic treatment for postpartum depression: A systematic review. *Pharmacotherapy.* 2010;30(9):928-941.
70. US Food and Drug Administration. Revisions to Medication Guide. Medication Guide: Antidepressant Medications, Depression and Other Serious Mental Illnesses, and Suicidal Thoughts and Actions. www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/ucm100211.pdf. Accessed October 6, 2015.
71. Birmaher B, Brent D; AACAP Work Group on Quality Issues, et al. Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *J Am Acad Child Adolesc Psychiatry.* 2007;46(11):1503-1526.

BACK TO PAGE 1

City Health Information

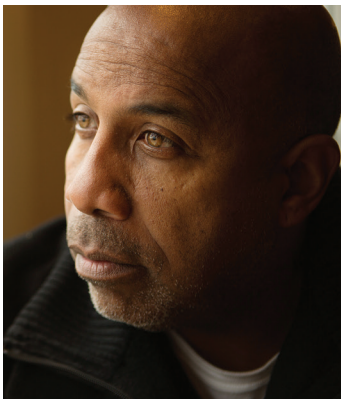
Volume 35 (2016) The New York City Department of Health and Mental Hygiene No 3; 21-28

Addressing Alcohol and Drug Use—An Integral Part of Primary Care

- **Unhealthy alcohol and drug use are treatable, but often go unrecognized and unaddressed in primary care.**
- **Incorporate a continuum of substance use health services into your practice.**
- **Use electronic health records and the clinical care team to facilitate service delivery.**

INSIDE THIS ISSUE (click to access)

Unhealthy substance use is a leading cause of preventable death in New York City. In 2014, nearly 1,800 New Yorkers died of alcohol-related causes.[1] Unintentional drug overdose deaths increased by 43% from 2010 to 2014 (8.2 vs 11.7 per 100,000 residents, respectively); in 2014, 79% of the 800 deaths that occurred involved an opioid.[2]



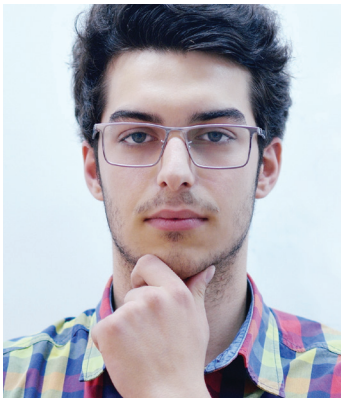
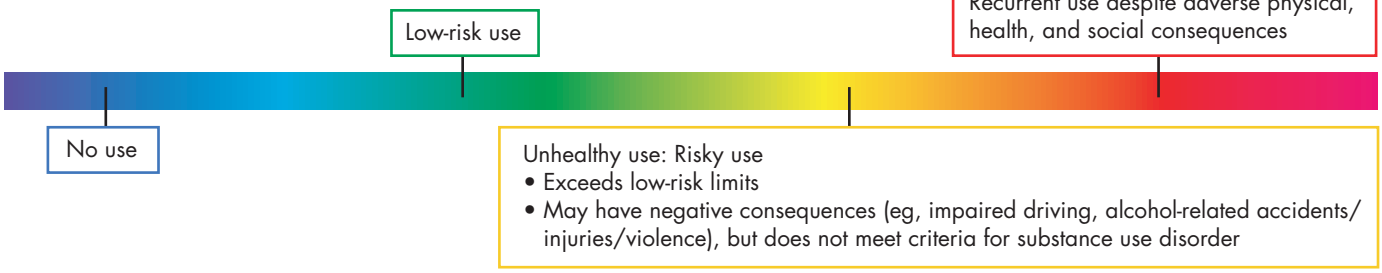


FIGURE. THE SPECTRUM OF SUBSTANCE USE[3,4]



While unhealthy substance use is common, it often goes unrecognized and unaddressed by health care providers. In 2013, an estimated 22 million people aged 12 and older in the United States had a substance use disorder in the past year, but only 2.5 million reported receiving treatment.[5] In 2011, only 1 in 6 adults in the United States reported ever discussing alcohol consumption with a health professional.[6] Primary care providers are ideally situated to identify and manage unhealthy substance use. Integrating substance use screening and management into primary care improves access to treatment, reduces stigma, improves patient outcomes (including treatment retention),[7,8] supports relapse prevention,[9] and allows you to address coexisting health risks and illness.[10] Prevent substance-related illness, injury, and death among your patients by providing

1. screening for unhealthy substance use,
2. intervention based on screening results, using brief intervention and referral to specialty care when appropriate,
3. pharmacotherapy,
4. relapse prevention support, and
5. harm reduction services.

BOX 1. SCREENING FOR ALCOHOL AND DRUG USE IN ADULTS[a,11-14]

Step A		Step B[b]
Alcohol Single-question screen: *How many times in the past year have you had X or more drinks in a day?* (X = 5 for men and 4 for women and for men >65) OR	If ≥1 →	AUDIT
AUDIT-C	If ≥4 for men, or ≥3 for women and patients aged >65 →	AUDIT
Drugs *How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?*	If ≥1 →	DAST-10

[a] For adolescents, use the CRAFFT. Consult the 2011 American Academy of Pediatrics statement, Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians, for detailed guidance (**Resources for Providers: Screening Tools**).

[b] See **Resources for Providers: Screening Tools** for more options.

ROUTINELY SCREEN FOR UNHEALTHY SUBSTANCE USE

Substance use screening is a 2-step process (**Box 1**[11-14]). Step A identifies unhealthy use (**Figure**[3,4]) and Step B assesses severity of use. In a nonjudgmental tone, explain that you routinely ask all your patients about these issues and then ask the initial screening questions (Step A). For those who screen positive, assess severity of misuse with a validated tool (Step B).

USE THE SCREENING RESULT TO DETERMINE ACTION STEPS

Alcohol

If you used the AUDIT for Step B, the score will guide the action steps needed (**Box 2**[12,15-17]).

Drugs

If you used the DAST-10 for Step B, the score will guide the action steps needed (**Box 3**[14,18-20]).

BOX 2. ACTION STEPS FOR ALCOHOL USE BASED ON AUDIT SCORE[12,15-17]

AUDIT score	Action Steps
0-7 (low risk):	• Reinforce healthy behavior. • Give educational messages about low-risk alcohol use (no more than an average of 1 drink per day for women and for men aged >65 and 2 drinks per day for men).
8-19 (risky use):	• Offer a brief intervention to give personalized advice about alcohol use (see page 23).
≥20 (very high risk, probable disorder):	• Provide access to treatment, either in primary care or by referral.

Note: Pregnant women, people who take certain medications (eg, benzodiazepines), and people who have certain health conditions (eg, chronic hepatitis B or C infection) have different recommended thresholds for at-risk alcohol use (eg, no alcohol use); modify action steps accordingly, recognizing that although no use is recommended, cutting back is likely beneficial.

BACK TO PAGE 1

Brief intervention for unhealthy substance use

Brief intervention (**Boxes 4**[21-23] and **5**[24]) is a 5- to 10-minute conversation that helps patients understand the risks of continued substance use and strengthens their motivation to change.[25]

Address health needs of patients who use alcohol or drugs

Recognize and address the impact of drug use on the patient's overall health (**Box 6**).

OFFER PHARMACOTHERAPY*

Alcohol

Medications for alcohol use disorder are effective but considerably underused. Both acamprosate and naltrexone are associated with improved drinking outcomes in patients with alcohol use disorder.[26]

- **Naltrexone** given once daily reduces risk of return to any drinking and return to heavy drinking.[26]
- **Acamprosate** given 3 times a day reduces risk of return to any drinking.[26]

*See product prescribing information for details.

Opioids

Pharmacotherapy with opioid agonists (buprenorphine or methadone) is the most effective form of treatment for opioid use disorder; opioid agonist treatment reduces opioid misuse, decreases cravings, improves social functioning, and decreases mortality.[27-30]

- Buprenorphine is an office-based treatment that can be integrated into primary care along with management of patients' other health issues. Buprenorphine is an important clinical tool that should be available in primary care settings and offered to patients with opioid use disorder. To learn more about buprenorphine, including how to obtain training and a waiver to prescribe buprenorphine, see City Health Information: Buprenorphine—An Office-Based Treatment for Opioid Use Disorder or visit the Substance Abuse and Mental Health Services Administration website (**Resources for Providers: Buprenorphine**).
- Methadone is only available in specialized treatment settings; it may be a good option for patients who could benefit from more structured and co-located services.
- Long-acting naltrexone is another option for office-based treatment of opioid use disorder. Limited data show that long-acting naltrexone formulations may improve treatment retention without relapse to opioid use compared with placebo.[31,32]

PROVIDE RELAPSE PREVENTION SUPPORT

Be sure your patients understand that substance use disorders are chronic conditions that can follow a relapsing course[33] (**Box 7**[34,35]).

BOX 3. ACTION STEPS FOR DRUG USE BASED ON DAST-10 SCORE[14,18-20]

Score	Action Steps
0 (no problem):	Reinforce healthy behavior.
1-2 (low-level problem):	Provide simple education; monitor the patient and reassess in the future. Consider a brief intervention.[a]
3-5 (moderate-level problem):	Offer a brief intervention (see **Boxes 4** and **5**).
6-10 (substantial- to severe-level problem):	Assess further to diagnose a substance use disorder and to provide access to treatment.

[a] Evidence supporting brief interventions for drug use is lacking; however, several studies are under way.

BOX 4. BRIEF INTERVENTION FOR UNHEALTHY SUBSTANCE USE[21-23]

When providing brief intervention,

- Use a concerned, nonconfrontational approach.
- Provide clear, personalized advice about cutting down or abstaining.
- If possible, link alcohol use to a specific medical problem, such as hypertension or liver disease.
- Listen reflectively—summarize and repeat what your patient says.
- Involve the patient in setting mutually acceptable goals.
- Help the patient identify drinking triggers and discuss practical ways to cope.

See Helping Patients Who Drink Too Much and City Health Information—Brief Intervention for Excessive Drinking (**Resources for Providers: Screening, Brief Intervention, and Referral to Treatment**) for guidance.

BOX 5. WHAT TO SAY IN A BRIEF INTERVENTION—SAMPLE STATEMENTS AND QUESTIONS[24]

"Help me understand, through your eyes, some of the things you like about using X; how about some of the things you don't like about using X?"

"I have some information on reducing the risk of drinking and drug use; would you mind if I shared them with you?"

"What are some of the steps/options that will work for you to make a change?"

"What supports do you have for making this change?"

"Great ideas! Is it okay for me to write down your plan to keep with you as a reminder?"

BACK TO PAGE 1

There are several frameworks for helping patients avoid relapse, including the *PRIME*Care Model (for alcohol use disorders)[36] (**Resources for Providers: Relapse Prevention**) and "recovery management checkups" (quarterly screening, early re-intervention, and referral to treatment, provided by a nonphysician).[37] Mindfulness approaches that enable the patient to be aware of physical or emotional discomfort without automatically reacting are emerging and promising.[38]

Link patients to peer-based support

Social support, including support specific to substance use, can be an important aspect of recovery.[39,40] Alcoholics Anonymous, a mutual support group, is a widely used option that can be associated with reduced alcohol consumption.[41]

BOX 6. PREVENTIVE CARE CONSIDERATIONS FOR PATIENTS WHO USE DRUGS OR ALCOHOL

Screening	Comments
Sexual history[a]	All patients, especially • People who o Use injection drugs (and their partners) o Have multiple partners o Had a prior sexually transmitted infection • MSM • Transgender people • Sex workers
Pregnancy intention counseling (including plans to father a child)	• Offer contraception counseling • Explain risks of substance use for fetus/infant/pregnant women
Intimate partner violence	See NYC Health Department Intimate Partner Violence page
Reproductive and sexual coercion, other sexual trauma	See Addressing Intimate Partner Violence, Reproductive and Sexual Coercion and Seeking Safety
HIV	• Annually • Every 3-6 months if high risk See HIV Testing Laws and CDC Recommendations. Consider Pre- and Post-Exposure Prophylaxis (PrEP and PEP)
Hepatitis B	Once
Hepatitis C	Annually for all patients who use drugs (see HCV Testing and Linkage to Care)
Tuberculosis	• Annually • PPD or QuantiFERON
Vaccination[b,c]	
Hepatitis A and B	All patients who use drugs
Pneumococcal (PPSV23)	Patients aged >18 years with alcohol use disorders

[a] See www.nycptc.org/x/STD_Screening_chart_2015.pdf for screening guidelines and www.nycptc.org/x/STD_TreatmentTable_2015.pdf for treatment guidelines.
[b] See www.cdc.gov/vaccines/schedules/hcp/adult.html for adult immunization recommendations.
[c] Vaccination recommendations given here that may be different from routine recommendations.
MSM, men who have sex with men; PPD, purified protein derivative.

The use of peer support workers who are in recovery to offer support, encouragement, hope, and mentorship is a promising practice.[42-44]

PROVIDE HARM REDUCTION SERVICES

Prescribe naloxone

Naloxone safely reverses opioid overdose and can be given to an overdosing person by trained friends and family members. Naloxone presents no potential for abuse and has not been shown to increase risky drug use.[45]

- **Assess risk factors** for opioid overdose (**Box 8**).
- Talk to your patients about risk factors for opioid overdose. Explain that solitary use is also a risk factor.
- Offer a naloxone prescription to your patients at risk for opioid overdose.[46] Any trained clinical staff can teach patients about naloxone use.
- Explain that harm reduction programs and many pharmacies also offer naloxone. See **Resources for Providers: Opioid Overdose Prevention** for additional information.

BOX 7. SUPPORTING RELAPSE PREVENTION[34,35]

- Explain that relapses are just temporary setbacks and not a sign that treatment isn't working.
- Help the patient identify triggers for relapse.
- Teach coping skills.
- Approach relapses nonjudgmentally. Patients who relapse are likely to feel negative feelings like guilt, shame, and anxiety. Being nonjudgmental will help them learn from a relapse and cope more effectively in the future.
- Involve the family whenever possible, with the patient's permission. Refer family members to peer support groups to learn about their roles in the patient's recovery.

BOX 8. INDICATIONS FOR NALOXONE PRESCRIBING

- High-dose opioid prescription (≥100 total morphine milligram equivalents/day)
- Chronic opioid therapy (≥3 months)
- Opioid misuse/illicit use, including[a]:
  - o Current or past history
  - o Current treatment for opioid use disorder (eg, methadone, buprenorphine, naltrexone, treatment without pharmacotherapy)
  - o Opioid overdose history
- Family member or friend of an individual who is at risk for opioid overdose.

[a] Refers to all opioid drug types (eg, opioid analgesic prescription, heroin) and all routes of administration (eg, injection drug use, oral, intranasal).
Note: Patients who meet any of the first 3 criteria may be at higher risk if they either experience decreased tolerance after a period of abstinence (eg, incarceration, hospitalization, detoxification) or use other central nervous system depressants (eg, benzodiazepines, alcohol) concurrently with opioids.
See Naloxone for Overdose Prevention: Prescribing Guidance for Clinical Settings for more information.

BACK TO PAGE 1

Prescribe sterile syringes

The New York State Expanded Syringe Access Program (ESAP) allows licensed pharmacies, health care facilities, and providers to sell or provide up to 10 syringes at one time to any person aged 18 or older.

Become an ESAP provider and prescribe sterile syringes to your patients who inject drugs (registration is required). Alternatively, refer your patients to ESAP pharmacies where syringes are dispensed without a prescription or to a harm reduction program that provides this service.[47] See **Resources for Providers: Syringe Services** for information on how to register with ESAP and lists of ESAP pharmacies and harm reduction programs.

SUMMARY

Unhealthy substance use is common and treatable in the primary care setting. Routinely screen for substance use and provide brief intervention, pharmacotherapy, relapse prevention support, harm reduction services, and referrals, as needed. ◆

INTEGRATING SUBSTANCE USE CARE INTO PRACTICE WORKFLOW[48-50]

- Include screening in the electronic health record—it may improve efficiency and fulfill provisions of the Affordable Care Act.
- Consider distributing the work broadly across the care team, including nurses and medical assistants.
- With patient's permission, communicate and coordinate with behavioral health providers through coordinated care, co-located care, or fully integrated care where primary care and behavioral health providers share location, treatment plan, and organizational support.

HOW TO ADDRESS SUBSTANCE USE IN PRIMARY CARE

- Routinely screen adults for substance use.
- Use screening results to determine action steps.
- Educate patients about risks of unhealthy substance use.
- Offer pharmacotherapy.
- Offer relapse prevention support.
- Provide harm reduction services.

RESOURCES FOR PROVIDERS

Alcohol and Drug Use

- New York City Health Department of Health and Mental Hygiene. Alcohol & Drug Use: www1.nyc.gov/site/doh/health/health-topics/alcohol-and-drug-use.page
  Information on drugs and health, alcohol and health, overdose prevention, and substance use treatment services

Screening Tools

- AUDIT: libdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf
- ASSIST: www.who.int/substance_abuse/activities/assist/en/index.html
- NIDA Quick Screen and NIDA-Modified ASSIST: www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
- CRAFFT (for adolescents): ceasar-boston.org/clinicians/crafft.php
  - American Academy of Pediatrics Committee on Substance Abuse. *Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians:* pediatrics.aappublications.org/content/128/5/e1330.full/
- DAST-10: www.drugabuse.gov/sites/default/files/files/DAST-10.pdf

Screening, Brief Intervention, and Referral to Treatment

- NYC Health Department
  - Alcohol & Drug Use: Screening, Brief Intervention and Referral to Treatment: www1.nyc.gov/site/doh/providers/health-topics/screening-brief-intervention-and-referral-to-treatment.page
  - City Health Information: Brief Intervention for Excessive Drinking
- American Academy of Pediatrics Committee on Substance Abuse. *Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians:* pediatrics.aappublications.org/content/128/5/e1330.full
- National Institute on Alcohol Abuse and Alcoholism. *Helping Patients Who Drink Too Much: A Clinician's Guide.* Updated 2005 Edition: pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
- New York State Office of Alcoholism and Substance Abuse Services (OASAS). Screening, Brief Intervention, and Referral to Treatment: www.oasas.ny.gov/admed/sbirt/index.cfm
- Institute for Research, Education & Training in Addictions. SBIRT toolkit: ireta.org/improve-practice/toolkitforsbirt/
- Substance Abuse and Mental Health Services Administration (SAMHSA). Screening, Brief Intervention, and Referral to Treatment (SBIRT): www.samhsa.gov/sbirt

Buprenorphine

- NYC Health Department
  - Buprenorphine Training and Technical Support Initiative: *For more information, e-mail:* buprenorphine@health.nyc.gov
  - City Health Information: Buprenorphine—An Office-Based Treatment for Opioid Use Disorder
- Providers' Clinical Support System (PCSS) for Opioid Therapies: pcss-o.org
  Includes mentoring program
- SAMHSA. General information on buprenorphine, waiver process, training: www.samhsa.gov/

(Continued on next page)

BACK TO PAGE 1

(Continued from previous page)

Relapse Prevention

- The PRIMECare Model of Maintenance Care for Moderated Alcohol Use: www.ncbi.nlm.nih.gov/pmc/articles/PMC1924751/ [See Appendix]

Treatment Locators

- SAMHSA Behavioral Health Treatment Services Locator: findtreatment.samhsa.gov/
- OASAS Treatment Provider Search and Directory: www.oasas.ny.gov/treatment/directory.cfm/

Opioid Overdose Prevention

- NYC Health Department
  - o Overdose Prevention Resources for Providers: www1.nyc.gov/site/doh/providers/health-topics/overdose-prevention-resources-for-providers.page
    Includes guidance on prescribing naloxone in clinical settings and a training video
  - o Naloxone and Overdose Prevention in Pharmacies: www1.nyc.gov/site/doh/providers/health-topics/naloxone-and-overdose-prevention-in-pharmacies.page
    Includes a list of participating NYC pharmacies and a patient handout
- New York State's Opioid Overdose Prevention Program: www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/

Syringe Services

- New York State Department of Health. Expanded Syringe Access Program (ESAP): Overview of the Law and Regulations: www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/esap/overview.htm
- ESAP Pharmacy Directory: www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/esap/docs/esap_pharmacies.pdf

City Health Information (CHI) Archives:
www1.nyc.gov/site/doh/providers/resources/chi-archives.page

- Buprenorphine—An Office-based Treatment for Opioid Use Disorder
- Brief Intervention for Excessive Drinking

RESOURCES FOR PATIENTS

Alcohol and Drug Use

- New York City Department of Health and Mental Hygiene.
  Alcohol & Drug Use: www1.nyc.gov/site/doh/health/health-topics/alcohol-and-drug-use.page
  Information on drugs and health, alcohol and health, overdose prevention, and substance use treatment services

Publications

- NYC Health Department
  - o Health Bulletins
    - *Cocaine: Do You Have a Problem?:* www1.nyc.gov/assets/doh/downloads/pdf/public/dohmhnews10-06.pdf
    - *Marijuana: Is it holding you back?:* www1.nyc.gov/assets/doh/downloads/pdf/public/dohmhnews7-11.pdf
    - *Excessive Drinking Is Dangerous:* www1.nyc.gov/assets/doh/downloads/pdf/public/dohmhnews9-08.pdf
    - *Prescription Painkillers: The Dangers of Misuse:* www1.nyc.gov/assets/doh/downloads/pdf/public/dohmhnews11-01.pdf

Treatment Locators

- LIFENET website: www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-lifenet.page
- Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Services Locator: findtreatment.samhsa.gov/
- New York State Office of Alcoholism and Substance Abuse Services. Treatment Provider Search and Directory: www.oasas.ny.gov/treatment/directory.cfm

BACK TO PAGE 1

REFERENCES

1. New York City Department of Health and Mental Hygiene. Bureau of Vital Statistics. Summary of Vital Statistics 2014—The City of New York. www1.nyc.gov/assets/doh/downloads/pdf/vs/2014sum.pdf. Accessed June 9, 2016.
2. Paone D, Tauzon E, Nolan M, Mantha S. Unintentional drug poisoning (overdose) deaths involving opioids in New York City, 2000-2014. *Epi Data Brief.* 2015; No 66. Updated March 2016. www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief66.pdf. Accessed May 13, 2016.
3. Saitz R. Clinical practice: unhealthy alcohol use. *N Engl J Med.* 2005;352(6):596-607.
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. Arlington, VA: American Psychiatric Association; 2013.
5. Substance Abuse and Mental Health Services Administration. Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings. www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf. Accessed April 5, 2016.
6. McKnight-Eily LR, Liu Y, Brewer RD, et al; Centers for Disease Control and Prevention (CDC). Vital signs: communication between health professionals and their patients about alcohol use—44 states and the District of Columbia, 2011. *MMWR Morb Mortal Wkly Rep.* 2014;63(1):16-22.
7. O'Connor PG, Oliveto AH, Shi JM, et al. A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone clinic. *Am J Med.* 1998;105(2):100-105.
8. Willenbring ML, Olson DH. A randomized trial of integrated outpatient treatment for medically ill alcoholic men. *Arch Intern Med.* 1999;159(16):1946-1952.
9. Friedmann PD, Saitz R, Samet JH. Management of adults recovering from alcohol or other drug problems: relapse prevention in primary care. *JAMA.* 1998;279(15):1227-1231.
10. Shim R, Rust G. Primary care, behavioral health, and public health: partners in reducing mental health stigma. *Am J Public Health.* 2013;103(5):774-776.
11. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. Primary care validation of a single-question alcohol screening test. *J Gen Intern Med.* 2009;24(7):783-788.
12. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. *The Alcohol Use Disorders Identification Test (AUDIT): Guidelines for Use in Primary Care.* 2nd ed. Geneva, Switzerland: World Health Organization; 2001. apps.who.int/iris/bitstream/10665/67205/1/WHO_MSD_MSB_01.6a.pdf. Accessed April 22, 2016.
13. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. *Arch Intern Med.* 2010;170(13):1155-1160.
14. National Institute on Drug Abuse. DAST-10. www.drugabuse.gov/sites/default/files/files/DAST-10.pdf. Accessed May 17, 2016.
15. American College of Obstetricians and Gynecologists. Committee opinion no. 496: At-risk drinking and alcohol dependence: obstetric and gynecologic implications. *Obstet Gynecol.* 2011;118(2 Pt 1):383-388.
16. New York City Department of Health and Mental Hygiene. Judicious prescribing of benzodiazepines. *City Health Information.* 2016;35(2):13-20. www1.nyc.gov/assets/doh/downloads/pdf/chi/chi-35-2.pdf.
17. American Association for the Study of Liver Disease. HCV Testing and Linkage to Care. www.hcvguidelines.org/full-report/hcv-testing-and-linkage-care. Accessed May 3, 2016.
18. Vermont Department of Health, Screening, Brief Intervention, & Referral to Treatment. DAST 10 Scoring Guide and Interpretation. sbirt.vermont.gov/dast-10-scoring-guide/. Accessed April 22, 2016.
19. Skinner HA. The drug abuse screening test. *Addict Behav.* 1982;7(4):363-371.
20. Massachusetts Department of Public Health. SBIRT: A Step-by-Step Guide. June 2012. www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf. Accessed April 22, 2016.
21. Ockene JK, Adams A, Hurley TG, Wheeler EV, Hebert JR. Brief physician- and nurse practitioner-delivered counseling for high-risk drinkers: does it work? *Arch Intern Med.* 1999;159(18):2198-2205.
22. Fleming MF, Barry KL, Manwell LB, Johnson K, London R. Brief physician advice for problem alcohol drinkers. A randomized controlled trial in community-based primary care practices. *JAMA.* 1997;277(13):1039-1045.
23. Bertholet N, Daeppen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis. *Arch Intern Med.* 2005;165(9):986-995.
24. Boston University School of Public Health, The BNI ART Institute. www.bu.edu/bniart/. Accessed April 22, 2016.
25. Babor TF, Higgins-Biddle TF. *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care.* Geneva, Switzerland: World Health Organization; 2001. whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf. Accessed May 3, 2016.
26. Jonas DE, Amick HR, Feltner C, et al. Pharmacotherapy for adults with alcohol use disorders in outpatient settings: a systematic review and meta-analysis. *JAMA.* 2014;311(18):1889-1900. doi: 10.1001/jama.2014.3628.
27. Cornish R, Macleod J, Strang J, Vickerman P, Hickman M. Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. *BMJ.* 2010;341:c5475. doi: 10.1136/bmj.c5475.
28. Fiellin DA, Moore BA, Sullivan LE, et al. Long-term treatment with buprenorphine/naloxone in primary care: results at 2-5 years. *Am J Addict.* 2008;17(2):116-120.
29. Ball JC, Ross A. *The Effectiveness of Methadone Maintenance Treatment: Patients, Programs, Services, and Outcomes.* New York, NY: Springer-Verlag; 1991.
30. Davoli M, Bargagli AM, Perucci CA, et al; VEdeTTE Study Group. Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multi-site prospective cohort study. *Addiction.* 2007;102(12):1954-1959.
31. Krupitsky E, Zvartau E, Blokhina E, et al. Randomized trial of long-acting sustained-release naltrexone implant vs oral naltrexone or placebo for preventing relapse to opioid dependence. *Arch Gen Psychiatry.* 2012;69(9):973-981.
32. Lee JD, Friedmann PD, Kinlock TW, et al. Extended-release naltrexone to prevent opioid relapse in criminal justice offenders. *N Engl J Med.* 2016;374(13):1232-1242.
33. Scott CK, Foss MA, Dennis ML. Pathways in the relapse-treatment-recovery cycle over 3 years. *J Subst Abuse Treat.* 2005;28(Suppl 1):S63-S72.
34. Hendershot CS, Witkiewitz K, George WH, Marlatt GA. Relapse prevention for addictive behaviors. *Subst Abuse Treat Prev Policy.* 2011;6:17. doi: 10.1186/1747-597X-6-17.
35. Friedmann PD, Saitz R, Samet JH. Management of adults recovering from alcohol or other drug problems: relapse prevention in primary care. *JAMA.*1998;279(16):1227-1231.
36. Friedmann PD, Rose J, Hayaki J, et al. Training primary care clinicians in maintenance care for moderated alcohol use. *J Gen Intern Med.* 2006;21(12):1269-1275.
37. Scott CK, Dennis ML, Foss MA. Utilizing recovery management checkups to shorten the cycle of relapse, treatment reentry, and recovery. *Drug Alcohol Depend.* 2005;78(3):325-338.
38. Witkiewitz K, Lustyk MK, Bowen S. Retraining the addicted brain: a review of hypothesized neurobiological mechanisms of mindfulness-based relapse prevention. *Psychol Addict Behav.* 2013;27(2):351-365.
39. Groh DR, Jason LA, Davis MI, Olson BD, Ferrari JR. Friends, family, and alcohol abuse: an examination of general and alcohol-specific social support. *Am J Addict.* 2007;16(1):49-55.
40. Bond J, Kaskutas LA, Weisner C. The persistent influence of social networks and alcoholics anonymous on abstinence. *J Stud Alcohol.* 2003;64(4):579-588.

(Continued on next page)

BACK TO PAGE 1

City Health Information

Volume 35 (2016) The New York City Department of Health and Mental Hygiene No. 3; 21-28

NYC Health
nyc.gov/health

42-09 28th Street, Long Island City, NY 11101 (347) 396-2914

ASK CHI
Have questions or comments about addressing alcohol and drug use in primary care?
E-mail
AskCHI@health.nyc.gov

E-mail *City Health Information* at: nycdohrp@health.nyc.gov
New York City Department of Health and Mental Hygiene.
Addressing alcohol and drug use—an integral part of primary care.
City Health Information. 2016;35(3):21-28.

(Continued from previous page)

41. Humphreys K, Blodgett JC, Wagner TH. Estimating the efficacy of Alcoholics Anonymous without self-selection bias: an instrumental variables re-analysis of randomized clinical trials. *Alcohol Clin Exp Res.* 2014;38(11):2688-2694. doi:10.1111/acer.12557.
42. Tracy K, Burton M, Nich C, Rounsaville B. Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. *Am J Drug Alcohol Abuse.* 2011;37(6):525-531.
43. Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: a report from the field. *Schizophr Bull.* 2006;32(3):443-450.
44. Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry.* 2012;11(2):123-128.
45. Kim D, Irwin KS, Khoshnood K. Expanded access to naloxone: options for critical response to the epidemic of opioid overdose mortality. *Am J Public Health.* 2009;99(3):402-407. doi: 10.2105/AJPH.2008.136937.
46. New York City Department of Health and Mental Hygiene. Naloxone for Overdose Prevention: Prescribing Guidance for Clinical Settings. www1.nyc.gov/assets/doh/downloads/pdf/basas/naloxone-presc-guidance.pdf. Accessed May 16, 2016.
47. Tesoriero JM, Battles HB, Klein SJ, Kaufman E, Birkhead GS. Expanding access to sterile syringes through pharmacies: assessment of New York's Expanded Syringe Access Program. *J Am Pharm Assoc (2003).* 2009;49(34):407-416.
48. Tai B, McLellan AT. Integrating information on substance use disorders into electronic health record systems. *J Subst Abuse Treat.* 2012;43(1):12-19. doi: 10/10.1016/j.jsat.2011.10.010.
49. Babor T, Higgins-Biddle J, Dauser D, Higgins P, Burleson JA. Alcohol screening and brief intervention in primary care settings: implementation models and predictors. *J Stud Alcohol.* 2005;66(3):361-368.
50. Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders; Board on Health Care Services; Institute of Medicine. *Improving the Quality of Health Care for Mental and Substance-Use Conditions.* Washington, DC: National Academies Press; 2006.

BACK TO PAGE 1