STATE OF ALASKA
DEPARTMENT OF HEALTH AND
SOCIAL SERVICES
DIVISION OF BEHAVIORAL HEALTH

Alaska Screening Tool FY2011 and Initial Client Status Review FY2011

Supporting Clinical Decision Making and Program Performance Measurement

INTRODUCTION

Screening is often the initial contact between a person and the treatment system, and the client forms their first impression of treatment during screening and intake. For this reason how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client. Each provider has an Intake process that includes completion by the client of the AST2011. The process generally allows the clinician or counselor to talk informally with the individual to get to develop rapport prior to a review of the completed screening form.

This document describes how information provided by consumers in the Alaska Screening Tool 2011 (AST2011) may be used to inform the screening and assessment process. The Client Status Review (CSR) also provides valuable screening information when completed near the same time. Responses are reviewed by a clinician or counselor with the client to provide:[1]

- Treatment alliance-discussion of patient and program responsibilities
- Initial evaluation-formulation of the presenting problems, including prioritization
- Initial treatment plan

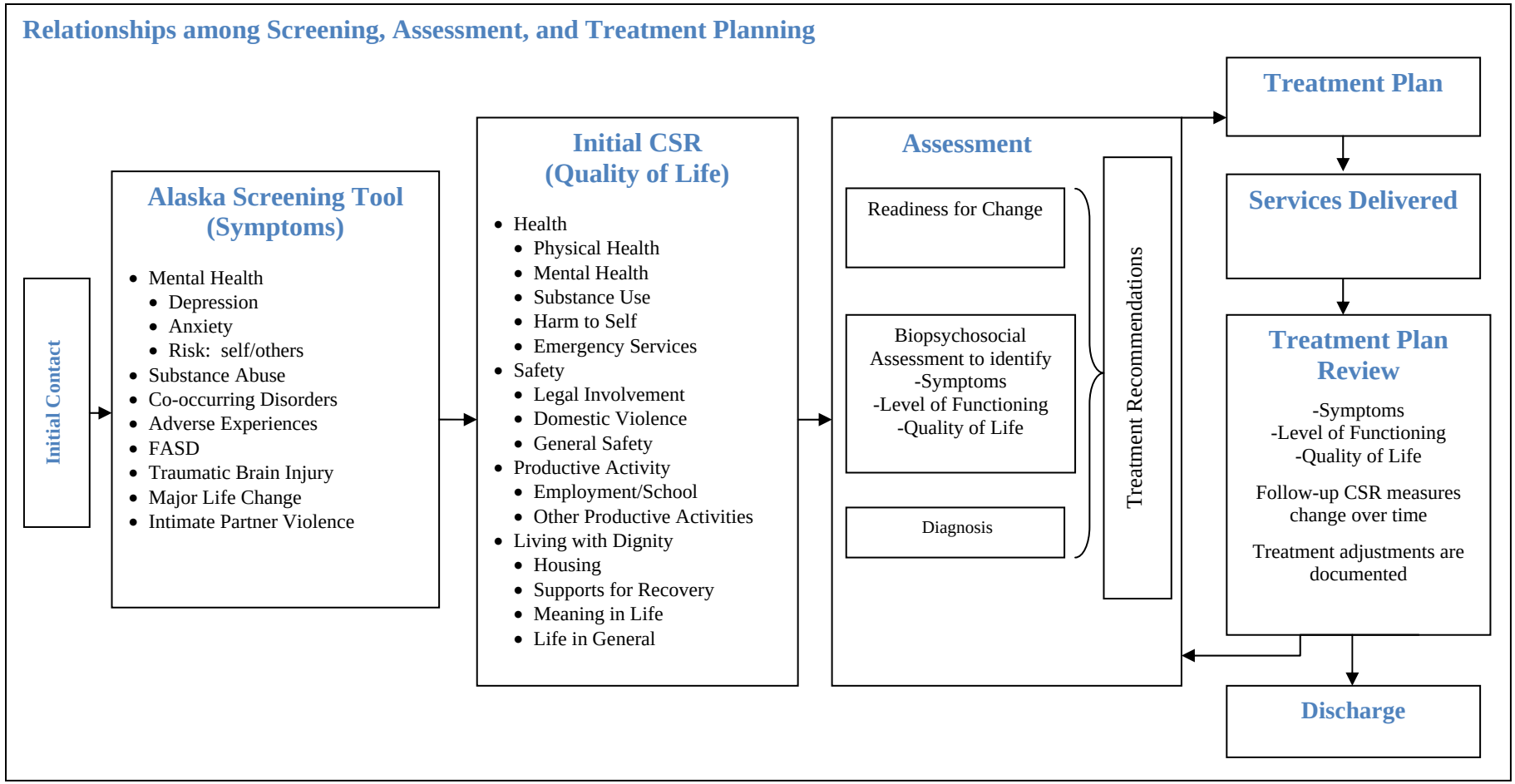
Screening, assessment, and treatment planning constitute three interrelated components of a process that, when properly executed, informs and guides the provision of appropriate, client-centered services to persons receiving services. [2]

Screening	Determines the likelihood that a client has a behavioral health disorder. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.
Assessment	Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence of a disorder. An Assessment determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.
Treatment Planning	Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that are tailored as needed to take into account issues related to the goals of the client.

[1] Modified SAMHSA COCE publication http://coce.samhsa.gov/cod_resources/PDF/ScreeningAssessment(OP2).pdf These forms may not be completed in a situation calling for stabilization or immediate assistance with a crisis.

[2] These definitions were modified from a SAMHSA Co-Occurring Center for Excellence publication that may be found at http://coce.samhsa.gov/cod_resources/PDF/ScreeningAssessment(OP2).pdf

The Treatment Plan describes the needs of the client and the plan for services to support the client in achieving the outcomes desired. The entire process is shown in the following graphic.



The focus of this document is on the Screening component. First the AST is described in detail, then the Initial CSR, and finally how together they combine to inform the assessment process between the client and their counselor. The structure of the document highlights the clinical utility of the information.

Please note this document: 1) Is in an early developmental stage and will change over time, and 2) Will be developed with more specific information for demographic groups, particularly children, adolescents, transitional age youths, and elderly.

Table of Contents

INTRODUCTION *2*

THE ALASKA SCREENING TOOL 2011 ..... *5*

What is the AST? **5**

How is it supposed to function? **5**

Who is expected to complete the AST? **5**

Why is the AST important to the Division? **6**

AST Screening Domains **6**

Scoring in the AST **8**

Sections I and IV - Mental Health Client Scoring Instructions 8
Section V - Substance Abuse Scoring Instructions 9
Section III - Traumatic Brain Injury Scoring Instructions 9
Section III - FASD Scoring Instructions 9
Section II - Adverse Experiences 9
Risk of Harm 10
Summary of Screening Outcomes 10

Fast Facts **12**

Depression: Fast Facts 12
Adverse Experiences 14
Harm to Self: Fast Facts 20
Harm to Others: Fast Facts 23
Domestic Violence and Child Maltreatment: Fast Facts 25
Alcohol and Illicit Drug Use: Fast Facts 29
Fetal Alcohol Spectrum Disorder (FASD): Fast Facts 35
Traumatic Brain Injury (TBI): Fast Facts 37

THE CLIENT STATUS REVIEW OF LIFE DOMAINS *40*

What is the Client Status Review? **40**

How does it support decision making? **40**

Who is expected to complete the CSR? **41**

Scoring the CSR **41**

Screening Using the AST and Initial CSR **43**

Appendix A: Searching AHRQ guideline.gov *45*

Disease/Condition **45**

Treatment/Intervention **45**

Appendix B: Rationale for Self Report on Quality of Life *49*

Appendix C: AST and CSR Instruments ..... *Error! Bookmark not defined.*

THE ALASKA SCREENING TOOL 2011

What is the AST?

The Alaska Screening Tool (AST) screens for substance abuse, mental illness, co-occurring substance abuse and mental illness, traumatic brain injury (TBI), and Fetal Alcohol Spectrum Disorders (FASD). It was developed in collaboration with behavioral healthcare care providers, the Alaska Mental Health Board, the Alaska Mental Health Trust Authority, and The Division of Behavioral Health. The tool was revised in 2011 to increase clinical utility.

The revised AST2011 refines the mental health component and adds a new section investigating “adverse experiences”. Refinements include a standardized depression scale which provides five levels of severity of depression from “no depression” to “severe depression”. The section on adverse experiences was added upon the findings of the Adverse Childhood Experiences (ACE) Study. The ACE Study found increasing health, mental health, and substance abuse problems corresponding to a greater number of adverse experiences.

The revised AST has the potential to make use of information from respondents to inform clinicians beyond the original screens for SA, MH, TBI, and FASD. For instance, the “risk of harm” questions may be combined with depression, substance use, major life changes, and adverse experiences to indicate to clinicians the level of risk of harm to self or others.

An important change in screening was to move a question on suicidal ideation from the AST to the Client Status Review (CSR). This change was made in order to monitor the risk of harm in an ongoing manner. Other information in the initial CSR may also be useful for screening.

It is important to note that screening and assessment are two separate and distinct processes as described in the introduction of this document

How is it supposed to function?

The AST functions largely as a screening instrument for substance abuse, mental health, co-occurring, FASD, and TBI. Each screening can produce multiple recommendations and may result in more than one referral. For example, one screening has the potential to result in both a substance abuse and mental health referral. Additionally, the same screen may also identify possible indicators of Traumatic Brain Injury and / or indicators of Fetal Alcohol Spectrum Disorders, each requiring a referral. Dual Diagnosis in this context indicates a positive screening for both a substance abuse and mental health referral

Who is expected to complete the AST?

All behavioral health grantee providers are required to administer and submit the AST as a condition of their grant award from the Division of Behavioral Health. The AST is completed by the provider with responses from the client and submitted to the Division of Behavioral Health via the Alaska Automated Information Management System (AK AIMS). The AST is completed

As a screening tool, the AST has strengths and limitations. Overall, screening instruments can be an efficient form of information gathering. The advantages of using screening tools are the simplicity of their use and scoring, the generally limited training needed for their administration, and, for well-researched tools, a known level of reliability and the availability of cut-off scores. One disadvantage of screening instruments is that they sometimes become the only component of the screening process. A second disadvantage is that a routinely administered screening instrument provides little opportunity to establish a connection with the client. Such a connection may be important in motivating the client to accept a referral for assessment if needed.[3]

The following table lists the areas providing information for screening in the revised AST and shows the location in the instrument. The table also shows how information may combine to inform the screening using risk of harm to self as an example.

(The complete AST instrument may be found in Appendix C.)

Table 1. Location of Screening Domains

	Location in the AST	
Mental Health Screen		
Depression	Five levels based on a standardized scale (#s 1-8)	*
Risk of Harm	Harm to self yes/no (either #28 or CSR #4 > 0)* Harm to others yes/no (either #29, #30)	*
Distress/Trauma	Sum of four new questions (#s 10-13)	*
Anxiety	Sum of two questions (#s 26, 27)	
Hallucination	Single indicator (#31)	
Paranoia	Single indicator (#32)	
Substance Abuse Screen	Sum of five questions (#s 33 - 37)	*
Co-occurring Disorders	Endorsement of any substance abuse question in addition to endorsement of any mental health question	
Additional Areas	**Location in the AST**	
FASD		
TBI	Five questions	
Major Life Change	One question	*
Adverse experiences	Sum of eight questions (#s 14-21)	*
Intimate Partner Violence	Single questions (#21.a.)	*

*Risk of harm is elevated with endorsement of these domains

[3] Modified SAMHSA COCE publication http://coce.samhsa.gov/cod_resources/PDF/ScreeningAssessment(OP2).pdf A compendium of relevant screening instruments can be found in TIP 42, Appendixes G and H, pages 487.512 (CSAT, 2005)

during the screening process *prior* to the formal assessment process. Policies around when and how to use and administer the AST are also available at:
http://hss.state.ak.us/dbh/perform_measure/PDF/pm_systempolicy.pdf

Why is the AST important to the Division?

The AST is an important tool for the Division of Behavioral Health, providers, and other stakeholders. The AST functions as a standardized state-wide screening instrument that provides a means of identifying the needs of individuals and families, leading to appropriate referrals and timely access to services. Further, over time the AST will assist the Division of Behavioral Health and providers in identifying the population needs of each agency, thereby providing useful data for program management of the service delivery system. The information from the AST will also serve to assist the state in federal reporting requirements.

AST Screening Domains

The Alaska Screening Tool is designed to support clinical judgment. The original AST screened for mental health, substance abuse, traumatic brain injury, and fetal alcohol spectrum disorders. The revised AST also screens for the same conditions as well as providing additional information to the clinician in several new areas as illustrated in Figure 1. The revised AST2011: adds a standardized depression scale; considers the potential for risk of harm; and investigates adverse experiences and domestic violence.

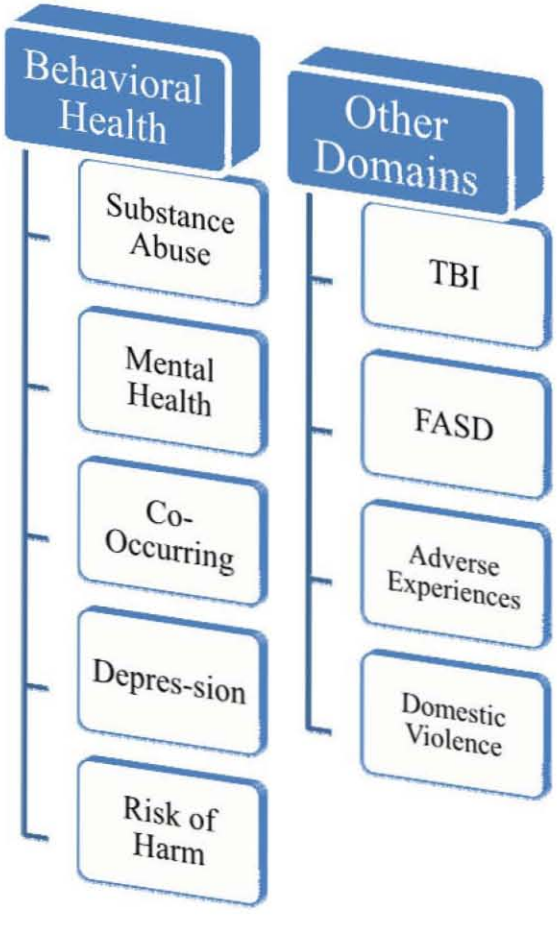


Figure 1: AST Screening Tool Domains

Scoring in the AST

Screeners are urged to error on the side of referring for an assessment when they are not sure of the likelihood of a positive screen. This minimizes the likelihood that symptoms indicating someone needs treatment will go undetected.

Sections I and IV - Mental Health Client Scoring Instructions

The mental health screen includes Section I (#1-13) and Section IV (#25-32). The first eight questions in Section I (#1-8) make up a standardized depression scale. Other mental health questions contribute to screening directly.

If a consumer does not indicate current depression, and the consumer responds negatively to all other mental health questions, and the interviewer has not learned anything during the interview that is contradictory, the client is not considered as a potential mental health client.

If consumer responses indicate:

- current depression in Section I (#1-8)
- and/or the consumer responds positively (1 or more days) to any of the remaining mental health questions in Section I (#9-13)
- and/or "Yes" to any question in Section IV (#25-32), then the client should be asked for clarifying information and if the positive response is validated, this will trigger a referral for a mental health assessment.

Scoring depression severity takes three steps:

Step 1) Convert the number of days entered for each question 1-8 into a count between 0 and 3:

If a client enters:	**Then the Question Counts:**
0 to 1 days	=0
2 to 6 days	=1
7 to 11 days	=2
12 to 14 days	=3

Step 2) Sum the counts for all eight questions

Step 3) Convert the sum to a severity of depression:

Sum of counts for all eight questions:	**Severity of Depression**:
0 to 4 represents	No meaningful Depressive Symptoms
5 to 9	Mild Depression
10 to 14	Moderate Depression
15 to 19	Moderately Severe Depression
20 to 27	Severe Depression

Section V - Substance Abuse Scoring Instructions

If a consumer responds negatively to all questions, and the interviewer has not learned anything during the interview that is contradictory, the client is not considered as a potential substance abuse client.
If a consumer responds positively (Yes) to any of the five questions (#33-37), the client should be asked for clarifying information about the question and if the positive response is validated, this will trigger a referral for a full substance abuse/dependence assessment.

Section III - Traumatic Brain Injury Scoring Instructions

If a consumer answers “Yes” to question #22 and/or #23 and has responded that they still have symptoms, the consumer needs to be assessed for traumatic brain injury or referred to someone who can conduct an assessment.

Section III - FASD Scoring Instructions

If a person responds positively to both questions #24 and #24 a, they should be referred for an FASD assessment.

Section II - Adverse Experiences

The Division is collecting information on difficulties that clients have experienced in their lifetimes. This information by itself does not trigger an assessment. The information is useful because research has found that people with three or more adverse experiences are more likely to have mental health and/or substance use conditions as well as complicating medical issues.

The number of adverse experiences is the count of “Yes” responses to the eight questions in Section II (#14- 21). Question #21 goes on to ask about intimate partner violence. A response of “Yes” to question #21a requires follow up during the screening about the personal safety of the respondent and other household members.

Risk of Harm

No tool is definitive for safety screening. Clinicians should use safety screening tools only as an initial guide and proceed to detailed questions to obtain relevant information. The potential risk of harm most frequently takes the form of suicidal intentions, and less often the form of homicidal intentions. Overall, individuals who have suicidal or aggressive impulses when intoxicated are more likely to act on those impulses; therefore, determination of the seriousness of threats requires a skilled mental health assessment, plus information from others who know the client very well.[4]

There are several indicators of risk in the AST2011. In addition, the initial CSR has information that contributes to the initial screening and ongoing monitoring during the course of treatment. There are questions on risk of harm to self, risk of being harmed, and risk of harming others.

The risk of harm to self is directly asked by these questions: AST item #28: (In the past 12 months) Have you tried to hurt yourself or commit suicide?

CSR item #4: How many days in the past 30 days have you had thoughts about suicide or hurting yourself?

A "Yes" on AST question 28 and/or any number of days greater than "0" on the CSR requires careful follow up during the screening. Other information contributes to the level of risk to self including the severity of depression (AST #1-8), number of adverse experiences (AST #14-21), a major life change (AST #25), and screening positive for substance use (AST # 33-37) as illustrated in Table 1 above. If the initial CSR is not available to the clinician doing the screening the clinician may consider asking the individuals if they have had thoughts about suicide or harming themselves.

The AST also asks about the risk of being harmed. Section II on Adverse Experiences in a person's lifetime asks if they have been physically mistreated or seriously threatened and follows up with two questions on intimate partner violence (question 21 and 21a). If either has a positive response the clinician would want to inquire about how recently the experience occurred.

The risk of harm to others is directly asked in two AST questions concerning destroying property or setting a fire (AST # 29) and physically harmed or threatened to harm an animal or person on purpose (AST # 30). The strongest current predictors of interpersonal violence at present are a history of violence, a history of substance abuse and a coercive interactional style.

Summary of Screening Outcomes

A clinician may find it useful to document the screening outcome. An optional form is provided on the following page for this purpose. This form allows a clinician to:

1) indicate if a person screened positive on any AST category (substance abuse, mental health, FASD, dual, or TBI) and 2) record the follow-up step to the screening, e.g., an assessment is not necessary, the follow up will be for an in-house assessment or referral, etc.

4 SAMHSA/CSAT TIP 51: Chapter 4: Screening and Assessment. Screening tools and procedures in evaluating risk are discussed in depth in TIP 50 Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (CSAT 2009*a*).

Summary of Screening Outcomes (Optional)

These questions are to be answered by the clinician conducting the screening.
Circle "Yes" or "No" for each area.
Check one Follow-up Step for each area regardless of "Yes" or "No" answer.

Is client a potential Substance Abuse consumer? **Yes No**

Substance Abuse Follow-up Step: **check <u>only</u> one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Is client a potential Mental Health consumer? **Yes No**

Mental Health Follow-up Step: **check <u>only</u> one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Does client need a FASD assessment? **Yes No**

FASD Follow-up Step: **check <u>only</u> one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Is client a potential Dual Diagnosis (SA & MH) consumer? **Yes No**

Dual Diagnosis Follow-up Step: **check <u>only</u> one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Does client show evidence of a Traumatic Brain Injury? **Yes No**

Traumatic Brain Injury Follow-up Step: **check <u>only</u> one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

_____ _____

Staff Signature Date

Fast Facts

This section of the report provides information relevant to specific domains of the AST. This information is a brief summary of what is currently supported in the research literature. References for this information are provided and the clinician is encouraged to refer to the original sources of information if they wish to know more about a given topic.

Depression: Fast Facts

Prevalence

- In any one-year period, 9.5 percent of the U.S. population, or an estimated 19 million American adults, suffer from a depressive illness.[5]
- One of every 4 women and 1 in 10 men can expect to be diagnosed with depression during their lifetime. This gender difference may be attributable to the fact that men are less likely to admit feelings of depression and doctors are less likely to diagnose it.[6]
- Women are almost twice as likely as men to be diagnosed with depression and reasons may include hormonal changes women go through during menstruation, pregnancy, and menopause. Doctors are also more likely to diagnose depression in women. [7]
- Depression can also be caused by stress, medication, or other medical illnesses. Certain personality traits and family history can also contribute to depression.

Causes

- The multiple causes of depression include biological, cognitive, gender, co-morbid (having other conditions at the same time), drug or medication related, genetic, and situational factors.[8]
- Medical illnesses such as a heart attack, stroke, or cancer can also cause or contribute to depressive symptoms[5] and vice versa.
- For children, teens and elders social isolation increased depression.
- For teens employment increased social isolation which in turn increased depression.
- For elders death of a spouse lead to social isolation which in turn increased depression. Community involvement or volunteering helped decrease depression.
- For adults unemployment was strongly associated with depression.
- Women appeared to be especially effected by the relationship between paid employment and depression. This could be due to a variety of reasons and/or gender inequalities within society regarding the financial stability and independence of women.

Impact

- According to the World Health Organization, depression is projected to become the leading cause of disability and the 2nd leading contributor to the global burden of disease by the year 2020.[9]

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[5] National Institute of Mental Health*: The Numbers Count: Mental Illness in America;* Science on Our Minds Fact Sheet Series. Accessed August 1999. Bethesda, Maryland

[6] Blehar MD, Oren DA. Gender differences in depression. *Medscape Women's Health*, 1997;2:3. Revised from: Women's increased vulnerability to mood disorders: Integrating psychobiology and epidemiology. *Depression*, 1995;3:3-12.

[7] National Mental Health Association, *Depression: What You Need to Know.* Fact Sheet accessed October 2003. Found at: http://www.nmha.org/infoctr/factsheets/21.cfm

[8] National Mental Health Association, *Depression and Co-Occurring Illnesses.* Fact Sheet accessed October 2003. Found at: http://www.nmha.org/ccd/support/cooccurfacts.cfm

- At any one time, 1 employee in 20 is experiencing depression.[10]
- Depression costs the United States an estimated $44 billion each year in terms of absenteeism, lost productivity, reduced quality of work, employee turnover, and on-the-job accidents.[11]

Treatment

- Depending upon the patient, depression may be treated with medication, psychotherapy, or a combination of treatments.
- More than 80 percent of those who seek treatment for depression show improvement.[12]
- Selective serotonin reuptake inhibitors (SSRIs) are the most common forms of treatment for depression.[13]

Depression and Other Illnesses

- Depression and anxiety are distinct disorders, with a notoriously high incidence of comorbidity between them - some studies have shown that up to 90 percent of patients suffer from both disorders at some point during their lives.[14]
- Comorbid depression is common in people diagnosed with a range of anxiety disorders, including generalized anxiety disorder, panic disorder, social anxiety disorder, obsessive-compulsive disorder, and others.[15]

National Guideline Clearinghouse

The National Guideline Clearing House is a public resource for evidence-based clinical practice guidelines published by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (www.guideline.gov). It provides a useful reference for depression and other behavioral health conditions. Appendix A describes how to search the Guideline website by diagnostic/disease type or by treatment/intervention and demonstrates a search.

National Guideline Clearinghouse on Depression

Guidelines for depression are very thorough and presented separately for adults and adolescents. They include information on recognizing and diagnosing depression as well as recommendations for treatment. These specific guidelines may be found at the site: *Practice parameters for the assessment and treatment of children and adolescents with depressive disorders; Screening for depression in adults; Major depression in adults in primary care.*

As an example, the Guidelines for major depression in adults describe presentations for major depression and risk factors.

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[9] Murray CJL, Lopez AD, eds. *Summary: The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

[10] National Institute of Mental Health*, Effects of Depression in the Workplace;* June 1,1999. NIMH. Bethesda, Maryland. Found at: http://www.nimh.nih.gov/publicat/workplace.cfm

[11] National Institute of Mental Health, *What to Do When an Employee is Depressed;* Updated: November 1, 1999. NIMH Publication No. 96-3919. Bethesda, Maryland. Found at: http://www.nimh.nih.gov/publicat/depemployee.cfm

[12] Mental Help Online, *Treatment for Depression.* Accessed October 2003. Found at: http://mentalhelp.net/poc/view_doc.php?type=doc&id=611&cn=5&clnt%3Dclnt00001&

[13] Greco, N., Zajecka, J.M. Evaluating and Treating Comorbid Depression and Anxiety in Women. *Women's Health in Primary Care.* May 2002; 3:349-60

[14] Comorbid depression and anxiety spectrum disorders. *Depress Anxiety.* 1996-97; 4:160-8

[15] Lydiard RB, Brawman-Mintzer O. Anxious depression. J Clin Psychiatry. 1998;59(suppl 18):10-17.

The close relationship of mind and body results in the presentation of medical illness with major depression in various forms:

- Medical illness may be a biological cause (e.g., thyroid disorder, stroke).
- Medical illness or patient's perception of his or her clinical condition and health-related quality of life may trigger a psychological reaction to prognosis, pain or disability (e.g., in a patient with cancer).
- Medical illness may exist coincidentally in a patient with primary mood or anxiety disorder.

Presentations for major depression include:

- Multiple (more than five per year) medical visits
- Multiple unexplained symptoms
- Work or relationship dysfunction
- Changes in interpersonal relationships
- Dampened affect
- Poor behavioral follow-through with activities of daily living or prior treatment recommendations

Risk Factors for Major Depression Include:

- Weight gain or loss
- Sleep disturbance
- Fatigue
- Dementia
- Irritable bowel syndrome
- Volunteered complaints of stress or mood disturbance

- Family or personal history of major depression and/or substance abuse
- Recent loss
- Chronic medical illness
- Stressful life events that include loss (death of a loved one, divorce)
- Domestic abuse/violence
- Traumatic events (car accident)

- Major life changes (job change) Emotional and behavioral reactions to these social stressors can include symptoms of major depression.

Adverse Experiences

Adverse Experiences in the AST (#'s 14-21) were modeled on the Adverse Childhood Experiences (ACE) Study.[16] The purpose of including adverse experiences was to recognize how common they are, how influential they are on health and well being, and finally to reinforce their implications for treatment.

There are two major differences between adverse experiences in the AST2011 and the ACE Study. 1) The AST2011 has several, but not all questions in common with the ACE Study. 2) The AST asks about *lifetime experiences* while the ACE study asked about childhood experiences. Childhood experiences are unique due to the development process. However, research shows childhood adverse experiences tend to persist into adulthood.

Findings from the ACE Study are reviewed here since they apply to the AST2011. They are informative in showing the influence of these experiences throughout the life span. A greater number of these experiences have been associated with trauma and adoption of health risk

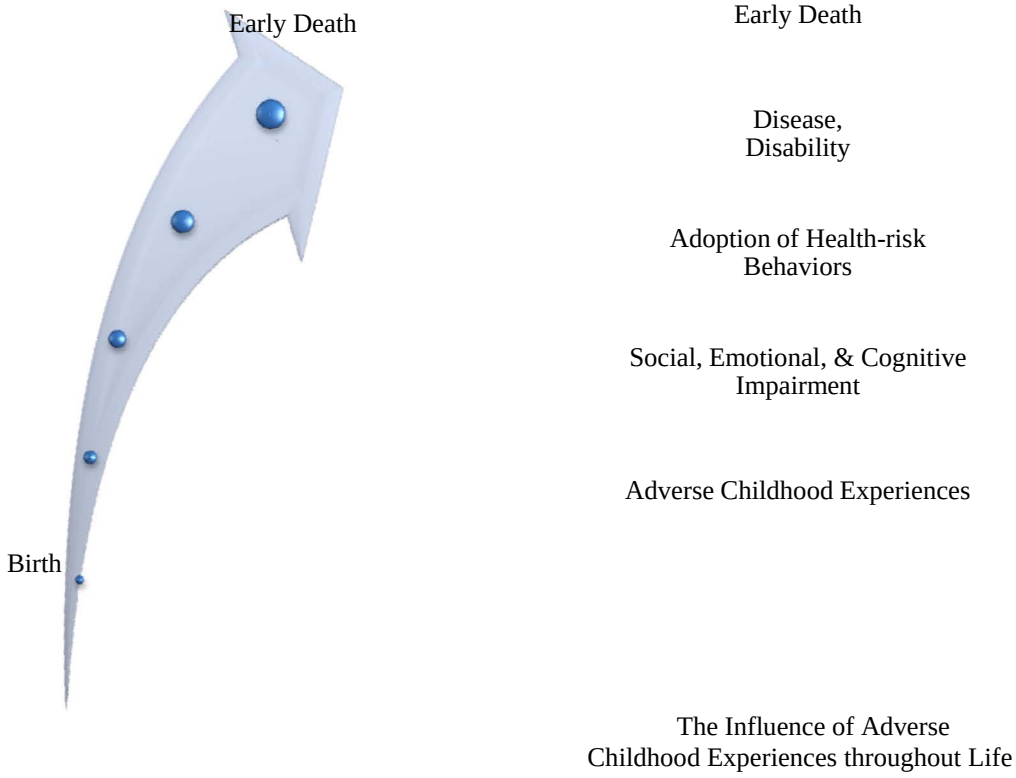
[16] The ACE Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. Led by Co-principal Investigators Robert F. Anda, MD, MS, and Vincent J. Felitti, MD. http://www.acestudy.org/

behaviors to ease the pain. For instance, there is a strong relationship between the number of adverse experiences and alcoholism and injection of illegal drugs. The long term consequences of trauma are disease and disability as well as social problems.

The ACE Study found a strong, graded relationship to the number of adverse childhood experience categories and a wide range of physical, emotional, and social problems including: smoking, chronic obstructive pulmonary disease, hepatitis, heart disease, fractures, diabetes, obesity, alcoholism, fifty or more sexual intercourse partners, other substance abuse including IV drug use, depression and attempted suicide, teen pregnancy (including paternity), sexually transmitted diseases, rape, hallucinations, poor occupational health and poor job performance.

The influences that adverse childhood experiences may have on an n individual's life are illustrated in Figure 2 below.

Figure 2. Influences of Adverse Childhood Experiences throughout Life



ACEs are common: "We found that **ACEs are common**, even in a relatively well educated population of patients enrolled in one of the Nation's leading HMOs. More than 1 in 4 grew up with substance abuse and two-thirds had at least one ACE! More than 1 in 10 had 5 or more ACEs! And we found that **ACEs are highly interrelated**."[17]

Articles on the ACES) study can be found at http://www.ncbi.nih.gov/entrez'query.fegi. Search for either author "Felitti" or "Anda" to find over 50 references with titles and abstracts.

[17] 1. The Health and Social Impact of Growing Up With Adverse Childhood Experiences: The Human and Economic Costs of the Status Quo. Robert Anda, MD, MS, Co-Principal Investigator Adverse Childhood Experiences (ACE) Study

Adverse Childhood Experiences and Health and Well-Being over the Lifespan

This chart shows the sequence of events that unaddressed childhood abuse and other early traumatic experiences set in motion. Without intervention, adverse childhood events (ACES) may result in long-term disease, disability, chronic social problems and early death. 90% of public mental health clients have been exposed to multiple physical or sexual abuse traumas. Importantly, intergenerational transmission may continue to perpetuate ACES without implementation of interventions to interrupt the cycle.

Adverse Childhood Experiences

Abuse of Child
- Psychological abuse
- Physical abuse
- Sexual abuse

Trauma in Child's Household Environment
- Substance abuse
- Parental separation and/or divorce
- Mentally ill or suicidal household member
- Violence to mother
- Imprisoned household member

Neglect of Child
- Abandonment
- Child's basic physical and/or emotional needs unmet

Impact of Trauma and Adoption of Health Risk Behaviors to Ease Pain of Trauma

Neurobiological Effects of Trauma
- Disrupted neuro-development
- Difficulty controlling Anger – Rage
- Hallucinations
- Depression
- Panic reactions
- Anxiety
- Multiple (6+) somatic problems
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

Health Risk Behaviors
- Smoking
- Severe obesity
- Physical inactivity
- Suicide attempts
- Alcoholism
- Drug abuse
- 50+ sex partners
- Repetition of original Trauma
- Self-injury
- Eating disorders
- Perpetrate interpersonal violence

Long-Term Consequences of Unaddressed Trauma

Disease and Disability
- Ischemic heart disease
- Cancer
- Chronic lung disease
- Chronic emphysema
- Asthma
- Liver disease
- Skeletal fractures
- Poor self rated Health
- Sexually transmitted disease
- HIV/AIDS

Social Problems
- Homelessness
- Prostitution
- Delinquency, violence and criminal behavior
- Inability to sustain employment – welfare recipient
- Re-victimization: rape; domestic violence
- Inability to parent
- Inter-generational transmission of abuse
- Long-term use of health, behavioral health, correctional, and social services systems

Data supporting the above model can be found in the Adverse Childhood Experiences Study (Center for Disease Control and Kaiser Permanente, see www.ACEstudy.org) and The Damaging Consequences of Violence and Trauma (see www.NASMHPD.org). Chart created by Ann Jennings, PhD. www.annafoundation.org

Impact

The extensive literature on the impact of the ACE Study is outlined in the tables below and this literature continues to develop. A recent study found women who were victims of childhood abuse may be at increased risk of developing diabetes in adulthood. While much of this association is explained by weight gain of girls with a history of abuse, there appear to be other mechanisms involved. These theories are intriguing yet further research is needed.

> "One theory is that abused women develop disordered eating habits as a compensatory stress behavior, leading to excess weight gain," Rich-Edwards said. "Another theory suggests that child abuse may increase levels of stress hormones that later cause weight gain and insulin resistance, characteristic of diabetes."
>
> Rich-Edwards, J. Childhood Abuse Linked to Diabetes Risk in Adult Women. *American Journal of Preventive Medicine*. December 2011.

- The greater the ACE score, the greater risk of experiencing domestic violence as an adult[18]:

ACE Score	Risk for D.V. as an adult
0	1.0
1	1.8x
2	2.4x
3	3.3x
4 or more	5.5x

- The greater the ACE score, the greater risk of attempted suicide during childhood or adolescence[19]:

ACE Score	Risk for Suicide Attempt
0	1.0
1	1.4x
2	6.3x
3	8.5x
4	11.9x
5	15.7x
6	28.9x
7 or more	50.7x

- The greater the ACE score, the greater risk of alcohol use before age 14[20]:

ACE Score	Risk of Alcohol use before age 14
0	1.0
1	1.5x
2	2.4x
3	3.9x
4	6.2x.

- The greater the ACE score, the greater risk of illicit drug use21

ACE Score	Risk of illicit drug use
0	1.0
1-2	2.0 x
3	2.5x
4	4.0x
5	6.5x

- The National Co-morbidity Study (2004) resulted in a key finding that a history of childhood neglect more than doubles (2.2x) the risk for adult diabetes.[22]

[18] RF Anda et al. (2006) Eur. Arch Psychiatry Clin Neurosci. v256:174-86
[19] S.H. Dube et al. (2001) JAMA v 286:3089-96

[20] S. R. Dube et al. (2006) J Adolescent Health, v38:444.e1-444.e10
[21] SR Dube et al. (2003) Pediatrics, v111:564-572
[22] RD Goodwin (2004) Psychol. Medicine v34:509-20

- ACE's impact behavioral health: there is a stepwise increased risk for

Clinical depression	Suicide
Domestic violence	Anxiety disorders
Hallucinations	Sleep disturbances
Autobiographical memory disturbances	Poor anger control
Relationship problems	Employment problems

- ACE's impact health risk behaviors: there is a stepwise increased risk for

Smoking	Alcohol abuse
Over eating and obesity	Illicit drug use
Promiscuity	IV drug use

- ACE score of 4 or greater nearly doubles the risk for cancer.[23]

- ACE's plays a role of increased risk for cardiovascular disease[24]:

Risk Factors for Heart Disease	Relative Risk
Domestic violence in home	1.4x
Childhood sexual abuse	1.4x
Childhood neglect	1.4x
Childhood physical abuse	1.5 x
Physical inactivity	1.7x
Hypertension	1.9x
Severe obesity	2.7x
Multiple ACEs	3.6x

- ACE's impact health: there is a stepwise increased risk for common diseases

Heart disease	Cancer
COPD	Skeletal fractures
Sexually transmitted diseases	Liver disease
Autoimmune disorders	

- ACE's impact reproductive health: there is a stepwise increased risk for

Early age at first intercourse	Teen pregnancy
Unintended pregnancy	Teen paternity: Fetal death

- Parental mental illness is an ACE, with measurable effects on lifelong health:

Increases risk for suicide attempts later in life 3.3x	Increases risk for substance use disorder 2x
Increases risk for heart disease 40%	Increases risk for early use of tobacco by 70%
Increases risk of lifetime illicit drug use 1.9x	

[23] VJ Felitti et al. (1998) Am J Prev. Med. v14: 245-58
[24] M Dong et al. (2004) Circulation v110:1761-66

Adverse Experiences and Trauma Informed Care

The role of violence and trauma in the lives of people in the pubic mental health system is increasingly recognized. SAMHSA has a goal to implement trauma-informed approaches in health systems information is available on the website at http://www.samhsa.gov/nctic/.

The core principles underlying a trauma-informed service system are safety, trustworthiness, choice, collaboration, and empowerment.[25]

Safety: Ensuring physical and emotional safety

- To what extent do service delivery practices and settings ensure the physical and emotional safety of consumers? Of staff members?
- How can services and settings be modified to ensure this safety more effectively and consistently?

Trustworthiness: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries

- To what extent do current service delivery practices make the tasks involved in service delivery clear? Ensure consistency in practice? Maintain boundaries, especially interpersonal ones, appropriate for the program?
- How can services be modified to ensure that tasks and boundaries are established and maintained clearly, consistently, and appropriately?

Choice: Prioritizing consumer choice and control

- To what extent do current service delivery practices prioritize consumer experiences of choice and control?
- How can services be modified to ensure that consumer experiences of choice and control are maximized?

Collaboration: Maximizing collaboration and sharing of power with consumers

- To what extent do current service delivery practices maximize collaboration and the sharing of power between providers and consumers?
- How can services be modified to ensure that collaboration and power-sharing are maximized?

Empowerment: Prioritizing consumer empowerment and skill-building

- To what extent do current service delivery practices prioritize consumer empowerment, recognizing strengths and building skills?
- How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximized?

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[25] Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol. Community Connections; Washington, D.C. Fallot and Harris April, 2009

Harm to Self: Fast Facts

Prevalence

- There were 34,598 suicides in 2007 in the U.S.[26]
- The number of emergency department visits for self inflicted injury was 472,000 in 2007. In Alaska there were 1,223 hospitalizations for self inflicted injury during 2001 and 2002.[27]
- The rate of suicide was 10.9 per 100,000 in the U.S. between 2000 and 2006. In Alaska, the suicide rate was 20.9 per 100,000 the highest in the nation.[28]
- Four times more men than women commit suicide; but three times more women than men attempt suicide. It is generally estimated that the ratio of attempted suicides to completed suicides is 25:1.[29]
- The highest risk groups are youth, young adults, and the elderly. Suicide is the third leading cause of death among 15-24 year olds in the U.S. Suicide is the second leading cause of death among 25 to 34 year olds in the U.S.[30] Among the elderly, those aged 80 and older are at particular risk. [31]
- From 1999 to 2004, American Indian/Alaska Native males in the 15 to 24 year old age group had the highest rate of suicide 27.99 per 100,000 compared to white (17.54), black (12.80), and Asian/Pacific Islander (8.96) males of the same age.[32]
  - Suicide is twice as likely among Rural Alaskans as among urban Alaskans.[33]

Causes

- There are many interrelated factors that may cause an individual to commit suicide. These interrelated factors include lifestyle related demographics, psychological, social, family, or health related variables.[34]
- Being unmarried or living alone may increase the risk of suicide. Being unemployed, or employed in certain occupations (i.e. physician or psychiatrist), may also increase risk.
- Poor coping skills (i.e. lack of problem solving skills, or inability to deal with emotional crises) may also increase risk. Personality patterns such as impulsivity or self blaming are also risk factors. In fact, many times when people commit suicide they are in the midst of a crisis and they feel as if their current situation is inescapable and out of their control.[35]

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[26] American Association of Suicidology www.suicidology.org
[27] Perkins, R. (2005). Alaska Suicide Hospitalizations 2001-2002. The Alaska Mental Health Trust Authority. Available at: http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/SuicideHospitalizations.pdf
[28] CDC Injury Prevention and Control: Data and Statistics (WISQARS) http://www.cdc.gov/injury/wisqars/index.html
[29] American Association of Suicidology www.suicidology.org
[30] CDC 10 Leading Causes of Death by Age in the U.S.-2007 http://www.cdc.gov/injury/wisqars/pdf/Death_by_Age_2007-a.pdf
[31] American Association of Suicidology www.suicidology.org
[32] Suicide Prevention Resource Center, Suicide Among AN/AI http://www.sprc.org/library/ai.an.facts.pdf
[33] Brems, C. (1996). "Substance Use, mental health, health in Alaska: Emphasis on Alaska Native peoples. *Arctic Medical Research* 55, 135-147.
[34] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[35] American Association of Suicidology www.suicidology.org

- Individuals who are unable to articulate reasons for living are at particular risk for suicide. This is especially true for male teens in Alaskan Villages.[36]
- Hopelessness is the best predictor of immediate suicide.[37]
- Individuals who lack social support or social acceptance (lesbian/gay groups or individuals with HIV/AIDS) are particularly at risk.[38]
- Individuals who have lost a family member to suicide, or who come from socially isolated families, are at increased risk for suicide.
- People commit suicide using a number of methods. However, firearms are the most commonly utilized method overall for completed suicides. This method accounted for 50.2% of completed suicide in men and women.[39] In Alaska, firearms accounted for over 66% of completed suicides in 2007.[40]
- In Alaska, among those hospitalized for attempted suicides, the most common method used in 2001-2002 was overdosing on medications, accounting for 77% of hospitalizations.[41]

Impact

- The total estimated cost of suicides per year is approximately $111.3 billion ($3.7 billion medical, $27.4 billion work-related, and $80.2 billion quality of life costs).
- The average hospital costs associated with suicide attempts in Alaska was $5,508,363 in 2002. Over 75% of these costs were paid through public funding resources.
- Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk of suicide and emotional problems.[42]

Treatment

- Suicide is preventable. When interacting with a suicidal person it is important to establish rapport, talk directly about suicide or death, listen both verbally and non verbally, know the right questions to ask, weigh protective and risk factors, engage the person in an action plan.[43]
- Discussing suicide does not cause someone to become suicidal. Talking about suicide may actually decrease the person's risk for carrying out the act.
- Immediate suicide predictors include: making suicidal statements or having thoughts about suicide, having a plan to commit suicide (method, time and place, access to means, lethality of means), having prior suicide attempts or ideation, closure behaviors

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[36] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[37] Stelmachers, Z.T. (1995). Assessing Suicidal clients. Clinical Personality Assessment: Practical Approaches. J.N. Butcher. New York, Oxford: 367-379.
[38] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[39] American Association of Suicidology www.suicidology.org
[40] Statewide Suicide Prevention Council. Fiscal Year 2007 Annual report to the Legislature. Available at http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/2007sspcannualreport.pdf
[41] Perkins, R. (2005). Alaska Suicide Hospitalizations 2001-2002. Alaska Injury Prevention Center. Available at: http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/SuicideHospitalizations.pdf
[42] American Association of Suicidology www.suicidology.org
[43] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.

(withdrawing from friends and family, writing a suicide note, giving away possessions), and experiencing a recent trauma or loss.

- Protective factors for suicide include: strong family commitments, social support, ability to articulate reasons for living or identify aspects of their lives that are enjoyable, having coping resources (as evidenced by coping with past difficulties), and no involvement in mental health treatment, having religious or cultural beliefs that discourage self harm.
- Significant protective factors for American Indian/Alaska Native youth are 1) being able to discuss problems with family and friends 2) connectedness to family and 3) emotional health.[44]
- After weighing the risk and the protective factors an action plan to prevent suicide should be developed in collaboration with the individual. Action plans can range from no formal treatment, outpatient treatment interventions, voluntary psychiatric hospitalization, involuntary psychiatric hospitalization, or commitment.[45]

Self Harm and Other Illnesses

- Individuals who have been diagnosed with: depression, schizophrenia, and or chemical dependencies are at particular risk for dying by suicide.[46]
- Major depression is the psychiatric diagnosis most often associated with suicide. The risk of suicide in people with major depression is about 20 times that of the general population. The risk of suicides among persons with substance use disorders is 50 to 70 percent higher than the general population.
- People who have a dependence on alcohol or drugs in addition to being depressed are at particular risk for suicide.
- There is an association between suicide and physical illnesses including: cancer, peptic ulcers, spinal cord injuries, multiple sclerosis, and head injury. This association is stronger among men and depressed individuals.[47]

National Guideline Clearinghouse on Unsafe to Self

Search the National Guideline Clearing House (www.guideline.gov) for this guideline. The Guideline for depression includes this section: *Is Patient Unsafe to Self or Others?* A portion of which is reproduced here.

The estimate of the lifetime prevalence of suicide in those ever hospitalized for suicidality is 8.6%. The lifetime risk is 4% for affective disorder patients hospitalized without specification of suicidality *[M]*.

> Assessing suicidal tendencies is a critical but often difficult process with a depressed patient. Consider asking and documenting the following progression of questions:
>
> 1. Do you feel that life is worth living?
> 2. Do you wish you were dead?
> 3. Have you thought about ending your life?
> 4. If yes, have you gone so far as to think about how you would do so?
> 5. Do you have access to a way to carry out your plan?
> 6. What keeps you from harming yourself?

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[44] Suicide Prevention Resource Center, Suicide Among AN/AI http://www.sprc.org/library/ai.an.facts.pdf
[45] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[46] American Association of Suicidology www.suicidology.org
[47] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.

Harm to Others: Fast Facts

Prevalence

- In 2009 there were approximately 4.3 million nonfatal violent victimizations of persons age 12 or older. Violent crime victimizations were experienced by 17.1 per 1,000 persons age 12 or older. [48]
- Simple assault is the most frequently occurring violent crime. In 2009 about 2.9 million simple assault victimizations affected about 11.3 per 1,000 persons age 12 or older.
- The rate of violent crime declined between 2008 and 2009.
- Nearly half of all nonfatal violent crimes were reported to the police in 2009.
- According to victim reports, between 1/5 and 1/4 of violent crimes were committed by juveniles.
- Literature suggests that there are two different types of aggressive people, those who only exhibit aggressive behaviors during adolescence, and those who develop severe and persistent aggressive and antisocial behaviors. It is estimated that 5% of boys will go on to develop severe and persistent aggressive and antisocial behaviors.[49]

Causes

- There are multiple interacting biological, psychological, and social factors that contribute to the development of serious and persistent aggressive and antisocial behavior.[50]
- Experiences of violence in the family, peer group, school, and in the mass media contribute to the development of perceptions and thinking patterns that are believed to encourage aggressive behavior.
- Child abuse and neglect are particularly strong risk factors for life course persistent aggression.[51] In fact, approximately one-third of children from abusing families develop serious aggression.[52]
- One indicator of risk of harm to others is a history of directly aggressive behaviors such as bullying, hitting, fighting, or cruelty to animals. These behaviors are associated with later assault, rape, or manslaughter. The risk of harm to others increases when there is a history of directly aggressive behaviors paired with a history of shoplifting, frequent lying, vandalism, or fire setting.
- Those with serious and persistent antisocial behavior most likely exhibited frequent aggression, delinquency, and other conduct problems during childhood. In fact,

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[48] Bureau of Justice Statistics http://bjs.ojp.usdoj.gov/index.cfm

[49] Moffitt T.E., & Caspi, A. (2001). Childhood predictors differentiate life-course persistent and adolescent-limited pathways among males and females. *Development and Psychopathology 13*, 355-375. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (2006). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

[50] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

[51] Huesmann, L.R., Dubow, E.F., & Boxer, P. (2009). Continuity of Aggression from Childhood to Early Adulthood as a Predictorof Life Outcomes: Implications for the Adolescent-Limited and Life-Course Persistent Models. Aggressive Behavior 35, 136-149.

[52] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

individuals who exhibit delinquent behaviors during early childhood are more likely to engage in more serious and violent crimes as adults than those who began to exhibit delinquent behavior as adolescents. [53]

- Nearly half of the youngsters who have committed a violent crime are delinquents.[54]
- Males have a higher risk than females for serious aggression.[55]

Impact

- Individuals with serious and persistent aggressive tendencies have higher rates of legal problems and divorce. They are more likely to perpetuate intimate partner violence against a spouse.[56]
- Individuals with antisocial behaviors in adulthood have difficulties with their work and employment. Furthermore, because low motivation and lack of connection with teaches are significant predictors for antisocial behaviors these individuals have poor educational qualifications, making it more difficult to obtain employment.

Treatment

- Theoretically well founded, structured cognitive behavioral, social therapeutic, multimodal and family oriented programs are particularly promising for intervening and preventing serious and persistent antisocial and aggressive behaviors.[57]

Harm to Others and Other Illnesses

- Aggressive behavior is associated with substance abuse which increases an individual's risk for committing serious violent crimes while they are under the influence.[58]
- Aggressive behaviors are also associated with depression and poor health.

National Guideline Clearinghouse on Harm to Others

Search the National Guideline Clearing House (www.guideline.gov) for this guideline. The Guideline for "*Antisocial personality disorder. Treatment, management and prevention"* include sections on risk assessment, treatment, and outcomes. A portion of the risk assessment outline is reproduced here.

1. Identifying children at risk of developing conduct problems

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[53] Farrington, D.P., & Loeber, R. (2001). *Child Delinquents.* Thousand Oaks, CA: Sage.
[54] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.
[55] Moffitt, T.E., Caspi, A., Rutter, M., & Silva, P.A. (2001). *Sex Differences in Antisocial Behavior: Conduct Disorder, Delinquency, and Violence.* Cambridge: Cambridge University Press.
[56] Huesmann, L.R., Dubow, E.F., & Boxer, P. (2009). Continuity of Aggression from Childhood to Early Adulthood as a Predictor of Life Outcomes: Implications for the Adolescent-Limited and Life-Course Persistent Models. Aggressive Behavior 35, 136-149.
[57] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.
[58] Huesmann, L.R., Dubow, E.F., & Boxer, P. (2009). Continuity of Aggression from Childhood to Early Adulthood as a Predictor of Life Outcomes: Implications for the Adolescent-Limited and Life-Course Persistent Models. Aggressive Behavior 35, 136-149.

2. Assessment and management of risk of violence including:
   - History of current and previous violence and current life stressors
   - Contact with the criminal justice system
   - Presence of comorbid mental disorders and substance misuse
   - Using standardized risk assessment tools (e.g., Psychopathy Checklist–Revised [PCL-R] or Psychopathy Checklist-Screening Version [PCL-SV], Historical, Clinical, Risk Management-20 [HCR-20])
   - Developing a comprehensive risk management plan

Domestic Violence and Child Maltreatment: Fast Facts

Prevalence

- During 2008, in the U.S., approximately 3% of the violence against males, and 23% of the violence against females, was committed by an intimate partner. The number of males assaulted by an intimate partner was 88,120. The number of females assaulted by an intimate partner was 504, 980.[59]
- In 2007 intimate partners committed 14% of all homicides in the U.S. The total estimated number of intimate partner homicide victims in 2007 was 2,340, including 1,640 females and 700 males.[60]
- Women of all ages are at risk for domestic violence and sexual violence, and those aged 20 to 24 are at the greatest risk of being assaulted by an intimate partner.[61]
- On average, about 23% of women in the U.S. who are assaulted by an intimate partner will contact an outside agency for assistance. Approximately 9% of male victims will seek assistance from an outside agency.
- Nearly 75% of Alaskans have reported experiencing or knowing someone who has experienced Domestic Violence or Sexual Assault.[62]
- In Alaska, it is estimated that 31% of adult women have experienced threats of physical violence in their lifetime; and 44.8% have been physically assaulted. Overall, it is estimated that 47.6% of adult women in Alaska have either been threatened with physical violence or been physically assaulted sometime in their life.[63]
- In 2011, it was reported that during the last year, 9.4% of adult women in Alaska experienced threats of physical violence or were physically assaulted.

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[59] Bureau of Justice Statistics. National Crime Victimization Survey: Criminal Victimization 2008. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/cv08.pdf
[60] Bureau of Justice Statistics. Intimate Partner Violence http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=971
[61] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf
[62] Alaska Network on Domestic Violence and Sexual Assault, *2006 Annual Report: Working in Alaska Communities For: Safety, Justice, Advocacy and Education, Violence Prevention.* In Domestic Violence Facts: Alaska, National Coalition Against Domestic Violence [electronic resource] available at: http://www.ncadv.org/files/Alaska.pdf
[63] University of Alaska Anchorage Justice Center. 2011 Alaska Victimization Survey. http://justice.uaa.alaska.edu/research/2011/1004.victimization/1004.01.avs.html

- Native American women are more likely than any other ethnic group to be assaulted by an intimate partner.[64]
- In 2008, there were approximately 2 million reports (involving 3.7 million children) of child maltreatment investigated in the U.S. Out of these investigations approximately 24% of these reports were substantiated.[65]
- In 2009, there were 3,388 substantiated cases of child maltreatment in Alaska.[66]
- In 2006, approximately 80% of perpetrators of child maltreatment were parents.[67]

Causes

- There are a number of individual, relational, and community factors that may increase the risk of being assaulted by an intimate partner.[68]
- Some individual victim factors include: low self-esteem, low academic achievement, low socioeconomic status, young age, having few friends and being isolated from other people, and belief in strict gender roles.
- Between 2001 and 2005, women living in households with lower annual incomes experienced higher rates of interpersonal violence.[69]
- Some relational factors might include: marital conflict-fights, tension, and other struggles; dominance and control of the relationship by one partner over the other; economic stress; unhealthy family relationships and interactions.[70]
- On average, between 2001 and 2005 both males and females who were married or widowed reported lower rates of intimate partner assault than those who were separated or divorced.[71]
- One community factor is the extent to which the community sanctions violence against intimate partners (e.g., unwillingness of neighbors to intervene in situations where they witness violence). This may be particularly true in Native American and rural communities.[72]
- Child abuse and neglect can occur in families where there is a great deal of stress. Stress can result from a number of factors including having a family history of violence;

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[64] The National Women's Health Center. Minority Women's Health: Violence. http://www.womenshealth.gov/minority/americanindian/violence.cfm
[65] Administration for Children and Families. Child Maltreatment Report 2008. [electronic resource] Available at: http://www.acf.hhs.gov/programs/cb/pubs/cm08/index.htm
[66] State of Alaska, Office of Children's Services. 2009 Allegation and Victim Data. http://hss.state.ak.us/ocs/Statistics/pdf/Annual_Allgs_09.pdf
[67] Child Welfare Information Gateway. Child Abuse and Neglect (2008). http://www.childwelfare.gov/pubs/can_info_packet.pdf
[68] Center for Disease Control. *Understanding Intimate Partner Violence Fact Sheet 2009.* [electronic resource] available at: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/consequences.html#
[69] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf
[70] Center for Disease Control. *Understanding Intimate Partner Violence Fact Sheet 2009*. [electronic resource] available at: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/consequences.html#
[71] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf
[72] Jones, L. (2008). The Distinct Characteristics and Needs of Domestic Violence Victims in a Native American Community. *Journal of Family Violence* 23, 113-118.

substance abuse; poverty; or chronic health problems. Families that lack social support are also at risk.[73]

- Protective factors for preventing child maltreatment include: a strong parental-child attachment; knowledge of parenting and child development; parental resilience (such as a positive attitude or problem solving skills); social support; and having basic needs met.[74]

Impact

- The cost of violence against women committed by an intimate partner exceeds $5.8 billion each year. $4.1 billion for direct medical and mental health care services, $0.9 billion in lost productivity from paid work and household chores, and $0.9 billion in lifetime earnings lost as a result of fatal violence.[75]
- In Alaska, the Council on Domestic Violence and Sexual Assault spent $11,453,200 in federal funds for victim services, batterer intervention programs, administration, and training/legal advocacy.[76]
- 43% of the Domestic Violence cases handled by the Alaska State Troopers in 2004 were in the presence of children.[77]
- The direct cost of child maltreatment in the United States totals more than $33 billion annually. (This figure includes law enforcement, judicial system, child welfare, and health care costs.) When factoring in indirect costs (special education, mental health care, juvenile delinquency, lost productivity, and adult criminality), the figure rises to more than $103 billion annually.[78][79]

Treatment

- In Alaska, the Council on Domestic Violence and Sexual Assault provides funding to programs that offer services such as: shelter, crisis intervention, personal advocacy, legal advocacy, children's services, case management, education, information and referral, counseling, and support groups.[80]

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[73] Center for Disease Control and Prevention. Understanding Child Maltreatment: Fact Sheet 2011. http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf

[74] Administration for Children and Families, Child Welfare Information Gateway. http://www.childwelfare.gov/pubs/factsheets/preventingcan.cfm#protective

[75] National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States.* Atlanta (GA): Centers for Disease Control and Prevention; 2003. [electronic resource] available at: http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipvbook-final-feb18.pdf

[76] Council on Domestic Violence and Sexual Assault, *Annual Report 2009*. [electronic resource] available at: http://www.dps.state.ak.us/cdvsa/docs/CDVSAAnnualReport2009.pdf

[77] Rivera, M., Rosay, A.B., Wood, D.S., Postle,G., & Tepas, K. (2008). Assaults in Domestic Violence Incidents Reported to Alaska State Troopers. *Alaska Justice Forum* 25(3): 1, 7–12.

[78] The National Center for Victims of Crime. Child Maltreatment. http://www.ncvc.org/ncvc/main.aspx?dbName=DocumentViewer&DocumentID=38709

[79] Prevent Child Abuse America. *Total Estimated Cost of Child Abuse and Neglect in the United States*. [electronic resource] Available at: http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf

[80] Council on Domestic Violence and Sexual Assault, *Annual Report 2009*. [electronic resource] available at: http://www.dps.state.ak.us/cdvsa/docs/CDVSAAnnualReport2009.pdf

- In 2009, there were 15 batterer intervention programs in Alaska; 13 were community based and 3 were prison based.
- For women who have been assaulted by an intimate partner specific treatment elements might include: boundary management; relationship skills; attending to negative feelings and depression; building a strong sense of identity; and identifying meaningful activities to participate in.[81]
- Child maltreatment is preventable. Providing parents with parenting skills including: communication skills; appropriate and consistent discipline; and being able to identify and appropriately respond to children's physical and emotional needs may be particularly helpful.[82]

Domestic Violence, Child Maltreatment, and Other Illnesses

- Individuals who have been assaulted by an intimate partner may also experience depression, eating disorders, and substance use disorders.[83]
- Between 2001 and 2005, alcohol and drugs were reported to be present in 42% of violent assault cases committed by an intimate partner.[84]
- Individuals who have been assaulted by an intimate partner are more likely to engage in risky sexual behavior and experience a wide range of reproductive health issues including miscarriages and sexually transmitted disease/HIV transmission.[85]

National Guideline Clearinghouse on Domestic Violence

The vast majority of intimate partner violence is against women. The Guideline for *Women abuse: screening, identification & initial response* may be found by searching www.guideline.gov. Excerpts are reproduced here.

Guideline Objective(s)

- To facilitate routine universal screening for woman abuse by nurses in all practice settings
- To increase opportunity for disclosure, which will promote health, well-being, and safety in women
- To offer nurses a repertoire of strategies that can be adapted to various practice environments

Target Population

Women aged 12 and older

Interventions and Practices Considered

Screening

1. Implement routine universal screening of women 12 years of age and older
2. Foster environments that facilitate disclosure
3. Use screening strategies that respond to the needs of all women taking into account differences

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[81] Saylors, K., & Daliparthy, N., (2006). Violence Against Native Women in Substance Abuse Treatment. *American Indian and Alaska Native Mental Health Research*, 13 (1), 32-51.
[82] Center for Disease Control and Prevention. *Understanding Child Maltreatment: Fact Sheet 2011.* [electronic resource] available at: http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf
[83] Center for Disease Control and Prevention. *Understanding Intimate Partner Violence Fact Sheet 2009*. [electronic resource] available at: http://www.cdc.gov/violenceprevention/pdf/IPV_factsheet-a.pdf
[84] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf
[85] Path. *Violence Against Women: Effects on Reproductive Health*. (2002) Outlook 20(1). [electronic resource] available at http://www.path.org/files/EOL20_1.pdf.

4. Use reflective practice
5. Document screening practice

Initial Management

1. Acknowledge the abuse
2. Validate the woman's experience
3. Assess immediate safety
4. Explore options
5. Refer to violence against women services at the woman's request
6. Document response to interaction
7. Understand legal obligations

Alcohol and Illicit Drug Use: Fast Facts

Prevalence

- According to the 2009 National Survey on Drug Use and Health, 51.9% of Americans, roughly 130.6 million people ages 12 and older report that they are current drinkers of alcohol. [86]
- Approximately one fourth, 23.7% or 59.6 million people 12 and older reported participating in binge drinking.
- In the 2009 survey, demographic information for past month alcohol use in persons aged 12 to 20, was listed as 16 % among Asians, 20% among blacks, 22% among American Indians or Alaska Natives, 25% among Hispanics, and 30% among whites.
- Among pregnant women aged 15 to 44, an estimated 10% percent reported current alcohol use, 4.4% reported binge drinking, and 0.8% reported heavy drinking.
- In 2009, an estimated 22.5 million persons aged 12 or older were classified with substance dependence or abuse. Of these, 3.2 million were classified with dependence on or abuse of both alcohol and illicit drugs, 4 million were dependent on or abused illicit drugs but not alcohol, and 15.4 million were dependent on or abused alcohol but not illicit drugs. Men were two times more likely to report substance abuse than women.[87]
- Lifetime substance abuse is significantly associated with age of onset. The three most commonly used substances among teens from 8th to 12th grade are Alcohol (36-73% of teens), Tobacco (20-44% of teens), and Marijuana (15-42% of teens).
- For youth between grades 8 and 12, 10-24% reported using illicit drugs other than marijuana and around 2% reported using methamphetamines and 9% reported engaging in binge drinking.

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[86] 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm
[87] National Institute on Drug Abuse InfoFacts: Nationwide Trends available at http://drugabuse.gov/infofacts/nationtrends.html

- Age is a significant factor in substance dependence and abuse. Among substance users, 61% of youth, 38% of adults ages 18-25, and 25% of adults ages 26 or older were dependent on illicit drugs. [88]

Risk Factors

- Early age of drug and alcohol use is one of the strongest risk factors for adult drug and alcohol dependence and abuse. Individuals who experience their first substance use before the age of 14 are at a higher risk of developing lifetime drug and alcohol use problems. [89]
- Children and adults coming from low socioeconomic status are at increased risk for drug and alcohol abuse. [90]
- For adults ages 18 and older, a lower level of education, unemployment and being on parole were all associated with illicit drug and alcohol dependence. [91]
- Research has shown that for children and teens, disrupted family structure, and being raised out of the home are significant predictors of substance abuse.[92] In addition, maternal marital status, having a teen mother, inadequate parental monitoring, and family modeling of drug use behaviors are also significant predictors of substance abuse.
- Children with low birth weight (<2500g) have been found to be more likely to report symptoms of a variety of mental health problems including substance abuse. [93]
- Individuals who experienced 2 or more adverse childhood experiences such as domestic violence, or death of a parent, were at increased risk for substance dependence. [94] For more information please see the Adverse Experiences Fast Facts section of this document (pg 14).
- For immigrant youth being bilingual with parents who do not speak English, was a risk factor for drug use because parents were not able to monitor their child's interaction with peers. [95]
- For women, experiencing intimate partner violence was also a risk factor for substance abuse.
- Genetics may also play an important role in substance abuse, as recent research indicates that there are several genes linked to alcohol dependence. [96]

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[88] National Institute on Drug Abuse InfoFacts: Nationwide Trends available at http://drugabuse.gov/infofacts/nationtrends.html
[89] 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm
[90] Hayatbakhsh, M.R. et al (2008). Early Childhood predictors of early substance use and substance use disorders: prospective study. *Journal of Psychiatry* 42, pg 720-731.
[91] 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm
[92] Dishion, T.J. & McMahon, R.J. (1998). Parental Monitoring on initiation of drug use through late childhood. *Journal of American Child and Adolescent Psychiatry*. 35, 91-100.
[93] Alati, R. et al (2007). Is there a fetal origin of depression? Evidence from the mater university study. *American Journal of Epidemiology*. Vol 165, pg 575-582.
[94] Pilowsky, D. et al (2009). Adverse Childhood Events and Lifetime Alcohol Dependence. *American Journal of Public Health*. Vol 99 (2), pg 258-263.
[95] Marsiglia, F. et al (2004) Ethnicity and Ethnic Identity as Predictors of drug norms and drug use among preadolescents in the US southwest. *Substance Use and Misuse* vol 39(7), pg 1061-1094.

- Though studies show that ethnic minorities may be at an increased risk for substance abuse, it is likely that this is a result of being the victim or discrimination, and experiencing economic and neighborhood disadvantages. [97]
- Additional risk factors for substance abuse included being male, having no children, having less than an 11th grade educational level, living in an urban area, and using other substances such as tobacco. [98]

Protective Factors

- Protective factors for teens including having non-substance using peer supports, and having a positive influence from family members. In particular more time spent with their mother appeared to be associated with decreased use rates. [99]
- For Native American teens, bilingualism was associated with drug abstinence as it was typically an indicator of ethnic pride.[100] Overall, ethnic pride and high self esteem are considered protective factors for drug use.
- For individuals experiencing adversity the ability to internalize feelings (often resulting in depression and anxiety) was a protective factor for substance use when compared with externalization such as aggression and risk taking. Though internalized feelings may be protective factors for drug use, they may be risk factors for other mental health issues.[101]
- Research has indicated that overall; insight, independence, supportive relationships, personal initiative, humor, and creativity are considered protective factors for substance use.[102] Though these factors may not apply to all cultures and populations.
- Some studies indicate that religious involvement, particularly of the family unit, may be a protective factor for drug and alcohol use. [103]
- For the Alaska Native community, participation in traditional subsistence activities, as well as being a parent were considered protective factors against substance use. [104]
- Other protective factors may include, having a high educational attainment and being employed as well as being married. [105]

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[96] Foroud, T. et al. (2011). Genetic Research, Who is at risk for alcoholism? Alcohol Research and Health vol 33 (1), pg 64-75.
[97] Chartier, K. & Caetano, R. (2011). Ethnicity and Health Disparities in Alcohol Research. *Alcohol Research and Health* Vol 33 (1), pg 152-162.
[98] Swendsen, J. et al (2009). Socio-demographic risk factors for alcohol and drug dependence: the 10-year follow-up of the national comorbidity survey. *Addiction* vol 104(8) 1346-1355
[99] Best, D. et al (2005). Cannabis use in adolescents: the impact of risk and protective factors and social functioning. *Drug and Alcohol Review*. Vol 24, pg 483-488.
[100] Marsiglia, F. et al (2004) Ethnicity and Ethnic Identity as Predictors of drug norms and drug use among preadolescents in the US southwest. *Substance Use and Misuse* vol 39(7), pg 1061-1094.
[101] Gibbons, F. et al (2011). Exploring the link between racial discrimination and substance use: what mediates? What buffers? Journal of Personality and Social Psychology. Vol 99(5), pg 785-801.
[102] Wolin, S. J., & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity.* Villard Books
[103] Sanchez, Z. et al (2008) Religiosity as a protective factor against the use of drugs. *Substance use and misuse*. Vol 43, pg 1476-1486.
[104] Lyness, K. (2002) Alcohol Problems in Alaska Natives. *Journal of Ethnicity in Substance Abuse*. Vol 1(3), pg 39-55.

Impact

- In 2006, there were 1,742,887 drug-related emergency room visits nationwide[106]
- In 2007, there were 23,199 national deaths due to alcohol, this number does not include car accidents, unintentional injuries or homicides related to alcohol use. In addition, in 2007 approximately 14,400 people died from alcohol related liver disease.[107]
- In 2007, 38,371 people died of drug induced causes nationally.
- For the state of Alaska, the total cost of drug and alcohol dependence during 2003 was estimated to be $738 million.[108]
- In 2007, an estimated 12,998 people were killed in alcohol-impaired driving crashes. Alaska ranked among the top 15 states for the highest rate of Alcohol related car accidents. [109]
- In 2003 nearly 16,000 Alaska residents were victims of alcohol and other drug abuse related crimes. During this period state costs attributed to alcohol and other drug abuse related crimes were nearly $154 million.
- Alcohol and other drug abuse cost Alaska an estimated $367 million in lost productivity during 2003. Lost productivity occurs when alcohol and other drug abuse results in premature death, reduced efficiency of workers through physical or mental impairment, incarceration for criminal offense, and residents requiring inpatient treatment or hospitalization.
- In 2003 alcohol and drug use was related to 30% of all assaults, 22% of all sexual assaults, and 30% of all murders within the state of Alaska.[110]

Treatment

- Appropriate diagnosis and referral are critical for helping patients with substance use disorders.
- Various types of programs offer help in drug rehabilitation, including: residential treatment (in-patient), out-patient, support groups, extended care centers, and recovery or sober houses.
- According to the National Institute on Drug Abuse (NIDA) it is recommend that medication and behavioral therapy combined are important elements of detoxification. Following detoxification individuals may need recovery treatment that includes relapse

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[105] Parks, C. et al (2003) Factors affecting entry into substance abuse treatment : Gender differences among alcohol-dependent Alaska Natives. *Social Work Research,* Vol 27(3), pp. 151-161. As well as 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm
[106] National Survey on Drug Use & Health NIDA InfoFacts: Drug-Related Hospital Emergency Room Visits available at http://drugabuse.gov/infofacts/HospitalVisits.html
[107] National Vital Statistics Reports from the Center for Disease Control and Prevention. Available at http://www.cdc.gov/nchs/fastats/alcohol.htm
[108] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf
[109] Traffic Safety Facts from the National Center for Statistics and Analysis available at www.nhtsa.gov
[110] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf

prevention. It is also essential for treatments to address needs at multiple levels of the patient's life including medical, mental health, community and family.[111]

- Relapse is likely to occur within the first 26 to 90 days of treatment. Some significant factors contributing to relapse are withdrawal related anxiety and life stress. [112]
- Individuals with substance abuse issues are more likely to view themselves in a negative way than individuals without these issues. Studies indicate that it takes substance abusers longer to identify personal traits that are positive than it does non-abusers.[113] This may have implications for self esteem and motivations for change.
- Research has shown that there are at least 2 major factors that influence the outcomes of treatment for individuals with substance abuse and dependency. 1) Individual client issues such as denial and lack of motivation. 2) Access to treatment and availability of treatment.
- Recent research generated by faculty at the University of Alaska Fairbanks found that for Alaska Native Individuals there were 5 stages of alcohol recovery including (1) the person entered into a reflective process of continually thinking over the consequences of his/her alcohol abuse; (2) that led to periods of experimenting with sobriety, (3) a turning point, marked by the final decision to become sober. (4) active coping with craving and urges to drink and (5) moving beyond coping or 'living life as it was meant to be lived' in which alcohol was no longer a problem.[114]

Alcohol and Drug Use & Other Illnesses

- Between 25-50% of alcohol and drug users have a comorbid diagnosis of depression or anxiety. This same research also showed that integrated psychosocial treatment for depression and substance use disorders was a promising approach for patients with this comorbidity.[115]
- Alcohol and other drug use have been found to be co-occurring with virtually every other psychological disorder from ADHD, to schizophrenia. However, substance use disorders have the strongest and most frequent relationships with mood disorders such as depression and anxiety and adversity experienced during childhood.
- The current psychological research in the field of addictions recognizes that heavy alcohol consumption dramatically alters brain functioning and mood/emotional regulation which could be responsible for psychiatric disturbances that are present in heavy drinkers. [116]

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[111] NIDA InfoFacts: Treatment Approaches for Drug Addiction available at http://www.nida.nih.gov/Infofacts/TreatMeth.html/
[112] Howard, B. (2008) Alcohol Dependence, Withdrawal, and Relapse. *Alcohol Research and Health* 31(4), 348-361.
[113] Tarquinio, C. et al (2001). The self-schema and addictive behaviors: Studies of Alcoholic Patients. *Swiss Journal of Psychology*. 60(2), 73-81.
[114] Mohatt, G. et al (2008) Risk, resilience and natural recovery: a model of recovery from alcohol abuse for Alaska Natives. *Addiction* 103, 205-215.
[115] Hesse, M. (2009) Integrated psychological treatment for substance use and co-morbid anxiety or depression vs treatment for substance use alone. A systematic review of the published literature. *Psychiatry*, 9(6).
[116] Anthenelli, R. (2011) Focus on comorbid mental health disorders. *Alcohol research and Health* 33(1), 109-117.

- Substance use is highly related to all anxiety disorders including PTSD. However, the majority of comorbid individuals with anxiety disorder had a diagnosis of anxiety that predated the onset of alcohol dependence suggesting that an anxiety diagnosis increased vulnerability for misusing alcohol.
- Research suggests that comorbid anxiety and depression along with substance use is most common in individuals aged 20 to 49 regardless of sex. In addition, the presence of alcohol dependence significantly reduces the amount of insight and ability to change for individuals receiving treatment for depression and/or bipolar disorder. [117]
- There is a plethora of research evidence that supports the self medication hypothesis of drug use. Studies have found that a desire to repress negative emotions and hostility, as well as a denial of depressive symptoms was positively associated with alcohol use. Excessive goal orientation and the propensity to engage in obsessive behaviors were positively associated with cocaine use. Finally, the desire to sooth anger and trauma as well as negative feelings towards others was positively associated with heroin use. [118]
- Further studies have found that the majority of alcohol-dependent individuals had one or more comorbid axis II disorders.[119]
- Alcohol abuse has also been linked to suicide. It is unclear which comes first the suicidal ideation or drinking behavior as drinking can induce depressive symptoms but also may be used as a coping mechanism for suicidal thoughts. [120]
- Cannabis use or a cannabis use disorder at a younger age is related to onset of high-risk symptoms for psychosis and has been linked to the occurrence of psychosis at a younger age.[121]
- 20% of individuals with schizophrenia were also diagnosed with a substance use disorder. [122]
- Current ADHD symptoms, including inattentive and hyperactive symptoms, were significantly associated with the frequency of tobacco and marijuana use in the past month and past year, as well as to the frequency of alcohol use in the past month indicating that both youth and adults with ADHD symptoms were at increased risk for substance use. [123]
- Studies have shown that substance use disorder is co-occurring with all axis 2 disorders but it appears that individuals with borderline personality disorder are especially vulnerable. Borderline Personality Disorder patients have a high vulnerability for new

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[117] Bukner, J., et al (2008) Implications of comorbid alcohol dependence among individuals with social anxiety disorder. *Depression and Anxiety* 25, 1028-1037.
[118] Suh, J. et al (2008) Self-Medication Hypothesis connecting affective experience and drug choice. *Psychoanalytic Psychology*. 25(3), 518-532.
[119] Preuss, U.W., et al (2009) Personality Disorders in Alcohol Dependent Individuals: Relationship with alcohol dependence severity. *EUR Addictions Research* 15, 188-195.
[120] Gonzalez, V. (2009) Drinking to cope as a statistical mediator in the relationship between suicidal ideation and alcohol outcomes among underage college drinkers*. Psychology of Addictive Behavior*. 23(3), 443-451.
[121] Dragt, S. (2011) Age of onset of cannabis use is associated with the age of onset of high-risk symptoms of psychosis. *The Canadian Journal of Psychiatry* 55(3), 165-171.
[122] Lai, H. et al (2009) Comorbidity of mental disorders and alcohol-and-drug-use disorders. *Drug and Alcohol Review.* 28, 235-242.
[123] Upadhyaya, H. et al (2008) Is attention deficit hyperactivity disorder symptom severity associated with tobacco use? *The American Journal of Addictions* 17, 195-198.

onsets of Substance Use Disorders even when their psychopathology improves. These findings indicate some shared etiological factors between Axis 2 and substance use. [124]

- One of the strongest correlates to lifetime substance use is experiencing adverse or traumatic events during childhood. Studies indicated that individuals who experienced 2 or more traumatic events during childhood were at an increased risk for lifetime substance use and dependence. [125]

National Guideline Clearinghouse on Drug and Alcohol Use

Search the National Guideline Clearing House (www.guideline.gov) for this guideline (as well as others on treatment): *Substance abuse treatment for persons with co-occurring disorders.* For Substance Abuse and Criminal Justice: *Substance abuse treatment for adults in the criminal justice system.* For Working with Active Users: *Working with the active user.*

Fetal Alcohol Spectrum Disorder (FASD): Fast Facts

Prevalence

- Each year in the U.S., as many as 40,000 babies are born with an FASD.[126]
- There are an estimated 1.5 cases of FASD per 1,000 live births in certain areas of the United States[127]
- Estimates for Low Income and poverty stricken populations within the U.S. reach as high as 7 cases of FASD per 1,000 live births. [128]
- Alaska data showed an estimated FAS prevalence rate of 4.8 per 1,000 live births among Alaska Natives.[129]
- Alaska has the highest rate of FASD in the nation. As many as 180 children are reported to the Alaska Birth Defects Registry each year with a suspected FASD. [130]

Causes

- FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy.
- FASD is one of the most common causes of developmental disability and the *only* cause that is entirely preventable.
- FASD can be caused by drinking alcohol during pregnancy. During this process, alcohol reaches the embryo and fetus by passing through the mother's blood. Alcohol crosses the placenta and enters the fetal bloodstream. It can then pass into all developing tissues. There is no known "safe" amount of alcohol that can be used during pregnancy.

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[124] Walter, M. et al (2009)New onset of substance use disorder in borderline personality disorder. *Addiction* 104, 97-103.
[125] Pilowsky, D. et al (2009). Adverse Childhood Events and Lifetime Alcohol Dependence. *American Journal of Public Health*. 99(2), 258-263.
[126] Fetal Alcohol Spectrum Disorders Center for Excellence http://www.fasdcenter.samhsa.gov
[127] Fetal Alcohol Spectrum Disorder Home Page from the Center for Disease Control http://www.cdc.gov/ncbddd/fasd/research-tracking.html
[128] May, P. et al (2009). Characteristics of FASD from various research methods with an emphasis on recent in-school studies. *Developmental Disabilities Research Review* 15, 176-192.
[129] CDC, Tracking Fetal Alcohol Syndrome, www.cdc.gov/ncbddd/fas/fassurv.htm
[130] Hogan, B. (2011) FASD Fact Sheet. State of Alaska Department of Health and Social Services http://www.hss.state.ak.us/fas

- Alcohol may also be transmitted to a baby during breastfeeding. This can cause central nervous system and brain damage, because the brain continues to develop after birth.

Impact

- The cost to the nation for Fetal Alcohol Syndrome (FAS) alone is about $6 billion a year.[131]
- An FAS birth carries lifetime health costs of approximately $860,000 and is likely to result in lost wages or low lifetime productivity for the child diagnosed with FAS.
- Total economic costs resulting from services to all individuals with FAS in Alaska totaled approximately $47.0 million in 2003.[132]
- For Alaska estimated lifetime costs in 2003 for providing services to an individual with FAS was $3.1 million dollars.[133]

Treatment

- FASDs cannot be cured, but with proper diagnosis, treatment, and a support network of family and friends, many people with an FASD can learn coping skills and lead happy lives.
- FASD cannot be outgrown, but early identification and intervention are key factors in helping individuals to develop coping and life skills.
- The most successful interventions for individuals with FASD are those that maximize predictability and structure in their daily lives. [134]
- Individuals with FASD may have poor communication skills poor impulse control and an inability to predict the consequences of their behavior. For this reason behavior management and modification techniques may be effective, and most importantly consistency is key for success.
- The Role of the Family is very important for individuals with FASD and studies show that the quality of care-giving and the family function are associated with long term behavioral and health outcomes for individuals with FASD. Birth parents may indicate feelings of guilt and shame, financial strain, and frustration. Regardless of family type the research has identified two primary needs: respite care and greater understanding of FASD.[135]
- Education for families should include the nature of their child's disability, including the ways in which their deficits will manifest in their daily lives, appropriate goals for intervention, and how to effectively advocate for services.

FASD and Other Illnesses

- Because FASD is associated with social isolation it may cause anxiety and depression, particularly among teens. Studies suggest that alcohol-exposed adolescents have substantial impairments in their abilities to solve problems in their everyday life, even in the absence of mental retardation. Such impairments are likely to have a significant impact on social and academic functioning. [136]

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[131] Harwood, H. The Lewin Group, Economic Costs of FAS available through SAMHSA at http://www.fasdcenter.samhsa.gov/publications/cost.cfm
[132] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf
[133] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf
[134] The Family Empowerment Network http://www.fammed.wisc.edu/fen/strat.html
[135] Olson, H. et al (2009). Family Matters: FASD and the Family. *Developmental Disabilities Research* 15, 235-249.
[136] McGee, C. et al (2008). Deficits in Social Problem Solving in Adolescents with Prenatal Exposure to Alcohol. *The American Journal of Drug and Alcohol Abuse* 34, 423-431.

- FASD is not ADHD and should not be treated as such. FASD is distinct from other learning disorders and should be treated distinctly. Research advocates for consistency and routine, providing numerous opportunities for behavioral rehearsal, making contingencies (if you do X, then Y will happen), breaking activities down into small steps, and using visual cues in addition to verbal instruction. [137]
- Individuals with FASD are likely to experience poorer physical health and lower levels of quality of life than their peers. [138]

National Guideline Clearinghouse on FASD

Search the National Guideline Clearing House (www.guideline.gov) for this guideline (as well as others on treatment): *Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening*.

Traumatic Brain Injury (TBI): Fast Facts

Prevalence

- Each year, approximately 1.7 million people in the U.S. sustain a traumatic brain injury.[139]
- In the state of Alaska approximately 800 people are hospitalized or die from traumatic brain injury each year, and approximately 3,000 individuals state wide visit the emergency room.[140]
- The highest risk groups are youth and elders. Nationwide, approximately 18% of all TBI-related emergency department visits involved children aged 0 to 4 years and 22% of all TBI-related hospitalizations involved adults aged 75 years and older. Males are more often diagnosed with a TBI (59%) than females (41%).
- The highest rates of TBI in Alaska are seen among Alaska Natives and/or residents of rural Alaska, youth ages 15-19 involved in motor vehicle or ATV accidents and elders who fall.
- Of the 1.7 million people nationwide who sustain a traumatic brain injury, 52, 000 die, and 275,000 are hospitalized. TBI is a contributing factor to a third (30.5%) of all injury related deaths in the U.S.
- Alaska has one of the highest rates of TBI in the nation with more than 10,000 Alaskans currently living with TBI.

Causes

- A TBI is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI.[141]

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[137] Paley, B. & O'Connor, M. (2009) Intervention for Individuals with FASD: Treatment Approaches and Case Management. *Developmental Disabilities Research Reviews* 15, 258-267.
[138] Stade, B. et al (2006). Health-related quality of life of children and youth prenatally exposed to alcohol. *Health and Quality of Life Outcomes.* 4, 81.
[139] The Center for Disease Control and Prevention http://www.cdc.gov/traumaticbraininjury/
[140] The Alaska Brain Injury Network www.alaskabraininjury.net
[141] The Center for Disease Control and Prevention http://www.cdc.gov/traumaticbraininjury/

- In the state of Alaska the four most common causes of TBI are: (1) Motor Vehicle Accidents, (2) ATV and Snow Machine Accidents, (3) Falls, and (4) Assault.
- Shaken Baby Syndrome is a form of TBI and can be caused by shaking a baby for 5-20 seconds. This most often occurs because the caregiver becomes frustrated and reacts to inconsolable crying by shaking the baby. An estimated 50,000 cases of shaken baby syndrome occur each year in the U.S. [142]

Impact

- Direct medical costs and indirect costs such as lost productivity of TBI totaled an estimated $60 billion in the United States in 2000.143
- Less than 50% of individuals with TBI are able to return to work post-injury.
- Approximately one third of all Alaskans who apply for behavioral health services have a history of TBI.
- 72% of Alaskan's hospitalized for TBI are sent home with no assistance, and only 1% of Alaskans will receive rehabilitation after discharge from the hospital.[144]

Treatment

- Appropriate diagnosis, referral, and patient and family/caregiver education are critical for helping patients with TBI achieve optimal recovery and to reduce or avoid significant adverse health outcomes.
- A person who has sustained a TBI may experience headaches, sleep changes, neck/shoulder pain, sensory changes such as blurred vision or ringing in the ears, mood changes such as increased irritability, trouble communicating, or thinking difficulties such as memory loss. If these symptoms are present they should be address by a doctor or a board-certified neuropsychologist.
- TBI rehabilitation includes a multidisciplinary array of services such as occupational therapy, physical therapy, medication management, speech therapy, counseling, and/or educational or vocational support services.[145]
- When working with individuals who have sustained a serous TBI it is important to speak clearly and use brief to the point instructions. Explain your intentions or what will happen next so that the person knows what to expect. Avoid sudden touching or grabbing. Formally end conversations or interactions so that the person is clear that you will be leaving or that the conversation is over. [146]

TBI and Other Illnesses

- Nearly 20% of U.S. military veterans returning from combat have experienced or sustained a TBI. One third of all vets who experiences a TBI also had co-occurring depression.[147]

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[142] http://www.kidshealth.org/parent/medical/brain/shaken_p3.html
[143] Finkelstein E, Corso P, Miller T and associates. The Incidence and Economic Burden of Injuries in the United States. New York (NY): Oxford University Press; 2006.
[144] The Alaska Brain Injury Network and the Alaska TBI Coalition www.alaskabraininjury.net
[145] The Alaska Brain Injury Network www.alaskabraininjury.net
[146] The University of Alabama, Traumatic Brain Injury Model System http://main.uab.edu/tbi/show.asp?durki=50770
[147] Tanielian, T., & Jaycox, L. H. (Eds.). (2008). Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery. Santa Monica, CA: RAND Corporation

- For veterans PTSD and TBI were often co-occurring and presented unique challenges to assessing and diagnosing each of these conditions. Research suggests that best practices included treating any and all symptoms regardless of etiology. [148]
- Studies have shown that TBI patients have an increased risk of developing depressive symptoms and major depression even decades after the injury.[149] Studies suggest that TBI symptoms such as slowness in psychomotor speed and impaired sustained attention may be mostly related to depressive symptoms. [150]
- People with TBI may be at increased risk for suicide, with a recent study indicating that 17% of TBI out-patients had attempted suicide. In addition, individuals with a history of TBI reported a higher frequency of suicide attempts than those without. [151]
- Alcohol and TBI appear to be closely related. Alcohol use is a risk factor for sustaining a TBI with approximately half of all national TBI's associated with alcohol use. [152] Individuals who were using alcohol at the time of brain injury also experience a greater degree of brain damage, and one third of individuals who were intoxicated at the time of brain injury also had a diagnosis of alcohol dependence. [153] In addition, some studies have shown that alcohol and drug use declined during the first year following TBI, but increased after the first year, with a total of 78% of patients diagnosed with TBI engaging in drug or alcohol use. [154]
- Childhood conduct problems and loss of a parent in childhood may predict adult risk taking behavior that leads to TBI in patients with substance use disorder. TBI is associated with higher rates of psychopathology in patients with substance use disorder.[155]
- In approximately 4-8% of TBI cases there is a co-occurrence between TBI and psychosis. A family history of psychosis and pre-TBI psychological disturbances is highly related to this dual diagnosis. [156]

National Guideline Clearinghouse on TBI

Search the National Guideline Clearing House (www.guideline.gov) for this guideline as well as others: *Traumatic brain injury: diagnosis, acute management and rehabilitation*.

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[148] Brenner, L., Vanderploeg, R., & Terrio, H. (2009). Assessment and Diagnosis of Mild Traumatic Brain Injury, PTSD and other Polytrauma Conditions: Burden of Adversity Hypothesis. *Rehabilitation Psychology*. 54 (3), 239-246.
[149] Holsinger, T. et al (2002) Head Injury in early adulthood and the lifetime risk of depression. *Archives of General Psychiatry*. 59, 12-22.
[150] Himanen, L. et al (2009) Attention and depressive symptoms in chronic phase after TBI. *Brain Injury* 23(3), 220-227.
[151] Simpson G, Tate R. (2002) Suicidality after traumatic brain injury: Demographic, injury and clinical correlates. *Psychological Medicine* 32:687–697.
[152] Corrigan, J. D. (1995). Substance abuse as a mediating factor in outcome from TBI. Archives of Physical Medicine and Rehabilitation, 76, 302–309
[153] O'Shanick, G. J., Scott, R., & Peterson, L. G. (1984). Psychiatric referral after head trauma. Psychiatric Medicine, 2, 131–137
[154] Ponsford, J. et al (2007). Alcohol and drug use following TBI: a prospective study. *Brain Injury* 21 (13) 1385-1392.
[155] Felde, A. et al (2006) Co-morbid TBI and substance use disorder: childhood predictors and adult correlates. *Brain Injury.* 20(1), 41-49.
[156] Fujii D, Ahmed I. (2002) Characteristics of psychotic disorder due to traumatic brain injury: An analysis of case studies in the literature. *Journal of Neuropsychiatry Clinics in Neuroscience*;14:130–140

THE CLIENT STATUS REVIEW OF LIFE DOMAINS

What is the Client Status Review?

The Client Status Review (CSR) is a self-report instrument that collects information on a persons' quality of life. Appendix B describes the rationale for self report measures and the DBH interest in quality of life.

Information from the CSR may be used in two ways:

1) The initial CSR conducted prior to the intake assessment process supplements screening information obtained in the Alaska Screening Tool (AST) to inform the assessment.
2) The initial CSR also functions as a baseline measure of a persons' quality of life prior to an assessment and entry into services. This initial CSR can be compared with subsequent CSR's to monitor change over time. The CSR becomes an outcome instrument that links the result of treatment with the treatment intervention.

This section describes briefly how the CSR may be used for both purposes.

As a quality of life instrument the CSR obtains information from a client in four broad areas: health, safety, productive activity, and living with dignity. The CSR has several domains under each of these areas as shown in the graphic on the right. In all the CSR measures fourteen quality of life domains.

CSR (Quality of Life)

- Health
  - Physical Health
  - Mental Health
  - Substance Use
  - Harm to Self
  - Emergency Services
- Safety
  - Legal Involvement
  - Domestic Violence
  - General Safety
- Productive Activity
  - Employment/School
  - Other Productive Activities
- Living with Dignity
  - Housing
  - Supports for Recovery
  - Meaning in Life
  - Life in General

How does it support decision making?

A completed CSR provides information for decision making by clinicians and clients working together, and it provides information for managers and purchasers of services.

For clinicians the AST screens for symptoms, the initial CSR baseline examines functioning and subsequent CSR's measure change over time, resulting from interventions, that improve functioning and quality of life (QoL).

The initial CSR works together with the AST to inform the clinician in two important ways. The AST provides a basis for exploring symptoms and the CSR provides a basis for exploring the level of functioning. The assessment process examines for presenting symptoms and impairment; together they provide information that supports clinical decisions leading to a diagnosis and treatment recommendations. Measurable goals and objectives can be formulated for use in treatment planning based on many of the CSR items.

Subsequent CSRs can be compared with the initial baseline to monitor change over time. If progress is being made as planned the clinician and client may decide to continue on the current course of treatment. If progress is not being made they may decide to look for

alternatives. The information documented in the CSR provides a basis to make choices that will improve a clients' quality of life (QoL).

For managers and purchasers of services the CSR provides a broad picture in a different way from clinicians and clients. Managers are interested in information from the CSR about groups of clients. They want to know the level of functioning and quality of life of clients entering programs and receiving specific treatment interventions. (It might be expected that clients receiving different treatment interventions would exhibit different levels of quality of life in specific QoL domains.)

Managers also want to know a particular intervention is effective in improving the clients functioning and quality of life. If a particular program shows promising outcomes managers can explore further. They can look into the specific problems experienced by clients in the program and the treatment strategies used in order to assess the potential of transferring the knowledge gained to other areas. A program not demonstrating improvements would lead to discussions among managers about the reasons that may lead to modifications of treatment strategies.

In general, the CSR links the care people get to the outcomes they experience thus providing a key to developing better ways to monitor and improve the quality of care.

Who is expected to complete the CSR?

All substance abuse and/or mental health grantee providers are required to administer and submit the CSR as a condition of their grant award from the Division of Behavioral Health. The CSR is completed by the client and reviewed with a clinician. The provider submits responses from the client to the Division of Behavioral Health via the Alaska Automated Information Management System (AK AIMS). The CSR is completed prior to the formal assessment process. Medicaid regulations reimburse the provider for the CSR with the understanding that information in the CSR is critical to development of the treatment plan for the client. Policies around when and how to use and administer the CSR are available at: http://hss.state.ak.us/dbh/perform_measure/PDF/pm_systempolicy.pdf .

Scoring the CSR

The CSR has twenty explicit questions with some questions having more than one response. The first sixteen questions relate to quality of life, one questions identifies who filled out the survey, and the final three questions ask about services received from the agency.

The first sixteen questions on quality of life may result in twenty-eight respones. A clinican may refer to all responses on the initial CSR to explore the clients level of functioning.

The intent is to combine respones on qualilty of life questions into summary scores. Summary scores are planned for fourteen domains in four broad groups. This is shown in the table on the following page. The table lists each group and the 14 domains in the first two columns. The next two columns provide information on CSR questions and question numbers associated with the domain. This is followed by a column on a change measure for reporting. The final columns provide room for scores obtained at the initial CSR and updates for treatment plan reviews.

(The complete CSR instrument may be found in Appendix C.)

CSR Scoring in Four Groups and 14 Domains

Life Domains		CSR 2011			Reporting	Treatment Plan Review			
Four Groups	**14 Domains**	**Description**	**Questions**		**Change measure**	**Initial**	**1**	**2**	**3**
Health	1 physical health	physical health	1, 2		average 2 '30 days' items				
	2 mental health	mental/emotional	2, 3		average 2 '30 days' items				
	3 self harm thoughts	self harm thoughts	4		single '30 days' item				
	4 substance use	substance use	5, 6		average 2 '30 days' items				
	5 emergency services	emergency services	7		single '30 days' item				
Safety	6 legal involvement	any legal	12		count of three yes/no				
		arrest in 30 days	13						
		arrest in 12 months	15						
	7 domestic violence	domestic violence	14		yes/no				
	8 general safety	feel safe in home		16c	average 2 'Terrible/Delighted' scores				
		feel safe outside		16d					
Productive Activity	9 financial security	employment	10	16b	employ status, 'Terrible/Delighted' rating				
		school alternative	9	16b	days absent, 'Terrible/Delighted' rating				
	10 productive activity	other productive	11		hours in a week				
Living with Dignity	11 housing	housing	8		housing status, 'Terrible/Delighted' rating				
		perception of housing		16a					
	12 support for recovery	friendships		16f	supports: count of 3 yes on Terrible/Delighted scores				
		family situation		16g					
		people support		16e					
	13 meaning in life	meaning in life		16h	single item				
	14 life in general	perception of life		16i	single item				

Screening Using the AST and Initial CSR

As noted above, information in the initial CSR may be combined with the AST to inform the screening process. An increase in the number of questions endorsed would increase the likelihood of the condition. The following page outlines examples of how clinicans may combine the information for both sources to inform the screeing. The three examples include screening for:

- substance use disorder
- serious mental health condition
- risk of harm to self

Examples of Screening Using the AST and Initial CSR

Increased Likelihood of a Substance Use Disorder

AST

substance use (#s 33-37)

adverse experiences (#s 14-21)

CSR

alcohol use (#5)

drug use (#5)

ER use (#7)

legal involvement (#12)

arrest (#1, #13)

dissatisfaction with life (#16)

Increased Likelihood of Risk of Harm to Self

AST

depression (#s 1- 8)

adverse experiences (#s 14-21)

major life change (#25)

CSR

mentally unhealthy days (#2)

thoughts about self harm (#4)

ER use (#7)

dissatisfaction with life (#16)

Increased Likelihood of a Serious Mental Condition

AST

depression (#s 1- 8)

adverse experiences (#s 14- 21)

anxiety

distress/ trauma

hallucination or paranoia

CSR

14 or more mentally unhealthy days (#2)

kept from doing usual activities (#3)

thoughts about self harm (#4)

ER use (#7)

dissatisfaction with life (#16)

Appendix A: Searching AHRQ guideline.gov

Information available at: http://www.guideline.gov/browse/by-topic.aspx

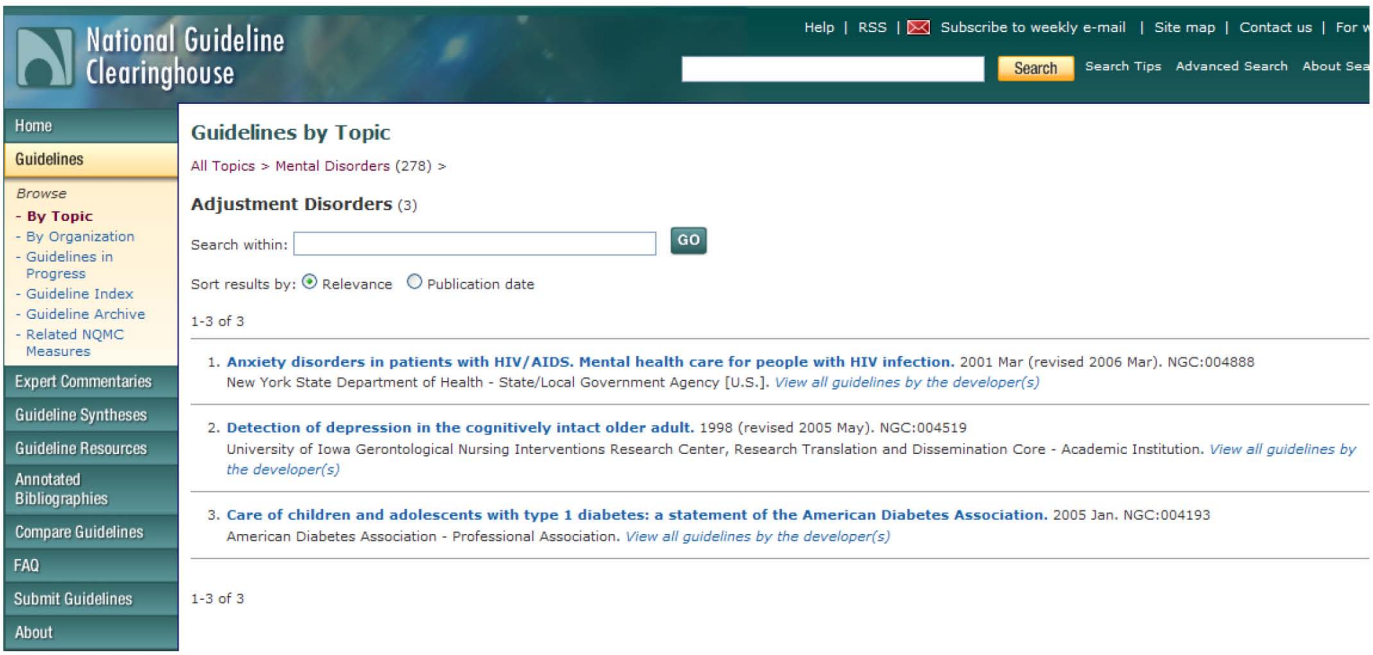
Online you may search by mental health diagnostic/disease type and also by treatment/intervention type below is a table that displays the categories you can search through for information regarding mental health diagnosis and treatment along with the number of references available for each search term. In addition to the wealth of information on mental health, this website also contains information on physical health and treatments which are not listed here.

Disease/Condition	Treatment/Intervention
Mental Disorders (278)	Behavioral Disciplines and Activities (504)
- Adjustment Disorders (3)	- Behavioral Sciences (20)
- Anxiety Disorders (17)	- Mental Health Services (302)
- Delirium, Dementia, Amnestic, Cognitive Disorders (61)	- Personality Assessment (1)
- Eating Disorders (11)	- Psychiatric Somatic Therapies (13)
- Impulse Control Disorders (1)	- Psychiatric Status Rating Scales (24)
- Mental Disorders Diagnosed in Childhood (48)	- Psychological Techniques (24)
- Mood Disorders (45)	- Psychological Tests (109)
- Personality Disorders (4)	- Psychotherapy (183)
- Schizophrenia and Disorders with Psychotic Features (12)	
- Sexual and Gender Disorders (13)	
- Sleep Disorders (24)	
- Somatoform Disorders (3)	
- Substance-Related Disorders (97)	

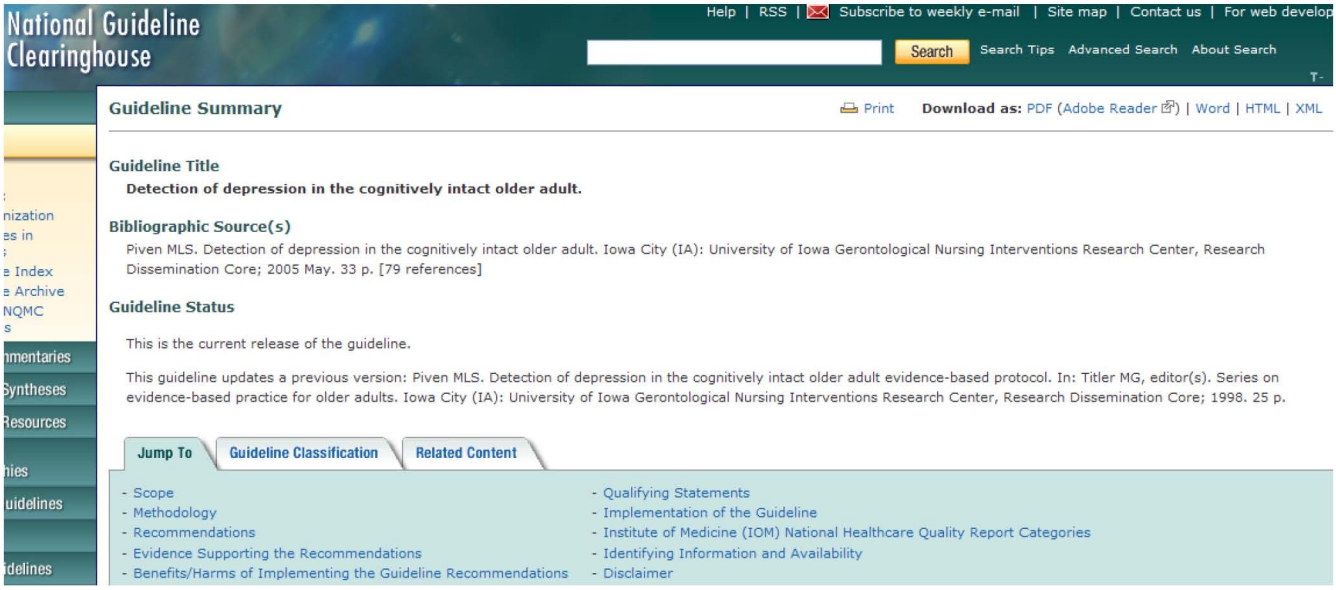
Walk Through Example:

In this example we will select the first disease criteria of adjustment disorder. For the purposes of this example we will pretend that we are working with an older adult who has depression and we would like more information about depression within aging populations. In this example we will select adjustment disorders and then the relevant information pertaining to the client. This example will illustrate what the computer screen will look like at each step in the process and will demonstrate how providers can use this website as a tool for obtaining more information about their specific clients.

Step 1: Click on the Adjustment Disorders tab and the following screen appears



Step 2: Select the second article presented because it applies to the client's needs.



With this tab currently open we can select from a number of options. Within the blue box we are currently on the tab labeled "Jump To". This tab allows users to jump to a specific section of information within the article. For the purposes of this example we will jump to the recommendations section of the article.

Step 3: We used the "Jump To" tab to jump to the recommendations section of the article.

Recommendations

Back to top

Major Recommendations

The grades of evidence (A-D) are defined at the end of the "Major Recommendations" field.

Individuals at Risk for Depression

The following characteristics increase the risk for major depression: (American Psychiatric Association [APA], 2000. *Evidence Grade = B*).

- A prior episode of major depression
- A family history for depressive disorders
- A personal history of prior suicide attempts
- Being female
- Recent loss of a spouse
- Medical co-morbidity (See Table 2 in the original guideline document)
- Lack of social supports
- Stressful life events, such as death of a loved one, divorce
- Current alcohol or substance abuse

Older individuals are at increased risk for depression because they frequently exhibit several of these risk factors simultaneously. In addition, caregivers of persons with dementia are extremely vulnerable to depression secondary to the burden of caregiving. Prevalence rates, ranging from 30 to 83% (Baumgarten et al., 1992; Cohen & Eisdorfer, 1988; Drinka, Smith, & Drinka, 1987; Gallagher et al., 1989; Kiecolt-Glaser et al., 1991; Schulz & Martire, 2004) are consistently reported in the literature. Elderly persons caring for their grandchildren are also at higher risk for depression (Burton, 1992; Fuller-Thomson & Minkler, 2000; Minkler et al., 1997). Major depression is one of the most prevalent conditions occurring concurrently with post-traumatic stress disorder (PTSD) (O'Donnell, Creamer, & Pattison, 2004) and increases the risk for suicidal behavior (Oquendo et al., 2005).

Assessment Criteria

Any individual over age 60, who is identified as at risk according to the factors listed earlier (e.g., caregiver, socially isolated, bereaved, physically ill), should be evaluated for depression (APA, 2000. *Evidence Grade = B*).

In practice, detection of depression in the older adult is a complex process and there are many factors which may interfere with detection. According to Rouchell and colleagues (Rouchell, Pounds, & Tierney, 2002), reasons for the under-diagnosis and under-treatment of depression in medically ill patients include the following:

- Emphasis on somatic rather than cognitive and mood complaints
- Reluctance to stigmatize patient with psychiatric diagnosis
- Mild or nonspecific symptoms of depression
- Fear of antidepressant side effects
- Mistaken notion that reactive depressions are not pathological (e.g., "She should be depressed; she has cancer.")
- Time limitations in primary care
- Inadequate training in psychiatry among primary care providers

The recommendations section of this article contains information about prior risk factors which may lead to depression in the elderly, and a description of the assessment process for depression. If we were to scroll further down on the page we would also find a description of current practices used for assessment and treatment of depression as well as the priorities of health screenings and suicide prevention. This information also contains a detailed list of references which we could use to gather further information if necessary.

Step 4: Return to the blue box found in step 2. Click from the "Jump To" tab over to the "Guideline Classification" tab.

Jump To | Guideline Classification | Related Content

Developer: University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core
Age of Target Population: Aged (65 to 79 years); Aged, 80 and over

UMLS Concepts (what's this?)
Click to view all guideline(s) indexed with these concepts

ICD9CM: Dysthymic disorder (300.4); Screening for depression (V79.0)
MSH: Adjustment Disorders; Depressive Disorder, Major; Dysthymic Disorder; Mood Disorders; Psychopathology
MTH: Adjustment Disorders; Affective Disorders; Dysthymic Disorder; Encounter due to screening for depression; Involutional Depression; MAJOR DEPRESSIVE DISORDER
PDQ: adjustment disorder
SNOMEDCT: Adjustment disorder (17226007); Dysthymia (78667006); Evaluation of psychiatric state of patient (90407005); Involutional depression (321717001); Major depressive disorder (370143000); Mood disorder (46206005); Psychological assessment (405783006); Psychological assessment (45392008)

Hide...

The “Guideline Classification” tab allows us to jump directly to other related topics. For example, if we were to click on the first blue word Dysthymic disorder a new list of related articles similar to those presented in the picture for step 1, would appear. From there we could select a number of articles related to the topic of interest for further information. In addition, the “Guideline Classification” tab lists different categorization codes which are used to label the disorders for different styles of paperwork. For example, the first line, the ICD9CM line lists the diagnostic codes for the International Classification of Diseases – Clinical Modification (ICD-9-CM). If the ICD-9-CM is a category that your agency uses for the completion of documentation this can hasten the paperwork process. If we were to scroll down the page while I had the “Guideline Classification” tab open, we would find the same content that was available under the “Jump To” tab.

Step 5: Click on the “Related Content” tab

Under the “Related Content” tab we will find the link for the publisher or developer of the information found under the “Jump To” tab. If we click on the text under the “Related Content” tab, in this example the University of Iowa, a new window will open. This new window will look similar to the picture from step 1, and it will contain all the information used on this website that was produced by the University of Iowa.

Overall, this website gives providers 3 ways to search for information. 1) Providers can search by disease/condition or treatment/intervention. 2) Providers can search by diagnostic code such as the ICD-9-CM. 3) Providers can search by publication venue such as the University of Iowa.

Appendix B: Rationale for Self Report on Quality of Life

This Appendix provides an overview of the Client Status Review (CSR) as a self-reported measure and as a measure of "quality of life" (QoL). Included is a review of 1) the development of quality of life measures for both clinical management and outcome evaluation, and 2) the validity and value of self reported measures for persons with behavioral health conditions.

The CSR was initially developed in 2001 when the Division of Substance Abuse and the Division of Mental Health were being integrated. A broad group of stakeholders recommended performance measures for the new service system including the Alaska Screening Tool, the Client Status Review of Life Domains, and the MHSIP Consumer Survey.157 The CSR instrument was tested and revised based on a pilot study conducted by the University of Alaska, Anchorage.158

The structure, intent, and logic of the CSR are consistent with current and emerging national policy and planning on QoL measurement. The Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS) focus on quality of life159; several required national outcome measures are represented in the CSR. The Substance Abuse Mental Health Services Agency (SAMHSA) has included "quality of life" in the working definition of recovery for mental health and substance abuse populations and is fundamental to "strategic initiative" #7: Data, Outcomes, and Quality: Demonstrating Results. 160

Quality of Life can be conceptualized as a multidimensional set of components consisting of a person's (1) satisfaction with his/her life as a whole, or *general wellbeing*; (2) observable social and material wellbeing, i.e. *objective quality of life*; (3) satisfaction with his/her social and material wellbeing, i.e. s*ubjective quality of life*; and (4) health and functional status, i.e. *health-related quality of life*.[161]

The measurement of *Quality of Life* as an outcome in health care interventions has progressed in application and is now fully positioned in the national discussion. This inclusion can be attributed to five interrelated health and health care changes: (1) health care technologies have reduced early mortality and prolonged the lives of those who would otherwise have died (usually from an infectious disease); (2) there has been a shift in economically developed societies from exogenous to endogenous chronic diseases, such as mental health conditions[162]; (3) there has

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[157] Mental Health Performance Measures Project – Phase One Report. C & S Management Associates, 2001.
[158] Mental Health Performance Measures Pilot Project: Final Report. June 5, 2002. Alaska Comprehensive Specialized Evaluation Services (ACSES), University of Alaska, Anchorage.
[159] For examples refer to "Strategic Initiative #7: Data, Outcomes, and Quality: Demonstrating Results" (http://www.samhsa.gov/about/siDocs/dataOutcomes.pdf) and the 10 by 10 Wellness Campaign (http://www.promoteacceptance.samhsa.gov/10by10/default.aspx)
[160] http://partnersforrecovery.samhsa.gov/docs/ROSCs_principles_elements_handout.pdf http://www.samhsa.gov/about/siDocs/dataOutcomes.pdf
[161] Eack S., Newhill C. Psychiatric symptoms and quality of life in schizophrenia: a meta-analysis. Schizophr Bull. 2007 Sep;33(5):1225-37.

[162] Exogenous disease originate outside the individual and medical care cannot remove the cause. Examples of endogenous diseases beside mental health include high blood pressure neuralgia and rheumatism.

been increasing recognition that interventions should respect patients' concerns and incorporate their experiences into medical decision-making; (4) many health services are now designed to prevent deterioration in quality of life; and (5) there is increasing conflict between potentially useful interventions and the (limited) resources available to fund them."[163]

Quality of life (QoL) in Behavioral Health

Quality of Life (QoL) has also been studied in the field of alcohol misuse. For example, one research article reviewed "… the ongoing and published work in the area focusing upon QoL characteristics of alcohol-dependent subjects... The main conclusions from the review were that the QoL of alcohol-dependent subjects is very poor and improved as a result of abstinence, controlled or minimal drinking..."[164] Another article on alcohol treatment concluded QoL "… represents an important area to consider in assessing individuals with alcohol use disorders and in evaluating alcoholism treatment outcome… Alcohol-dependent individuals experience improvements in QoL across treatment and with both short-term and long-term abstinence… Also, among hazardous and harmful drinkers, achieving and maintaining a marked reduction in drinking, even without complete abstinence, is associated with significant increases in QoL.[165]

Quality of life measures have been used with persons with serious mental illness[166], serious and persistent mental illness[167], and substance use.[168] The two following paragraphs summarize the current state of measuring health related quality of life in mental health.

> "… Over the past few decades health-related quality of life (HRQL) has emerged as the new image of medicine viewed from a psychosocial perspective. The concept of Quality of Life has attracted a good deal of interest, not only from a clinical perspective but also from psychosocial, health economics as well as cultural aspects. More recently, the neurobiological brain substrates that modulate many aspects of subjective experiences, which is relevant to quality of life such as affect, mood, cognition, pleasure, reward responses as well as feeling of wellbeing and satisfaction has been explored and elucidated.
>
> "Such increased interest in HRQL is highlighted by the large number of recent publications. Over the past 10 years at least 350 papers were published describing aspects of HRQL in the psychiatric and mental field. Among them 78% dealt with HRQL in

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163 Hawthorne, G. Measuring the value of health-related quality of life. In Quality of Life Impairment in Schizophrenia, Mood and Anxiety Disorders. Springer, 2006. Awad, A., Ritsner, M. (Eds).

164 Foster, J., Powell, J., Marshall, E., Peters, T. Quality of Life in alcohol-dependent subjects - a review. Quality of Life Research 8: 255±261, 1999.

165 Donovan et al. Quality of life as an outcome measure in alcoholism treatment research. J Stud Alcohol Suppl. 2005 Jul;(15):119-39; discussion 92-3.

166 Dickerson, F. et al. Quality of Life in Individuals With Serious Mental Illness and Type 2 Diabetes. Psychosomatics 49:2, March-April 2008.

167 Anderson, A. McNei, D., Reddon, J . Evaluation of Lehman's Brief Quality of Life Interview in Assessing Outcome in Psychiatric Rehabilitation in People with Severe and Persistent Mental Disorder. Social Work in Mental Health, 1533-2993, Volume 1, Issue 2, 2002, Pages 43 – 59

168 Ingela Schaar, I., Öjehagen, A. Predictors of improvement in quality of life of severely mentally ill substance abusers during 18 months of co-operation between psychiatric and social services. Social Psychiatry and Psychiatric Epidemiology Volume 38, Number 2, 83-87, 2003.

schizophrenia and schizoaffective disorders, 21% with major depression, 14% with anxiety disorders and 4% with bipolar disorder…"[169]

These authors go on to say there is a lag in the application of quality of life data in improving clinical practice.[170] The CSR provides an opportunity in Alaska behavioral health to use quality of life data to improve clinical practice.

CSR2011 Revision

The primary goal for the CSR modification was to improve the ability to assess change over time. Focus was placed on the scoring methodology and the language used to ask questions, the number (volume) of questions necessary in order to measure change, as well as, aligning with national data requirement (Block Grants for substance abuse and mental health; National Outcome Measures). Specific to the scales used to measure change, the original CSR lacked the sensitivity and range to measure the change over time. Findings from the initial CSR had most respondents at a level that could be described as "functioning well" resulting in a lack of space within the scale to measure improvement at a later point in time. Analysis of the pilot study demonstrated that the modified scales were successful in resolving this deficiency.

In the course of the revisions an opportunity presented itself to improve the CSR to strengthen it as a measure of QoL. A definition of QoL and the domains identified in the literatures is provided and two revisions are discussed, one on the first three "Healthy Days" questions on the CSR form, the other addition of subjective measures.

Domains. This definition of quality of life and domains included was taken from literature. "Quality of life is individuals' perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by persons' physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment". In a review of definitions of quality of life used in the literature, 27 studies were identified for inclusion in the review and of these 27 studies, 85% included domains related to emotional well-being, 70% included domains related to physical health, 70% included domains related to social and family connections, 59% included domains related to material wealth or well-being and 56% included domains related to work or other forms of productive activity."[171] (Editorial note: most studies included multiple domains.)

The reader will note all of the domains identified are represented in the CSR2011.

Healthy Days. The first three questions on the original CSR reflected three questions widely used for health related quality of life and referred to as "Healthy Days". These questions came from the CDC sponsored Behavioral Health Risk Factor Surveillance System (BRFSS) administered in each state to a random sample of households. The Alaska BRFSS survey includes these questions in an annual survey of approximately 2,500 persons (http://www.hss.state.ak.us/dph/chronic/hsl/brfss/method.htm).

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[169] Awad, A., Ritsner, M. (Eds). Quality of Life Impairment in Mood and Anxiety Disorders: New Perspective on Research and Treatment. Springer, 2007. Forward.
[170] Awad, Ritsner, 2007 ibid.
[171] Bullinger et al. Cross-Cultural Quality of Life Research in Mental Health. In Quality of Life Impairment in Schizophrenia, Mood and Anxiety Disorders. Springer, 2006. Awad, A., Ritsner, M. (Eds).

Here is a brief description from an article discussing how the "Healthy Days" measures were developed and validated.[172]

> To promote the health and quality of life of United States residents, the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) - with 54 state and territorial health agencies - has supported population surveillance of health-related quality of life (HRQOL). HRQOL was defined as "perceived physical and mental health over time." Commonly-used measures of health status and activity limitation were identified and a set of "Healthy Days" HRQOL measures was developed and validated. A core set of these measures (the CDC HRQOL-4) asks about self-rated general health and the number of recent days when a person was physically unhealthy, mentally unhealthy, or limited in usual activities… The brief standard CDC HRQOL-4 is now often used in surveys, surveillance systems, prevention research, and population health report cards.

All three "Healthy Days" HRQOL measures in the CSR2010 (the CSR excludes the fourth on self-rated general health) ask about the number of days in the past 30. This response frame was used in the CSR2011 and expanded to an additional four questions on health.

A number of studies have assessed the psychometric properties of HRQOL measures. "In older Canadian patients, a self-administered version of the CDC HRQOL-4 measures **had good construct and concurrent validity** based on reported health conditions, physical exams, and other measures [15]. The CDC HRQOL-4 measures **had acceptable test-retest reliability and strong internal validity** in a representative telephone sample of Missouri adults, but they were **less reliable among older adults** [16]. And in a large prospective study, each of the CDC HRQOL-4 measures **predicted 1-month and 12-month mortality, hospitalization, and non-hospital utilization of health care** [17]. In cognitive studies, elderly persons and those trying to respond with a counting strategy (recalling specific days) rather than an estimation strategy (guessing the approximate number of days) had more difficulty responding to the HRQOL measures[18]."[173]

Subjective Measures. In the course of making the revision to the CSR a "Quality of Life Toolkit" was reviewed to ensure best practices were incorporated into the CSR. This Toolkit is one of a series of such kits commissioned by the Evaluation Center at the Human Services Research Institute (HSRI) and supported by a cooperative agreement with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.[174] This proved to be a useful source to enhance the CSR2011.

The domains in the HSRI QoL Toolkit are similar to CSR domains. Both instruments asked the person to rate objective questions (such as "how many times") and subjective questions ("how do you feel"). The revision to the CSR increased the number of subjective questions and included the response scale from the QoL Toolkit. In addition, the seven-point "Terrible" to "Delighted"

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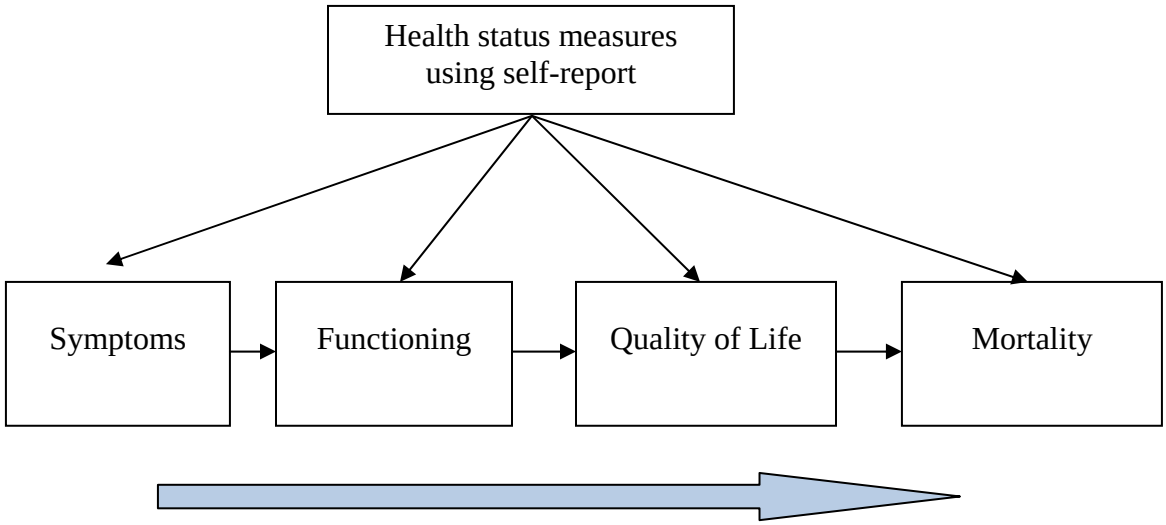
[172] Moriarty, D., Zack, M., Kobau, R. The Centers for Disease Control and Prevention's Healthy Days Measures - population tracking of perceived physical and mental health over time. Health Qual Life Outcomes. 2003 Sep 2;1:37.
[173] Donovan, 2005. Ibid.
[174] Lehman, A., Kernan, E., Postrado, L. Toolkit on Evaluating Quality of Life for Persons with Severe Mental Illness. 1995.
http://www.hsri.org/publication/toolkit_evaluating_quality_of_life_for_persons_with_severe_mental_illn/

response scale used in the QoL Toolkit has been found to be more sensitive to responses than other response sets. The pilot test of the CSR2011 demonstrated the value of using the “Terrible” to “Delighted” response scale. Average scores on items were in the mid-range as hoped.

Self-Report Measures

This category of health status measures is directly elicited from the patient. It might include assessments of symptoms, or broader concerns, such as "quality of life." They are unique in that they directly assess benefits to the patient for which no adequate observable or physical measures exist. They are designed to capture the patient's perspective, thereby adding another dimension to our understanding of a patient's health status.

The following figure depicts the relationships among various types of endpoints and the context in which self-reported measures are frequently used. Self-reported measures are commonly used to measure symptoms, functional status, health related quality of life, and quality of life.[175]



Functional status differs from symptoms in that it refers to the extent to which symptoms interfere with a patient’s ability to perform certain tasks or activities. The concept of Health Related Quality of Life (HRQOL) encompasses both symptoms and functional status. In principle, HRQOL instruments are designed to capture not only the level of impairment, but also the impact of that impairment on an individual’s perceived physical, psychological, and social well-being. Some investigators distinguish measures of ‘‘health status’’ from true ‘‘quality of life’’ instruments, which take into account the patient’s own expectations or internal standards.

What is the rationale for HRQL evaluation? “The purpose of HRQL evaluation is to go beyond the presence and severity of symptoms of disease or side effects of treatment, examining how patients perceive and experience these manifestations in their daily lives. Because this

[175] Adapted from: Hubert, C., Taichman, D., Doyle, R. Health-related Quality of Life and Patient-reported Outcomes in Pulmonary Arterial Hypertension. The Proceedings of the American Thoracic Society 5:623-630 (2008). http://pats.atsjournals.org/cgi/content/full/5/5/623

information will be used by both clinicians and patients to make treatment decisions, there is nothing more relevant than basing this decision on the patient's own HRQL assessment. In addition to relieving clinical symptoms and prolonging survival, a primary objective of any health care intervention is the improvement of HRQL. HRQL data strengthens treatment related outcomes by providing relevant information beyond traditional clinical endpoints."[176]

Self-report Validity with Behavioral Health

Two sources address the issue of the validity of self-report quality of life data for persons with behavioral health conditions. Evidence is provided of validity for persons with at least moderate symptoms and utility for all persons.

The QoL Toolkit (page 219)[177]

> "… These considerations underscore that this study provides a conservative estimate of the convergent validity of patients' assessments of their quality of life with clinicians' assessments. It should also be noted that the level of agreement between measures in the two quality of life instruments was comparable to that between the two standardized symptom measures, the SCL-90 and the BPRS. There is thus a basis for optimism about the validity of these quality of life measures…
>
> "This interpretation should not, however, obscure legitimate concerns about the validity of quality of life assessments for persons with SMI. A common dilemma encountered in the assessment of quality of life among persons with SMI is that at times their perceived quality of life differs from that predicted by social norms. Such counterintuitive QOL results frequently raise concerns about the reliability or validity of their QOL assessments. While such basic psychometric concerns may be reasonable, the fact is that the psychometric properties of the better QOL measures for the SMI are comparable to those in the general population. Rather than reflecting measurement 'limitations, such intuitively inconsistent QOL findings may offer valuable information for clinical interventions and service planning…"

Awad and Voruganti also discuss relevant self-report issues.[178]

> "… By definition, quality of life is a subjective construct that needs to include patients' self-reports and their subjective judgment. As such, it requires a degree of cognitive ability. Traditionally, clinicians have been suspicious of subjective assessment by patients of treatment outcomes. As patients with schizophrenia frequently experience disturbed thinking and communication, as well as a range of neurocognitive deficits, their reports about their feelings, values, and levels of satisfaction are frequently uncritically dismissed as unreliable. Paradoxically, clinicians do not feel reluctant to base diagnostic formulations of their patients on unobservable or non-objectively verifiable self-reports about their unique

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[176] Revicki, D, Osoba2, D., Fairclough, I. Barofsky, R. Berzon, N.K. Leidy & M. Rothman. Recommendations on health-related quality of life research to support labeling and promotional claims in the United States. Quality of Life Research 9: 887±900, 2000

[177] Lehman, A., Kernan, E., Postrado, L. Toolkit on Evaluating Quality of Life for Persons with Severe Mental Illness. 1995. http://www.hsri.org/publication/toolkit_evaluating_quality_of_life_for_persons_with_severe_mental_illn/

[178] Qeorge Awad, G., Voruganti, L. Intervention Research in Psychosis: Issues Related to the Assessment of Quality of Life. Schizophrenia Bulletin, Vol. 26, No. 3, 2000

psychotic experiences such as hallucinations and delusions, without questioning the reliability of such information. Over the past few years, a growing body of research has supported the notion that subjective self-reports can be both measured and reliably quantified (Van Putten and May 1978; Hogan et al. 1983; Hogan and Awad 1992; Naber et al. 1994; Awad et al. 1995; Voruganti et al. 1998)…"

As reflected in the literature self report measures for persons with serious behavioral health conditions are useful both clinically and in performance measurement. A significant recent clinical contribution has been the recommendations from the Schizophrenia Patient Outcomes Research Team, which provided an approach on how to translate research into practice (Lehman et al. 1998)[179]

The concern about bias in performance measurement has been minimized in the CSR2011 by taking a multidimensional approach to screening as recommended in the literature.[180] The CSR2011 is also supplemented by information from the Alaska Screening Tool and other information obtained during the intake process.

Quality of Life: Past, Present, and Future

"Over the past 50 years, biomedical and technological advances have significantly reduced to society the risk of life-threatening illnesses, but this risk has been replaced by the risk of chronic long-term conditions. With the rising cost of management of such chronic illnesses, emphasis has shifted from merely prolonging life, to enhancing quality of life. In such a context, quality of life measurement has become not only a new paradigm for enhancing the life of chronic patients but also a tool for comparing programs and various interventions, and subsequently, for allocating resources. In clinical management, quality of life measurements can serve a variety of important purposes. They can serve as a needs assessment, and they can yield valuable information for the clinician about gaps in management, which can lead to development of corrective measures. As an outcome, quality of life can demonstrate the effectiveness of the various management approaches, and conceptually, can change the focus of management from just symptoms improvement to broader outcomes that include function, satisfaction, and possibly the return to a somewhat productive role…"[181]

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[179] Awad, G., Voruganti, L. Intervention Research in Psychosis: Issues Related to the Assessment of Quality of Life. Schizophrenia Bulletin, Vol. 26, No. 3, 2000
[180] Awad, 2000. Ibid.
[181] Awad, 2000. Ibid.

ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks** (enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ..... _____
2. How many days have you felt down, depressed or hopeless? ..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much? ..... _____
4. Felt tired or had little energy? ..... _____
5. Had a poor appetite or ate too much? ..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ..... _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ..... _____
8. Moved or spoken so slowly that other people could have noticed? ..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual? ..... _____
10. Remembered things that were extremely unpleasant? ..... _____
11. Were barely able to control your anger? ..... _____
12. Felt numb, detached, or disconnected? ..... _____
13. Felt distant or cut off from other people? ..... _____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ..... ☐ Yes ☐ No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ..... ☐ Yes ☐ No
16. I have lived with someone who was seriously depressed or seriously mentally ill ..... ☐ Yes ☐ No
17. I have lived with someone who attempted suicide or completed suicide ..... ☐ Yes ☐ No
18. I have lived with someone who was sent to prison ..... ☐ Yes ☐ No
19. I, or a close family member, was placed in foster care ..... ☐ Yes ☐ No
20. I have lived with someone while they were physically mistreated or seriously threatened ..... ☐ Yes ☐ No
21. I have been physically mistreated or seriously threatened ..... ☐ Yes ☐ No
    a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ..... ☐ Yes ☐ No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐ Yes ☐ No ☐ D/N
23. I have had a blow to the head that was severe enough to cause a concussion . ☐ Yes ☐ No ☐ D/N

    If you answered "Yes" to 21 or 22, please answer a-c:

    a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No
    b. After the head injury, was there a permanent change in anything? ..... ☐ Yes ☐ No ☐ D/N
    c. Did you receive treatment for anything that changed?..... ☐ Yes ☐ No

24. Did your mother ever consume alcohol? ..... ☐ Yes ☐ No ☐ D/N
    a. **If Yes**, did she continue to drink during her pregnancy with you? ..... ☐ Yes ☐ No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐ Yes ☐ No
26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐ Yes ☐ No
27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐ Yes ☐ No
28. Have you tried to hurt yourself or commit suicide?..... ☐ Yes ☐ No
29. Have you destroyed property or set a fire that caused damage?..... ☐ Yes ☐ No
30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐ Yes ☐ No
31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐ Yes ☐ No
32. Do you think people are out to get you and you have to watch your step?..... ☐ Yes ☐ No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐ Yes ☐ No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much?..... ☐ Yes ☐ No
37. Do you think you might have a problem with your drinking, drug or inhalant use?..... ☐ Yes ☐ No

THANK YOU for providing this information! Your answers are important to help us serve you better.