Addressing Medical and Psychiatric Needs in Substance Abuse Treatment

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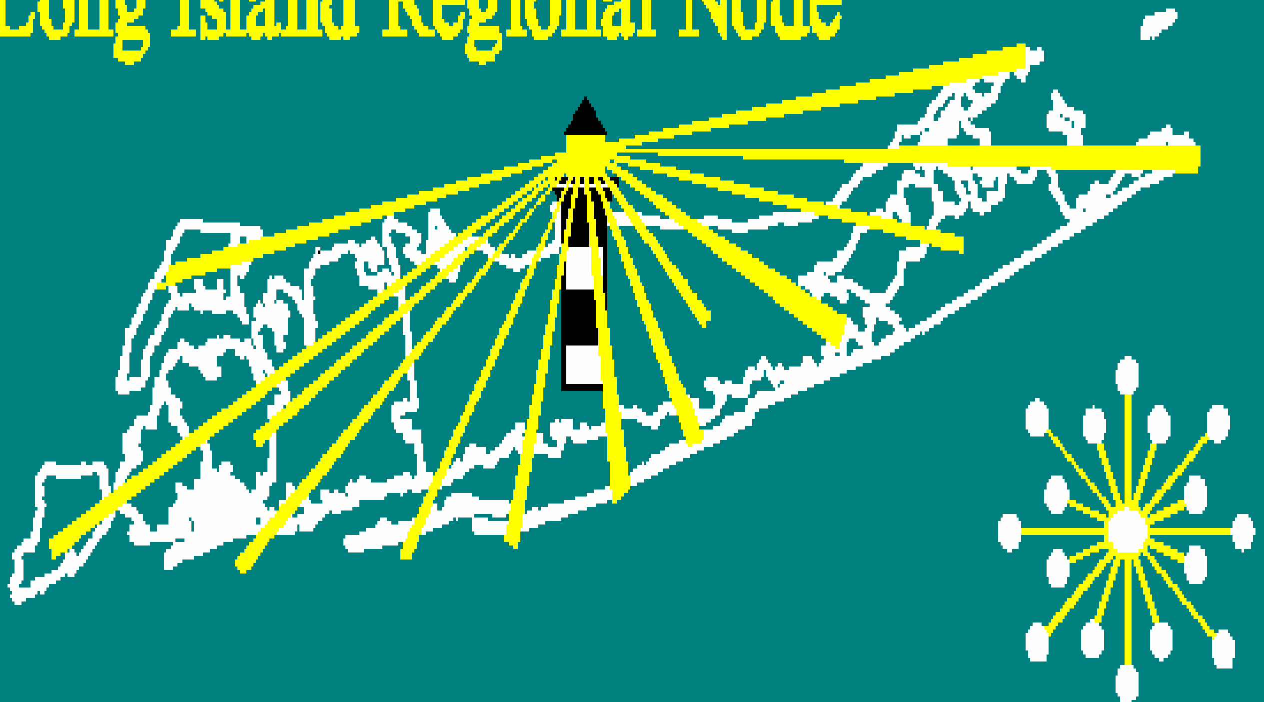
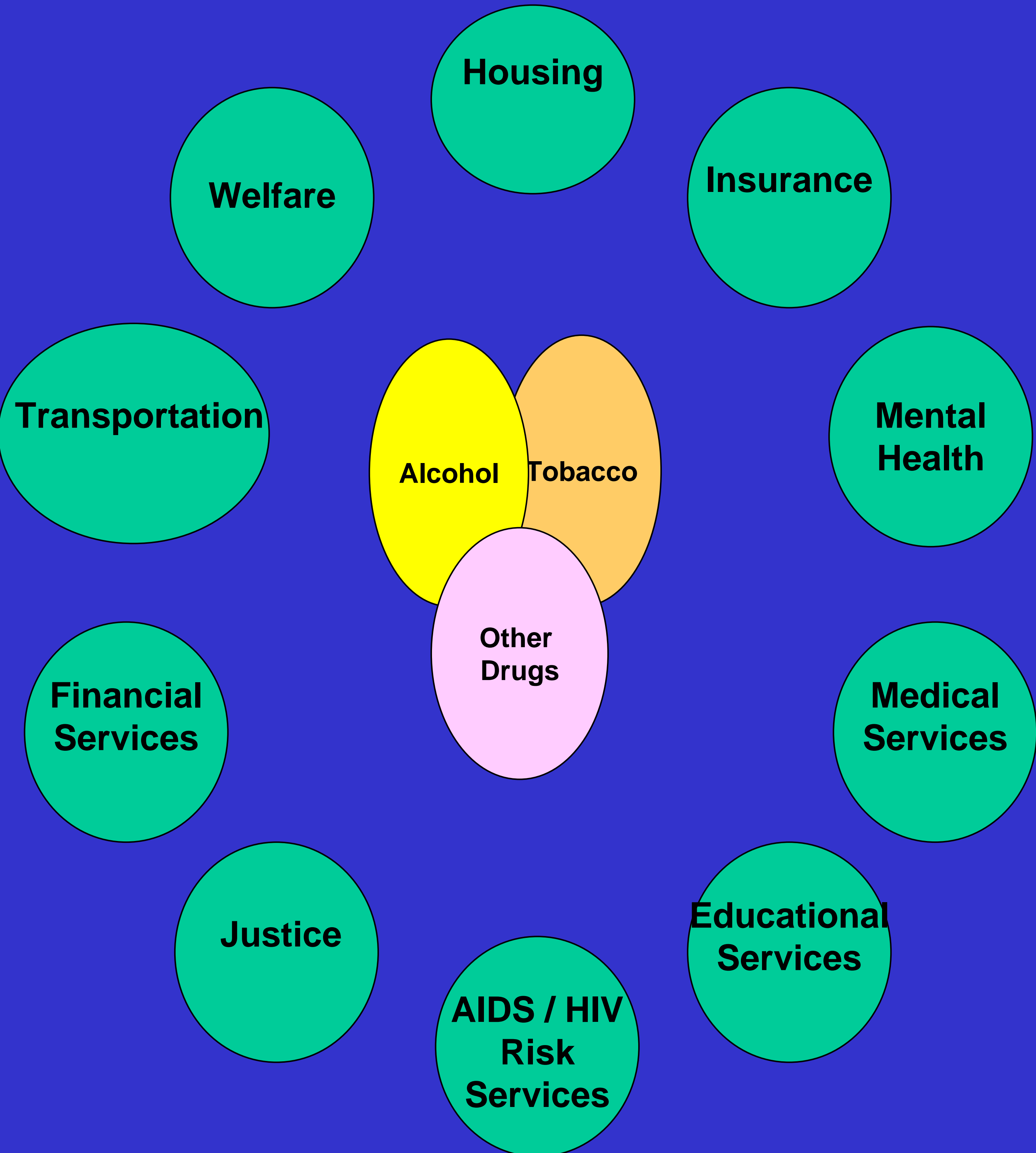
Long Island Regional Node of the CTN


NATIONAL Clinical Trials Network
Long Island Regional Node

Drug Abuse Treatment Core Components and Comprehensive Services



Thorough Clinical Assessment:

- Leads to a comprehensive problem list
- Guides treatment planning (setting priorities, deciding what to treat and what to monitor)
- Often shows why “dual diagnosis” is a misnomer (most patients have far more than 2 types of diagnoses)
- All clinical staff can be assisted to develop this as a competency (standardized screens and rating scales can be a great teaching aid)

PATIENT QUESTIONNAIRE – PRIME-MD

Nine Symptom Checklist

Patient Name: ____ **Date**: ______________________

1. **Over the <u>last 2 weeks,</u> how often have you been bothered by any of the following problems**?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

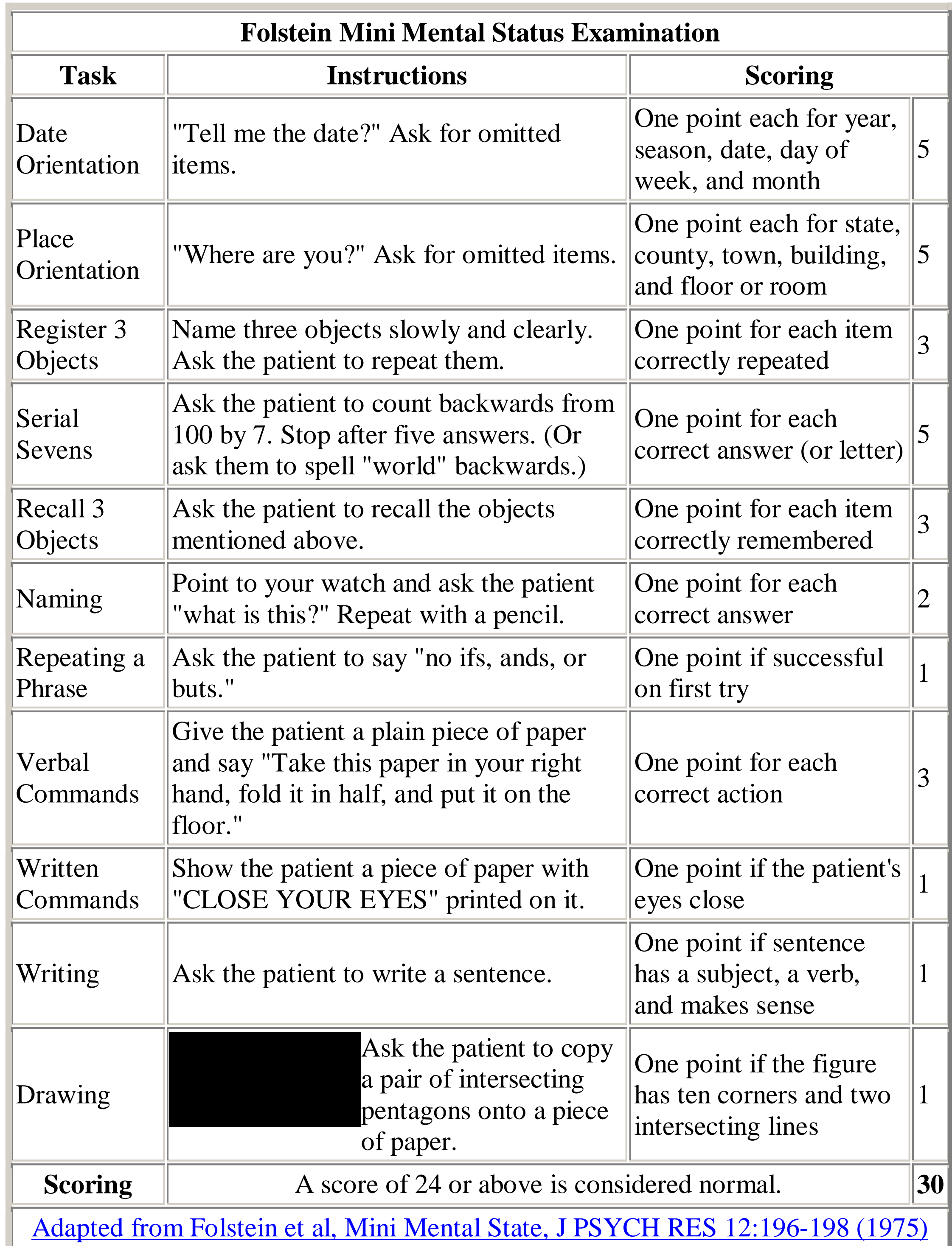
Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

Total Score: ______________

If you have scored 5 or greater on the first 9 questions above, you may have symptoms consistent with a depressive condition. For more information about depression and treatment options that are available, you are encouraged to make an appointment with your family physician or primary health care provider. You may want to print out this questionnaire and bring it to your appointment. Depression is a ***common*** and ***treatable*** disease. You deserve to feel better.

Mini Mental Status Examination

The "Mini" Mental Status Exam is a quick way to evaluate cognitive function.



Folstein Mini Mental Status Examination			
Task	**Instructions**	**Scoring**	
Date Orientation	"Tell me the date?" Ask for omitted items.	One point each for year, season, date, day of week, and month	5
Place Orientation	"Where are you?" Ask for omitted items.	One point each for state, county, town, building, and floor or room	5
Register 3 Objects	Name three objects slowly and clearly. Ask the patient to repeat them.	One point for each item correctly repeated	3
Serial Sevens	Ask the patient to count backwards from 100 by 7. Stop after five answers. (Or ask them to spell "world" backwards.)	One point for each correct answer (or letter)	5
Recall 3 Objects	Ask the patient to recall the objects mentioned above.	One point for each item correctly remembered	3
Naming	Point to your watch and ask the patient "what is this?" Repeat with a pencil.	One point for each correct answer	2
Repeating a Phrase	Ask the patient to say "no ifs, ands, or buts."	One point if successful on first try	1
Verbal Commands	Give the patient a plain piece of paper and say "Take this paper in your right hand, fold it in half, and put it on the floor."	One point for each correct action	3
Written Commands	Show the patient a piece of paper with "CLOSE YOUR EYES" printed on it.	One point if the patient's eyes close	1
Writing	Ask the patient to write a sentence.	One point if sentence has a subject, a verb, and makes sense	1
Drawing	Ask the patient to copy a pair of intersecting pentagons onto a piece of paper.	One point if the figure has ten corners and two intersecting lines	1
Scoring	A score of 24 or above is considered normal.		**30**

Adapted from Folstein et al, Mini Mental State, J PSYCH RES 12:196-198 (1975)

Addiction Research Foundation Clinical Institute Withdrawal Assessment-Alcohol (CIWA-Ar)

This scale is not copyrighted and may be used freely.

Patient: ____________________ Date: /___/___/___ Time: ___ : ______
(24 hour clock, midnight = 00:00)

NAUSEA AND VOMITING-- Ask "Do you feel sick to your stomach? Have you vomited? " Observation. 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting	**TACTICLE DISTURBANCES**--Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation. 0 none 1 mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
TREMOR--Arms extended and fingers spread apart. Observation. 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient's arms extended 5 6 7 severe, even with arms not extended	**AUDITORY DISTURBANCES**--Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation. 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations.
PAROSYSMAL SWEATS-- Observation. 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats	**VISUAL DISTURBANCES**--Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation. 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations

ANXIETY--Ask "Do you feel nervous?" Observation. 0 no anxiety, at ease 1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.	**HEADACHE, FULLNESS IN HEAD**--Ask "Does your head feel different? Does it feel like there is a band around your head? " Do not rate for dizziness or lightheadedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe
AGITATION-- Observation. 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about	**ORIENTATION AND CLOUDING OF SENSORIUM**--Ask "What day is this? Where are you? Who am I?" 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place and/or person
Total CIWA-A Score _____ Rater's Initials _____ Maximum Possible Score 67	

Information Transfer:

- Important patient for patient safety as patient moves from one treatment setting to another
- Important within same treatment setting as patient moves from one clinician to another
- Inadequate information transfer a repeated source of untoward patient incidents

NORTH SHORE LONG ISLAND JEWISH HEALTH SYSTEM
BEHAVORIAL HEALTH SERVICES
INTERINSTITUTIONAL PATIENT TRANSFER FORM

DATE OF TRANSFER____________________________

FROM:____
(PRINT)

OF:____(NAME OF HEALTH SYSTEM FACILITY)
(PRINT)

PHONE: __________________________

FAX: __________________________

BEEPER: _________________________

TO:____
(PRINT)

OF:____ (NAME OF HEALTH SYSTEM FACILITY)
(PRINT)

PHONE: _________________________

FAX: _________________________

BEEPER: ________________________

NAME OF PATIENT: __________________________________
(PRINT)

GENDER: _______M ______F DOB___________

ADDRESS: ____

____

PHONE: ________________________

NEAREST RELATIVE: _______________________________
(PRINT)

RELATIONSHIP TO PATIENT: ________________________

PHONE: _______________________

NEAREST RELATIVE NOTIFIED OF TRANSFER: _______ Y ________ N

REASON FOR TRANSFER: ____

____

DOES PATIENT REQUIRE 1:1 OBSERVATION? __________Y _________ N

HAS PATIENT BEEN ASKED ABOUT POSSESSION OF MEDICATION AND/OR CONTRABAND? __________ Y ___________ N

DOES PATIENT HAVE MEDICATION AND/OR CONTRABAND _____________Y _______________ N

WHAT IS MEDICATION AND/OR CONTRABAND: ___________________________________

____

IF PATIENT HAS MEDICATION AND/OR CONTRABAND IN POSSESSION, WAS IT GIVEN TO STAFF? _____________Y ___________N ______________N/A

DSM IV DIAGNOSIS:

AXIS I. ____________________________________
____
____

AXIS II ____________________________________
____
____

AXIS III* ____________________________________ * Consent required for disclosure of HIV status

____
____

AXIS IV ____________________________________
____
____

AXIS V ______________________ ___________________________
(CURRENT) (HIGHEST PAST YEAR)

SUCCINCT HISTORY OF ILLNESS & TREATMENT:

A. PSYCHIATRIC (reason for admission to referring facility, key hx, course of tx, current MSE):____
____
____
____

B. GENERAL MEDICAL (course of important general medical problems (consider Axis III), current vital signs and/or other objective data):___________________________________
____
____
____

WORK-UPS IN PROGRESS (pertinent pending consultation, pending labs, etc):
____
____
____

CURRENT MEDICATIONS (name; dose/schedule): ______________________________________
____
____
____

ALLERGIES: ____

SPECIAL NEEDS (e.g., disabilities, language, incontinence): _________________________
____
____
____

RECOMMENDATIONS FOR TREATMENT: ____
____
____
____

POTENTIAL CONTACTS:

A: Other clinicians working with patient:

NAME	RELATIONSHIP	PHONE
______________	______________	______________
______________	______________	______________
______________	______________	______________

B. Significant Others:

NAME	RELATIONSHIP	PHONE
______________	______________	______________
______________	______________	______________
______________	______________	______________

FOR PATIENTS BEING TRANSFERRED TO EMERGENCY DEPARTMENT:

IS PATIENT STABLE ON TRANSFER? _______ Y _______ N

HAS E.D. ATTENDING PHYSICIAN BEEN NOTIFIED OF TRANSFER? _______ Y _______ N

WERE REASONS FOR TRANSFER DISCUSSED WITH PATIENT? _______ Y _______ N

WERE REASONS FOR TRANSFER DISCUSSED WITH FACILITY? ___ Y _______ N

WAS PATIENT AND/OR FAMILY IN AGREEMENT WITH TRANSFER? ___ Y _______ N

IF NOT, PLEASE EXPLAIN ____

____
____
____

WAS THERE EMERGENCY TREATMENT TO STABILIZE PATIENT? _______ Y _______ N
(IF THERE WAS EMERGENCY TREATMENT, IT MUST BE DESCRIBED IN DOCUMENTS SENT TO RECEIVING FACILITY)

NAME OF E.D. ATTENDING____

DOES PATIENT HAVE:

A: DNR REQUEST? ___________ Y ___________ N ___________UNKNOWN
B: DNI REQUEST? ___________ Y ___________ N ___________UNKNOWN
C: OTHER ADVANCE DIRECTIVES? _____ Y ___________ N ___________UNKNOWN
D: HEALTH CARE PROXY? _____ Y ___________ N ___________UNKNOWN

TYPE OF ADMISSION: ________ VOLUNTARY __________ INVOLUNTARY

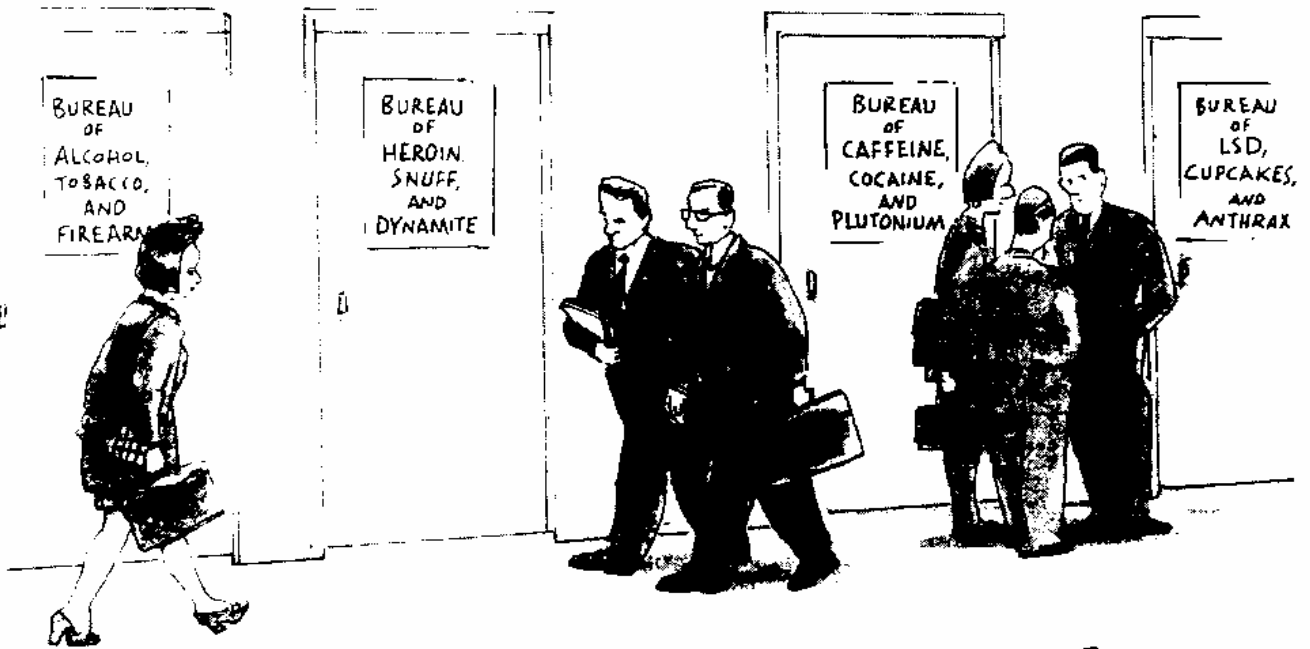
MEANS OF TRANSPORTATION TO RECEIVING FACILITY: ______________________________

LIST ANY DOCUMENTS ATTACHED TO “PATIENT TRANSFER FORM.”

____
____
____
____
____

____
SIGNATURE OF CLINICIAN

____
PRINT NAME


BUREAU OF ALCOHOL, TOBACCO, AND FIREAR
BUREAU OF HEROIN, SNUFF, AND DYNAMITE
BUREAU OF CAFFEINE, COCAINE, AND PLUTONIUM
BUREAU OF LSD, CUPCAKES, AND ANTHRAX
M.K. BROWN