V.A.S.T.
GUIDEBOOK
FOR
PUBLIC HEALTH PROGRAMS AND OFFICES

October 2005

Screening clients for:

Violence, **A**lcohol Abuse, **S**ubstance Abuse, and **T**obacco Use

Table of Contents:

The VAST initiative began in 1998, funded by the New Mexico Department of Health, Public Health Division, Title X Family Planning Program and the U.S. Department of Health and Human Services. Since then, many individuals have dedicated time, knowledge, and commitment to this initiative because they see the effects of violence, alcohol abuse, substance abuse, and tobacco use in their communities. This guidebook is a result of the efforts of these individuals, both from within the Department of Health and from the New Mexico health care community.

Chapter One OVERVIEW OF VAST

The New Mexico Department of Health is engaged in an initiative focusing on four major issues that impact the health and well-being of individuals, families and communities in New Mexico: Violence (family violence and sexual abuse), Alcohol, Substance Abuse and Tobacco use (VAST) are issues that affect many people in our state. An estimated half of the clients seen in the 55 Public Health Offices, programs and contractors in our state are affected by problems related to VAST. The VAST initiative is based on the fact that early detection and intervention can result in reduction of injury, illness and death that is related to family violence, alcoholism, substance abuse and tobacco use and ultimately improve the quality of life for many people in New Mexico.

The vision for the Department of Health initiative is to expand VAST screening to all public health programs and contractors and to provide these guidelines to other public and private providers who may want to implement this initiative. This begins with essential screening questions being asked of clients in all NM Department of Health, Public Health Division, public health offices and programs. Asking standardized screening questions in the areas of VAST will allow the public health workforce first to identify the problem and second, to conduct further assessment and clinical management in our public health settings. It is understood that most public health workers are already engaged in these problems every day in their clinical settings. The purpose of this guidebook is to identify the essential questions and to provide additional guidance for the clinical management once the essential questions have been asked.

VAST Training

This guidebook accompanies training that provides the opportunity for discussion and a better understanding of VAST issues. The training builds on the experiences of public health providers working with these issues and will expand their options and resources to respond to VAST issues.

Throughout the guidebook the term “provider” is used to identify a person who is conducting specific activities related to VAST. For purposes of this guidebook, provider is defined as a nurse, social worker, physician, nurse practitioner, nutritionist or any other health professional that provides services to clients.

Why VAST?

It is estimated that half of public health clients have been raped, battered or physically abused [(1)]. In 2000, New Mexico ranked fourth nationally for violent crimes and reported 757.9 violent crimes per 100,000 inhabitants. Almost half of female homicides in the New Mexico were related to domestic violence [(2)]. In 2002, violent crimes cost over $19.3 million in our state for medical care alone.

Alcohol is the leading cause of death under age 65 in New Mexico. Alcohol contributes to deaths from cirrhosis, motor vehicle crashes, homicide, suicide and some cancers. New Mexico has one of the highest rates of alcohol-related motor vehicle crash fatalities among states, and almost one in four New Mexico teens reports they have driven a car after drinking alcohol during the past year [(3)].

Addiction or chemical dependency is a biochemical response of the brain to addictive substances. Once the response starts, people begin to experience social, psychological and physical changes that interfere with daily functioning. The use of legal substances such as alcohol and prescription drugs contribute to deaths from motor vehicle crashes, alcohol poisoning, cirrhosis, falls, homicide and suicide. Illegal drugs also contribute to morbidity and mortality, with potent drugs such as heroin and cocaine resulting in fatal overdoses.

Illicit drugs cause deaths due to overdose and infections, including HIV and hepatitis C, and contribute to family dysfunction and domestic violence. New Mexico has the highest rates in the nation for deaths due to illicit drug overdose (all illicit drugs combined), heroin overdose, and polysubstance overuse, and the death rate has been climbing faster than the national rate. Illicit drug use among

adolescents sets the stage for negative consequences for the use later in life. While not all illicit drugs are equally harmful, using one type of illicit drug increases the likelihood that other illicit drugs will be used as well [(4)].

Although the lethal effects of tobacco are harder to see, cigarette smoking is the leading cause of lung cancer and heart disease and the second leading cause of premature death in New Mexico (second only to alcohol). Overall, tobacco is the single greatest cause of disease and premature death in America today.

Screening

The statistics create compelling evidence to take action in a clinical setting. Public health and health provider settings should be safe places to identify the people who are affected by these issues, to assess the extent and depth of the problem, and if needed, to assist the individual with the help he or she needs. The identification, assessment and management of VAST issues may occur during one encounter with a client but in some clinical settings, clinicians have the opportunity to build a client relationship over multiple visits. Regardless of the clinical situation, the opportunity exists to identify, assess and manage VAST issues with the client.

Guidebook Format

The content of this guidebook was developed by nurses, physicians, epidemiologists, health promotion specialists, nutritionists and other health professionals committed to strengthening the ability of the clinical workforce to address these critical client issues. These public health professionals offer both practical and evidence-based approaches to address VAST issues.

The purpose of the guidebook is to provide the tools and guidance necessary to address Violence, Alcohol, Substance Abuse and Tobacco issues in the clinical setting. The format for each of these issues is:

- **Background**
- **Definition of the issue**
- **Essential questions to be asked**
- **Follow-up questions and brief interventions**
- **Flowchart for clinical management of the issue**
- **Resources**

Background

Background information about the VAST issue is provided to give context to the topic.

Definitions

Each issue is defined to clarify what is being assessed.

Essential Questions

Essential questions are the few critical questions identified for each public health office/program to ask in the screening of clients. The intention is to have these questions included in all clinical records for public health, and in most cases, will be answered by client "self-report".

Follow-up Questions and Brief Interventions

The *follow-up questions and brief interventions* are developed for use by staff in the clinical setting. These questions and brief interventions are designed to be used by physicians, nurse practitioners, nurses, nutritionists, social workers, and/or other health providers who have an opportunity to discuss the initial screening with the client, may have a relationship with the client, or can use the follow-up questions and brief interventions to further assist the client. It is acknowledged that the work between the client and the provider will depend on

the relationship between them, the client's readiness to discuss the problem and the provider's time in the clinical setting.

There are several stages of change related to tobacco or alcohol use. These stages of change are: pre-contemplation (not ready for a change), contemplation (ambivalence about change), action (the act of change) and maintenance (maintaining the behavior). A provider's awareness of what stage the client may be in should help direct the actions and follow-up by the provider [5]. For clients in the pre-contemplation stage, the single act of discussing the issue may begin the change process.

Flowchart for Clinical Management of the Issue

Flowcharts provide a graphic image of the steps that health providers can follow as they work with clients to identify, assess and clinically manage the problem.

Resources / Referrals

Several resources are mentioned in the flowcharts; however, there are more resources available depending on the location of the clinical setting. Each local setting is encouraged to identify other resources that may be available and to customize the list of resources so it is most useful for their area. Recommended resources for both clients and clinicians can be included in a pocket in the back of the guidebook.

Chapter Two

CLINICAL MANAGEMENT OF VIOLENCE

Background

Violence and its effects take many forms. Primary concerns revolve around patterns of assault or coercive behavior directed at achieving compliance from, or control over, another person. This may take the form of physical, emotional, psychological, economic, and sexual abuse. Most abuse is kept secret and often the victim is forced to maintain secrecy. Abuse affects persons of all ages, genders, races, and across all stratifications of society. It has been reported that one in seven women is raped by her husband[(6)].

Definitions of the Types of Abuse

Physical abuse is the intentional or reckless causation or attempt to cause, bodily injury to another person. This may involve hitting, pinching, shoving, slapping, kicking, choking, smothering, partial drowning, holding or restraining, burning or threatening physical harm. Sometimes weapons such as belts, sticks, ropes, or guns are used. Physical abuse may also include malnutrition or failure to provide needed medical care.

Emotional abuse is defined as the destruction of self-esteem. The perpetrator may use “put downs”, call the person being abused names or make them think that he or she is “crazy”. Abused individuals are also often made to think they are the cause of the perpetrator’s actions or deserve to be punished. The perpetrator may “track” the targeted person all the time and may constantly accuse him or her of being unfaithful. Personal or sentimental items may be destroyed or physical isolation may be used. Relationships with family and friends may be discouraged or prevented, resulting in social isolation.

Economic abuse involves control of resources. The perpetrator may control all the household money or force the person affected to account for all money he or

she spends. The person affected may be prevented from working or his or her paycheck may be taken. Access to transportation may be curtailed. The person affected may not be allowed necessary food, clothing, shelter, transportation, or medical attention.

Domestic violence is also known as domestic abuse or battering. It is defined as the use or threatened use of abuse or mistreatment to control a partner in an intimate or dating relationship. Legally, in New Mexico, abuse is any behavior by a spouse, former spouse, partner, former partner or persons with whom the petitioner has a continuing personal relationship that results in: (a) physical harm, (b) severe emotional distress, (c) bodily injury or assault, (d) imminent fear of bodily injury, (e) trespassing, (f) criminal damage to property, (g) repeatedly driving by residence or work place, (h) telephone harassment, or (i) harm or threatened harm to children.

Family violence is the use or threatened use of abuse or mistreatment to control a family member, a partner in an intimate relationship, or a former partner or family member. This includes abuse of children, parents, grandparents, siblings, and other household or family members, as well as a partner or spouse.

Rape is defined as forced sexual intercourse against an individual's will. Rape includes penetration of the vagina, mouth or anus either sexually or with an object. Sex may be forced when the person is asleep or otherwise physically helpless. One in seven women is raped by her husband [(6)]. The common misperception that "rape is committed by a stranger" is actually a rare occurrence. The perpetrator for women is usually known through dating, partnerships, or marriage or by an acquaintance in a social or employment relationship. Rape frequently occurs in the victim's home and often in "safe" places. The force leading up to the rape is typically a non-physical force and occurs in the form of badgering, harassment, threats, or coercion.

Sexual abuse is the sexual degradation or forced sexual activity (rape) or forcing an individual to perform a sexual activity against his / her will. The perpetrator may force sexual activities in times, places or ways that a person does not want. This may involve hurting the person during sex or using objects or weapons in a woman's vagina, anus or mouth in a painful or objectionable manner during sex. The perpetrator may criticize the person's sexuality or call him or her sexually degrading names. Sexual abuse by a partner is an extremely serious form of marital violence [(7)]. It is often the most difficult aspect of domestic violence for a woman to discuss [(8)].

Sexual molestation is sexual contact, abuse or rape and frequently refers to a child. Sexual molestation of children is usually in the form of incest. The perpetrator for children is usually someone known to the child through blood, legal or social bonds, and is most frequently a father or a father figure.

Stalking is defined as repeated conduct from one individual that poses a threat to another person intended to cause fear or harm. This includes watching or following a victim or placing the victim's home or place of employment under surveillance. There may be threatening phone calls at home or at work. Calls may be made anonymously or in the middle of the night. Written messages or letters may also be used. Sometimes symbolic objects such as a dead animal, a tooth, a bloody bandage, a voodoo doll, a torn photograph, feces or a representation of weapon are sent or displayed to the stalking victim.

Essential Questions

The **essential questions** to assess clients for **violence** are:

1. Has anybody ever hit, kicked, punched, pushed, choked, slapped, threatened, forced sex, sexually abused, raped or otherwise hurt you or your child?
2. Have you ever hit, kicked, punched, pushed, choked, slapped, threatened, forced sex, sexually abused or otherwise hurt anyone?

3. Do you keep a gun in the house? Is it secured so that young people don't have unsupervised access to it [9]?

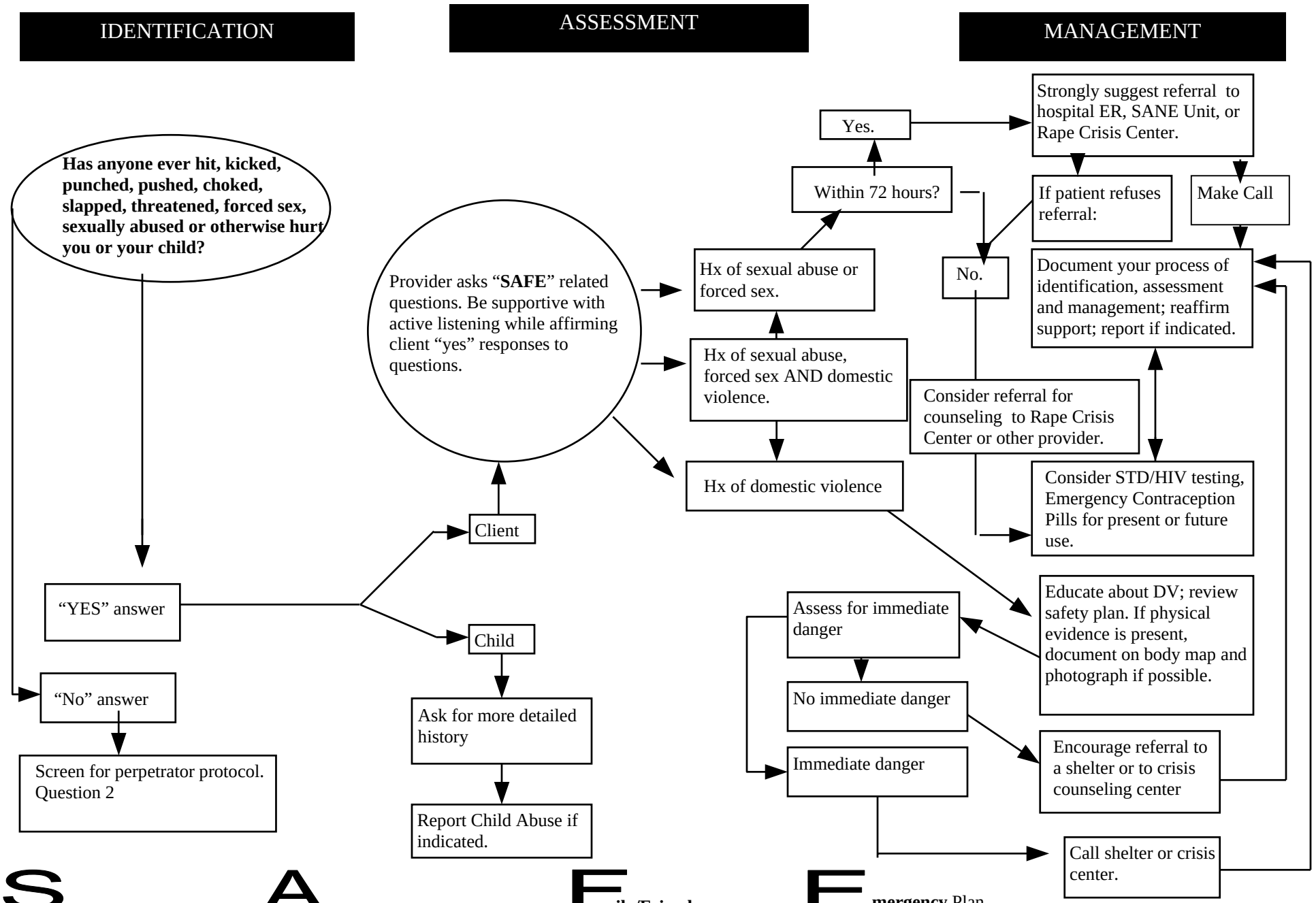
Follow-up Questions and Brief Interventions

If the client answers yes to *essential question 1*, then use the follow-up questions and brief interventions identified in Violence Flowchart Question #1 (Figure 1)[9].

If the client answers yes to *essential question 2*, then use the follow-up questions and brief interventions identified in Violence Perpetrator Flowchart (Figure 2) [9].

If the client answers yes to *essential question 3,* then the provider should discuss gun safety locks and safe practices.

Violence Victim Flowchart



Stress/ Safety
Do you experience a lot of stress in your relationship? Should I be concerned for your safety?

Afraid/Abuse
Are you afraid of your partner? Has he/she ever abused you in any way?

Family/Friends
Are your family and friends aware of the situation? Is there someone you can confide in? Who is your source of support?

Emergency Plan
Do you have an emergency plan to use when things get really difficult? Do your children know how to dial 911?

Figure 1

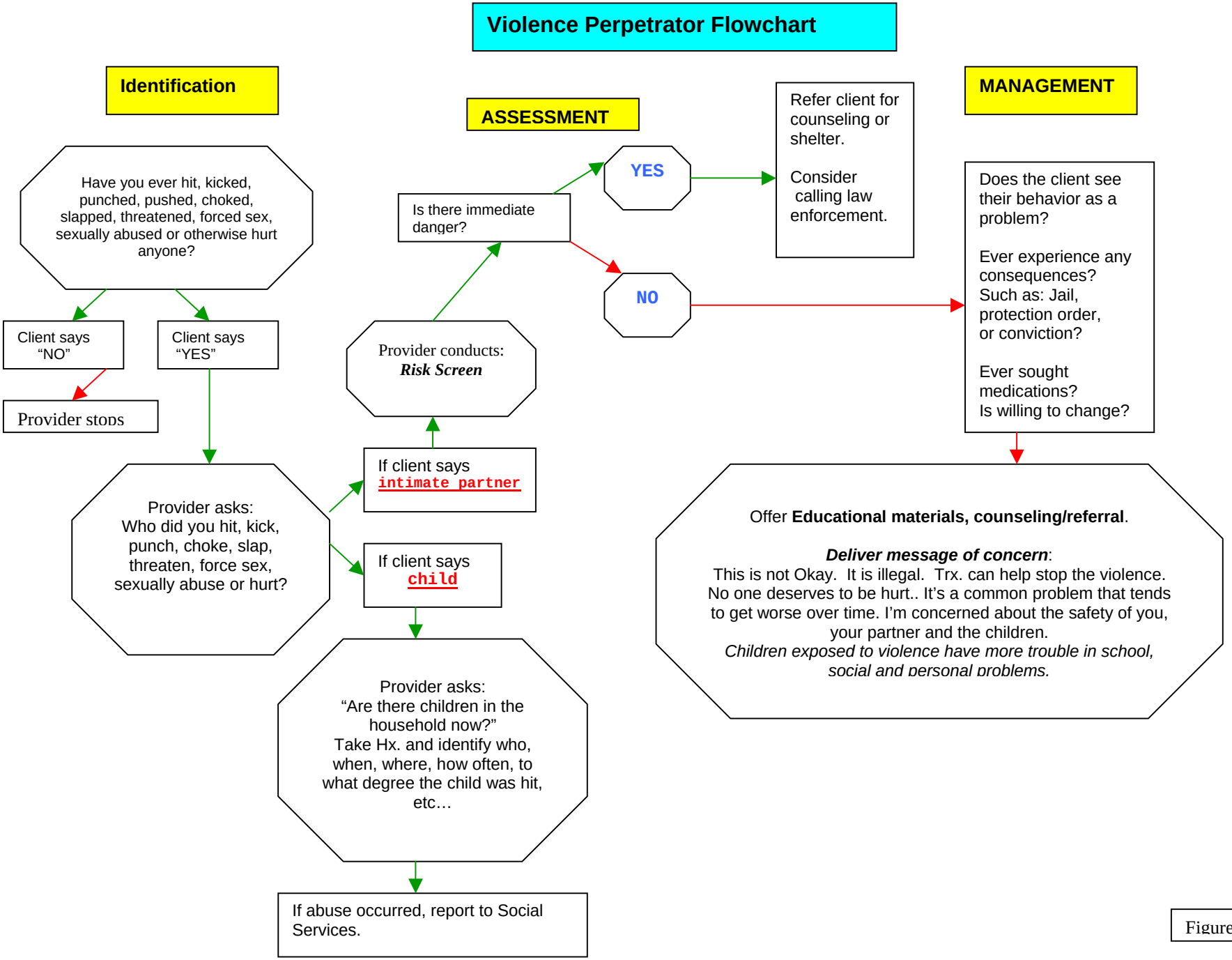

Violence Perpetrator Flowchart
Identification
ASSESSMENT
MANAGEMENT
Have you ever hit, kicked, punched, pushed, choked, slapped, threatened, forced sex, sexually abused or otherwise hurt anyone?
Client says "NO"
Client says "YES"
Provider stops
Provider asks: Who did you hit, kick, punch, choke, slap, threaten, force sex, sexually abuse or hurt?
If client says intimate partner
If client says child
Provider conducts: Risk Screen
Is there immediate danger?
YES
NO
Refer client for counseling or shelter.
Consider calling law enforcement.
Does the client see their behavior as a problem?
Ever experience any consequences? Such as: Jail, protection order, or conviction?
Ever sought medications?
Is willing to change?
Offer Educational materials, counseling/referral.
Deliver message of concern:
This is not Okay. It is illegal. Trx. can help stop the violence. No one deserves to be hurt.. It's a common problem that tends to get worse over time. I'm concerned about the safety of you, your partner and the children.
Children exposed to violence have more trouble in school, social and personal problems.
Provider asks: "Are there children in the household now?" Take Hx. and identify who, when, where, how often, to what degree the child was hit, etc…
If abuse occurred, report to Social Services.

Figure 2

Chapter Three CLINICAL MANAGEMENT OF ALCOHOL

Background

It is estimated that two-thirds of American men and one-half of American women drink alcohol [10] with three-fourths of drinkers experiencing no serious consequences from alcohol use [11]. However, abusive drinking patterns and behaviors may place people at increased risk for adverse health effects (e.g., drinking and driving, drinking while pregnant). Both low risk drinkers and high risk drinkers should be aware of the health risks associated with alcohol consumption.

Evidence shows that many drinkers reduce their drinking without formal treatment after personal reflection on the negative consequences of drinking [13]. Public health providers may assist clients who drink in risky ways, abuse or are dependent on alcohol by making them aware of their potential problem by asking questions. Once the awareness is created it is then possible to begin moving them toward healthier choices regarding their alcohol consumption. Several studies have demonstrated that early, brief interventions lead to a reduction in alcohol consumption and an improvement in alcohol related problems [14, 15].

The Surgeon General has stated that there is not a safe level of alcohol consumption during pregnancy. All alcohol consumed by the mother crosses the placenta and circulates to the fetus. Fetal metabolism and elimination of alcohol are slower and the amniotic fluid itself becomes a reservoir of alcohol. Heavy drinking can cause infants to be born with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE). FAS is the leading cause of mental retardation in the western world. It exceeds Down's syndrome and cerebral palsy. In the NM Department of Health, Substance Use Among Childbearing Age Females Study (SUCAF), 31 public and private participating clinics reported as many as 37% of pregnant women were current users of alcohol.

Clients should also be advised to abstain from alcohol when:

- Pregnant or considering pregnancy
- Taking medications that interact with alcohol
- Alcohol dependent
- A contraindicated medical condition is present (e.g., ulcer, liver disease) [12]

Definition

Moderate drinking has been defined by the National Institute on Alcoholism and Alcohol Abuse as:

- Men-no more than two drinks per day
- Women-no more than one drink per day
- Over 65-no more than one drink per day

A standard drink is defined as 12 grams of pure alcohol, which is equal to one 12 ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits [12].

The following definitions are provided to assist the reader to distinguish between alcohol abuse and dependence as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed, (DSM-IV)* [15].

Alcohol Abuse

A. A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions or expulsions from school; neglect of children or household).

2. Recurrent alcohol use on situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol use).
3. Recurrent alcohol-related legal problems (e.g., arrest for alcohol-related disorderly conduct).
4. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about consequences of intoxication, physical fights).

Alcohol Dependence

A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of alcohol to achieve intoxication or the desired effect.
   b. Markedly diminished effect with continued use of the same amount of alcohol.
2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome several hours to a few days following cessation (two or more of the following): automatic hyperactivity (e.g., sweating or pulse rate greater than 100); increased hand tremor; insomnia; nausea or vomiting; transient visual, tactile or auditory hallucinations or illusions; psychomotor agitation; anxiety or grand mal seizures.
   b. Alcohol or other substances are taken to relieve or avoid withdrawal symptoms.
3. Alcohol is taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control drinking.
5. A great deal of time is spent to obtain alcohol, or recover from its effects.
6. Important social, occupational or recreational activities are given up or reduced because of drinking alcohol.
7. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

Essential Questions

The **essential questions** to assess clients for **alcohol** use are:

1. Do you drink alcohol, including beer, wine or distilled spirits?
2. On average, how many days per week do you drink alcohol?
3. On a typical day when you drink, how many drinks do you have?
4. What is the maximum number or drinks have you had on any given occasion during the last month? [16]

Follow-up Questions and Brief Interventions

If the client does drink alcohol, then the clinician asks the **CAGE** questions to screen for alcohol abuse or dependence:

1. Have you ever felt that you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye openers)?

If there is a positive response to any of these questions, the clinician should ask if this has occurred in the past year. The client may be at risk for alcohol-related problems if the client has one or more positive responses to the CAGE questions

[12]. See the follow-up questions and brief interventions in the Alcohol Flowchart (Figure 3) [16].

RESOURCES/REFERRALS

Often a good assessment, discussing the alcohol use itself with a client is an intervention and will prompt a client to think about drinking behavior.
The severity of the alcohol problem and the client's readiness to change will determine the appropriate referral (if any) for the client [12].

Clients with evidence of alcohol dependence, if ready for intervention, should be referred to an alcohol treatment program.

Peer directed groups such as Alcoholic Anonymous and Al-Anon can be useful for adult family members with alcohol-dependent family members.

Alcohol Use Flowchart

Identification

Do you drink alcohol, including beer, wine or distilled spirits?

NO → Stop

Yes → On average, how many days per week do you drink alcohol?

On a typical day when you drink, how many drinks do you have? What is the maximum number of drinks you have had on any given occasion during the last month?

Continue with CAGE questions:

Assessment

High Risk Groups that automatically qualify as a positive screen:
If client is under 18, pregnant, elderly, has a medical condition that is affected by alcohol, or by using drugs that interact or altered by alcohol.

Management

A conversation about the effects of alcohol with at risk, or abusing clients can prompt a client to think about and potentially alter their behavior.

Severity of Problem	Criteria
At Risk	Men: > 14 drinks per week, > 4 drinks per occasion Women:> 7 drinks per week, > 3 drinks per occasion 1 positive response to a CAGE that have occurred in the past year or personal or family hx. of alcohol-related problem.
Current Problem (Equivalent to abuse)	2 positive responses to CAGE that have occurred in the past year, or Alcohol-related medical problems, or Alcohol-related family, legal or employment problems.
Alcohol Dependent	3 or 4 positive responses to CAGE that have occurred in the past year, or compulsion to drink, or increased tolerance.

Information adapted from The Physician's Guide to Helping Patients with Alcohol Problems. U.S. Department of Health and Human Services, Public Health Services, National Institute of Health, National Institute on Alcohol Abuse and Alcoholism, 1995; NIH publication no. 95-3769.

If clients with dependence are ready for intervention, refer to an alcohol treatment program.

C — Have you ever felt you should Cut down on your drinking?

A — Have people Annoyed you by criticizing your drinking?

G — Have your ever felt Guilty about your drinking?

E — Have your ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (Eye openers)?

Figure 3

Chapter Four

CLINICAL MANAGEMENT OF SUBSTANCE ABUSE

Background

People use drugs because they like the way drugs make them feel. People have control over when they start to use drugs but the effects of drugs may keep them using, resulting in addiction. Addiction is a disease that affects a person's brain and behavior. Substance abuse and addiction can refer to alcohol, tobacco, prescription drugs and illicit drugs. For purposes of VAST, this section refers to the use of prescription and illicit drugs.

Definition

The following adapted definitions are provided to assist the reader to distinguish between substance abuse and dependence as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed, (DSM-IV)* [15].

Substance Abuse

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home.
2. Recurrent substance use in situations in which it is physically hazardous.
3. Recurrent substance-related legal problems.
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts to achieve intoxication or the desired effect.
    b. Markedly diminished effect with continued use of the same amount.
2. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the substance is present.
    b. The same (or closely related) substance is taken to relieve or avoid withdrawal.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Essential Questions

The **essential questions** for assessing drug use and **substance abuse** are [17]:

1. Which of these drugs have you used in the last year: Pot, heroin, cocaine, inhalants, amphetamines, crack, estacy, steroids, GHB or any other drugs?

2. Have you ever injected drugs?
3. Do you misuse any medications?

Follow-up Questions and Brief Interventions

Clinician Follow-up Questions/Brief Interventions

1. Does your drug use interfere with your school, work or relationships?
2. Are you aware of the health risks?

These follow-up questions and brief interventions are illustrated in Figure 4 on the Substance Abuse Flowchart [17].

REFERRALS / RESOURCES

Skager, Rodney and Rosenbaum, Marsha, **"**Getting REAL about Teens and Drugs", Safety First. For more information: www.safety1st.org or Rodney Skager at 831-484-2767.

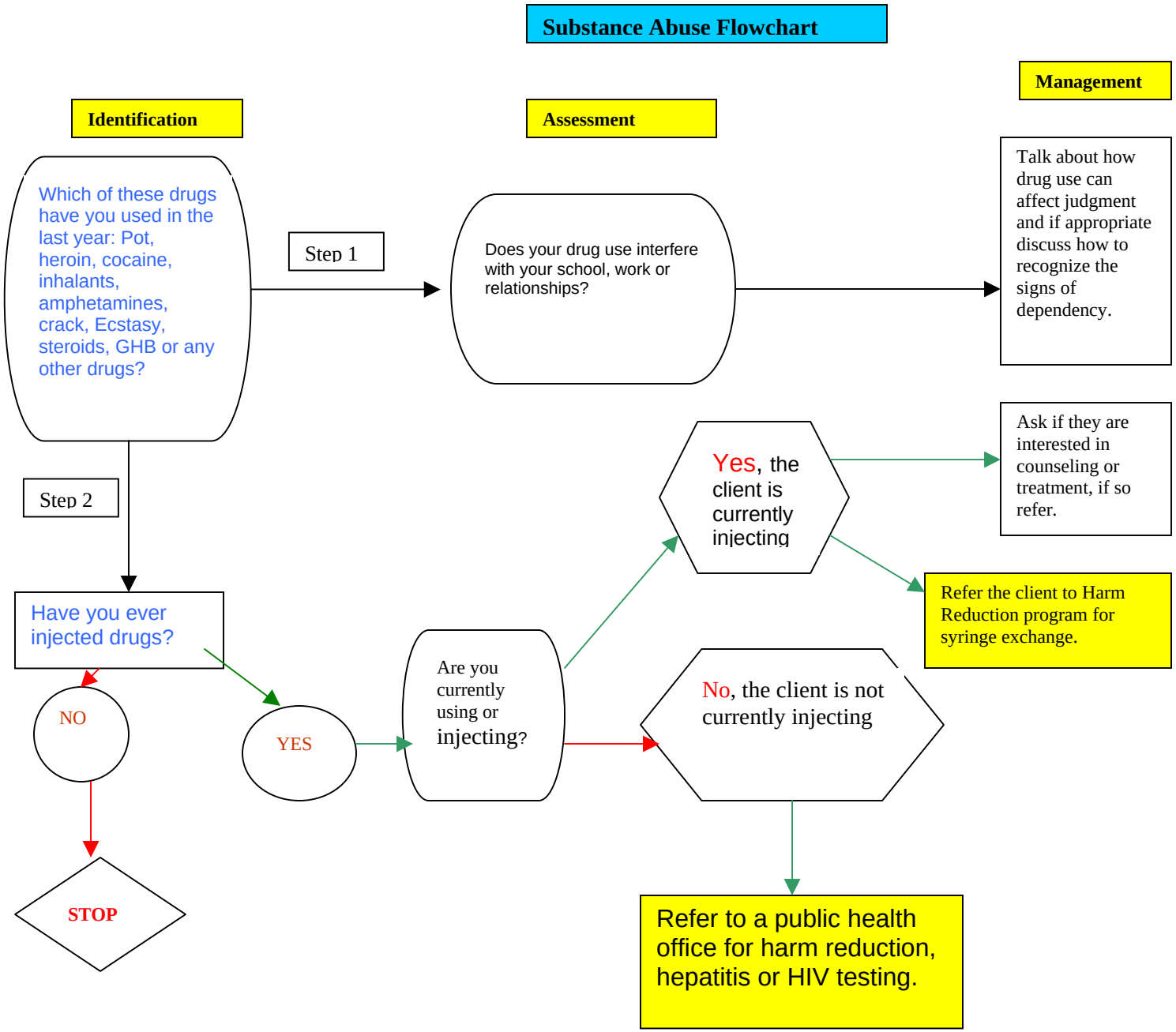

Substance Abuse Flowchart
Identification
Assessment
Management
Which of these drugs have you used in the last year: Pot, heroin, cocaine, inhalants, amphetamines, crack, Ecstasy, steroids, GHB or any other drugs?
Step 1
Does your drug use interfere with your school, work or relationships?
Talk about how drug use can affect judgment and if appropriate discuss how to recognize the signs of dependency.
Step 2
Have you ever injected drugs?
NO
YES
Are you currently using or injecting?
Yes, the client is currently injecting
Ask if they are interested in counseling or treatment, if so refer.
Refer the client to Harm Reduction program for syringe exchange.
No, the client is not currently injecting
STOP
Refer to a public health office for harm reduction, hepatitis or HIV testing.

Figure 4

Chapter Five CLINICAL MANAGEMENT OF TOBACCO

Background

Tobacco use remains the single greatest cause of disease and premature death in America today. It is estimated that tobacco use is responsible for more than 430,000 deaths each year. Nearly 25 percent of adults in America currently smoke and 3,000 children and adolescents become regular users of tobacco every day. The most important step to address tobacco use and dependence is screening for tobacco use. Once tobacco use is identified, the health-care provider is able to assess the individual's readiness to quit and provide more information on cessation [18].

Definition

The use of tobacco products results in physical and psychological dependency. Tobacco products include cigarettes, cigars, chewing tobacco, pipes and any other tobacco product.

Essential Questions [19]

1. Do you smoke? If yes, how much?
2. Do you use tobacco products in any form? If yes, what?
3. Are you exposed to the smoke of others?

Follow-up Questions and Brief Interventions

1. If yes to any of the questions, then discuss the risk factors of tobacco and the exposure to secondhand smoke especially with children in the home. Offer the 1-800-QUITNOW resource number. [(800) 784-8669]
2. Assess whether client is willing to quit.
   If yes, provide information on cessation.
   If no, use the 5 R's Relevance, Risk, Rewards, Roadblocks, and Repetition.

These follow-up questions and brief interventions are illustrated in Figure 5 on the Tobacco Flowchart [19].

PROMOTE MOTIVATION TO QUIT:

The "5 R's", *Relevance, Risk, Rewards, Roadblocks, and Repetition,* are designed to motivate smokers who are unwilling to quit at this time. Smokers may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising the smoker to quit, and assisting the willingness of the smoker to quit, it is important to provide the "5 R's" motivational intervention.

Relevance: Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks: The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low tar/low nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks.

Rewards: The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient.

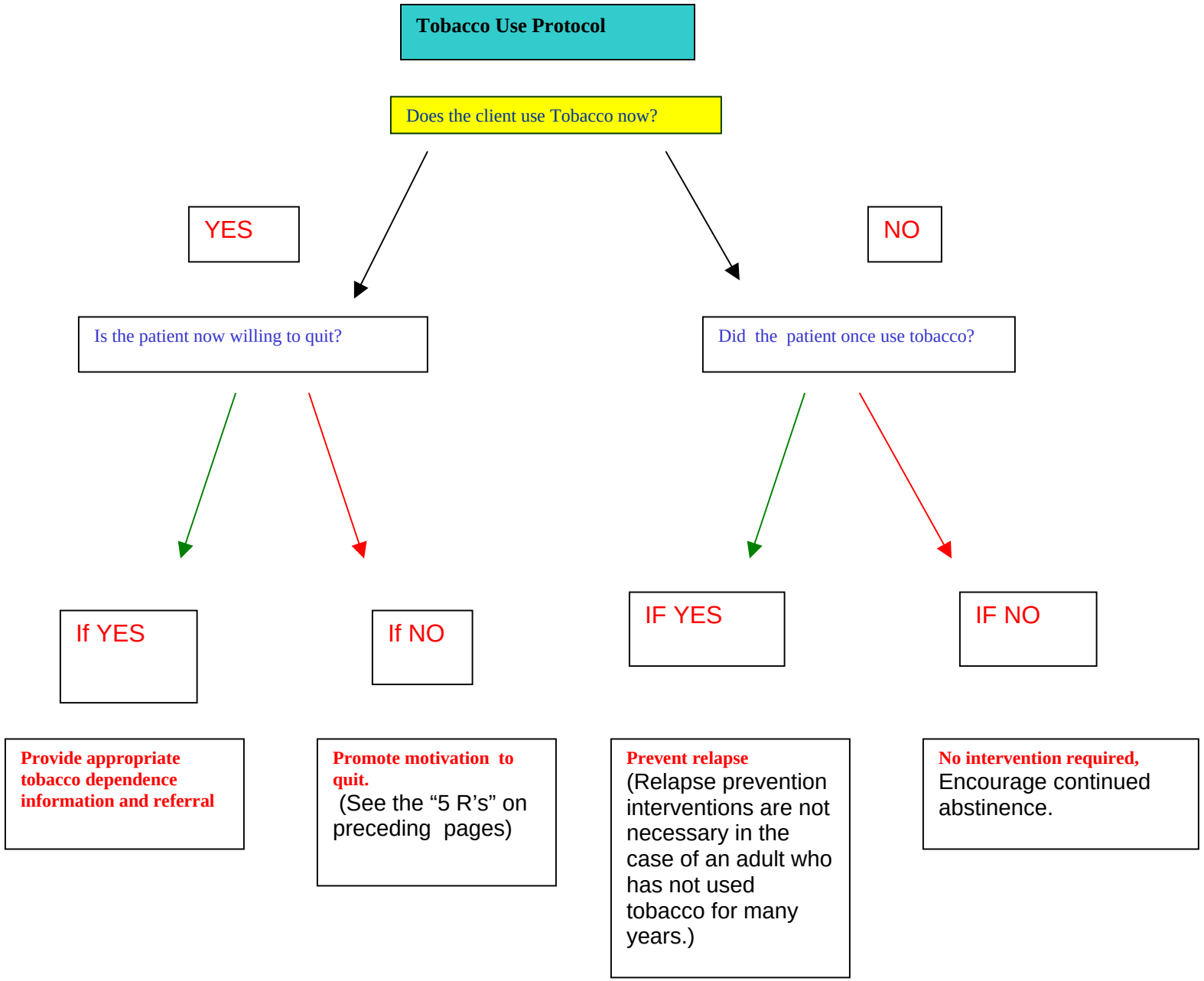
Roadblocks: The clinician should ask the patient to identify barriers or impediments to quitting and note elements of treatment.

Repetition: The motivational interventions should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in

previous attempts should be told that most people make repeated quit attempts before they are successful.

RESOURCES/REFERRALS

U.S. Department of Health and Human Services, Public Health Service, “Quick Reference Guide for Clinicians: Treating Tobacco Use and Dependence, October 2000.


Tobacco Use Protocol
Does the client use Tobacco now?
YES
NO
Is the patient now willing to quit?
Did the patient once use tobacco?
If YES
If NO
IF YES
IF NO
Provide appropriate tobacco dependence information and referral
Promote motivation to quit.
(See the "5 R's" on preceding pages)
Prevent relapse
(Relapse prevention interventions are not necessary in the case of an adult who has not used tobacco for many years.)
No intervention required,
Encourage continued abstinence.

Chapter Six DEPRESSION

Background

It is estimated that about 450 million people around the world have mental or psychosocial problems. Unfortunately, many who seek health services for help may not be correctly assessed, diagnosed, and treated [17]. Depression relates to the issues of violence, alcohol, substance abuse and tobacco and was discussed in the meetings convened to look at VAST issues. While the VAST committee is not recommending required depression screening questions at this time, information on depression is included for provider reference.

Definition

This definition is adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed, (DSM-IV)* [15].

1. Major Depressive Episode

A. Less than 5 symptoms present during the same 2-weeks and represent a change from previous functioning; 1 of the symptoms is either (1) depressed mood or (2) anhedonia, the inability to experience pleasure
(Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.)

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, this may also be expressed through irritability.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

Note:

In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not just subjective feelings of restlessness or slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for suicide

B. The symptoms do not meet criteria for a Mixed Episode (see DSM-IV).

C. The symptoms cause clinically significant distress or impairment in functioning.

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

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or

psychomotor retardation.

Screening

The U.S. Preventive Task Force has recommended that all adults be screened for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up. The questions recommended by the Task Force are:

1. Over the past 2 weeks, have you felt down, depressed, or hopeless?
2. Over the past 2 weeks, have you felt little interest or pleasure in doing things?

.

Chapter 7 DOCUMENTATION

There is a need to identify whether or not a VAST screen was performed with the client. To complete a VAST screen, questions must be asked in all four areas of Violence, Alcohol Use, Substance Abuse, and Tobacco to be considered a comprehensive screen. The screening questions are the essential questions identified for each of the VAST areas. The only information that is recorded on the encounter form is whether or not the client was VAST screened. *Results are not recorded on the encounter form.*

The client will answer the required essential VAST questions as a self report on the clinical record. Only information on whether a screening was done should be captured in INPHORM.

In summary, the essential questions for all public clients to answer are:

VIOLENCE

1. Has anybody ever hit, kicked, punched, pushed, choked, slapped, threatened, forced sex, sexually abused, raped or otherwise hurt you or your child?
2. Have you ever hit, kicked, punched, pushed, choked, slapped, threatened, forced sex, sexually abused or otherwise hurt anyone?
3. Do you keep a gun in the house and is it properly secured so that young people don't have unsupervised access to it?

ALCOHOL

1. Do you drink alcohol, including beer, wine or distilled spirits?
2. On average, how many days per week do you drink alcohol?
3. On a typical day when you drink, how many drinks to you have?
4. What is the maximum number or drinks you have on any given occasion during the last month?

SUBSTANCE ABUSE

1. Which of these drugs have you used in the last year? Pot, heroin, cocaine, inhalants, amphetamines, crack, estacy or any others?
2. Do you misuse any medications?
3. Have you ever injected drugs? If yes, when?

TOBACCO

1. Do you smoke? If yes, how much?
2. Do you use tobacco products in may form? If yes, what?
3. Are you exposed to the smoke of others?

At this time, depression is not a required screening.

Documentation of a VAST Screen in INPHORM

When all the VAST screening questions have been answered on the clinical record, then "VAST Screened" is documented in INPHORM as follows:
On the encounter form: (in the first column on the Clinical Encounter Form 2001) Select Procedure-VAST Screened (XX)- mark with the subprogram in which the client is being seen for services today.

SP	**Procedures**			
	Clinical Breast Exam	G0101	$0.00	
	Vasectomy	55250	$350.00	
(XX)	VAST Screened	99420	$0.00	

In the computer—INPHORM main---Encounters

1. Add a Detail to the existing Encounter for the Client's visit
2. Select Procedure Code 99420 on the Procedure Details tab

3. Enter the remainder of the required information
4. Save the client record.

Narrative Documentation

The provider will review the client's answers to the self-reported questions. Upon review, the provider will ask follow-up questions and conduct brief interventions as needed. This information needs to be documented. Documentation of information from the follow-up questions and brief interventions are to be recorded in the narrative section of the clinical record. This documentation is important to maintain a record of the client / provider discussions, to document significant findings, information provided or referrals given to the client. It is this documentation that will also provide important information to other providers in public health who see the client and help promote communication between providers and programs.

RESOURCES/REFERRALS

Resources for provider and client use can be located in the pocket of the VAST Guidebook.

Chapter 8 LOCAL PUBLIC HEALTH OFFICE / PROGRAM REFERRAL SYSTEM

As stated before, the intent is to have the essential screening questions asked in all programs and in all public health offices. Then the information that a VAST screen was done is to be entered into the INPHORM encounter form. The next step, follow-up questions and brief interventions need to be done by a provider. This may be a nurse, nutritionist, nurse practitioner, physician or social worker to name a few. The person will depend on the resources within the public health office. Therefore, a system needs to be developed in each local public health office to conduct the appropriate client follow-up and documentation.

System Development

To develop the system in the local public health office the following questions need to be asked resulting in a written plan.

1. List all the clinics and programs in the public health office in which a client will complete the clinical history form and, subsequently, answer all the essential VAST screening questions.
2. Discuss as an office who will review the clinical history form and identify if further follow-up and/or brief interventions are necessary.
3. Identify the person in each of these clinics or programs who will be trained to ask the follow-up questions and apply the brief interventions as appropriate.
4. Discuss as an office what system will work to have the client spend time with the provider when follow-up is indicated.

Chapter 9 ASSURANCES FOR VAST IMPLEMENTATION

Implementing the VAST initiative in all public health offices and programs requires a complete understanding of what is required. The following checklist is intended to inform and support the effort for complete VAST implementation. As desired, quality assurance measures could be developed to inform the local, district or state office or program about the progress of VAST implementation.

Key Implementation Questions

1. Are all the essential screening questions written on the clinical record form?
2. Have providers participated in training to further their understanding and familiarity of the follow-up questions and brief interventions for VAST? Including:

   Violence: Knows SAFE questions

   Alcohol: Knows CAGE questions and can begin to distinguish between alcohol abuse and misuse and alcohol addiction

   Substance Abuse: Understand the difference between abuse and dependence

   Tobacco: Knows the 5 R's: Relevance, Risk, Rewards, Roadblocks and Repetition
3. Has the local public office developed a plan to determine how clients in all programs will have the opportunity to talk to a provider so follow-up questions and brief interventions can be implemented?

BIBLIOGRAPHY

1. New Mexico Crime Rates 1960-2000. http://www.disastercenter.com/crime/nmcrimn.htm
2. Caponera, Betty. State of New Mexico, Injury Prevention and EMS Bureau, Department of Health. Incidence and Nature of Domestic Violence in New Mexico IV: An Analysis of 2002 Data from the New Mexico Interpersonal Violence Data Central Repository, June 2003.
3. The State of Health in New Mexico: 2000 Report.
4. The National Center on Addiction and Substance Abuse, Columbia University, Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use, October 1994.
5. Burge, Sandra and Schneider, F. David. Alcohol-Related Problems: Recognition and Intervention, University of Texas Heath Science Center, San Antonio, Texas, American Academy of Family Physicians, January 15, 1999.
6. Massachusetts Coalition of Battered Women Service Groups, Inc. For Shelter and Beyond: Ending Violence Against Battered Women and Their Children. 2nd ed. Boston: Massachusetts Coalition of Battered Women Service Groups, Inc., 1990.
7. Levy, Barrie, In Love and In Danger: A Teen's Guide to Breaking Free of Abusive Relationships, Seal Press, Seattle, WA, 1993.
8. Sonkin, Daniel Jay, Durphy, Michael, Learning to Live Without Violence: A Handbook for Men , Volcano Press, Volcano CA, 1989.
9. Violence Subcommittee of the VAST Steering Committee, November 2002.
10. Eighth special report to the U.S. Congress on alcohol and health from the Secretary of Health and Human Services. Rockville, Md.: Department of Health and Human Services, National Institutes of Health, National Institute of Alcohol Abuse and Alcoholism, 1994; DHHS publication no. 94-3699.

11. Regier, DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, et al. Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study JAMA 1990:264:2511-8.
12. U.S. Department of Health and Human Services, Public Health Service, National Institute on Alcohol Abuse and Alcoholism, The Physicians' Guide to Helping Patients With Alcohol Problems.
13. WHO Brief Intervention Study Group. A cross-national trial of brief intervention with heavy drinkers. Am J Public Health 1996;86:948-55.
14. O'Connor PG. The general internist. Supplement 1: identification and treatment of substance abuse in primary care settings. Am J Addict 1996;5:89-S19.
15. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington D.C.: American Psychiatric Association, 1994.
16. Alcohol Subcommittee of the VAST Steering Committee, November 2002.
17. Substance Abuse Subcommittee of the VAST Steering Committee, November 2002.
18. Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services, Public Health Services, October 2000.
19. Tobacco Subcommittee of the VAST Steering Committee, November 2002.
20. World Health Organization. World health report 2001: mental health: new understanding, new hope. Geneva: WHO, 2001.

Funded by the New Mexico Department of Health, Public Health Division, Title X Family Planning Program and by the U.S. Department of Health and Human Services.