



Northeast Behavioral Health Clinical Practice Guidelines

PRODUCED THROUGH THE COLLABORATIVE EFFORTS OF
NORTH RANGE BEHAVIORAL HEALTH,
LARIMER CENTER FOR MENTAL HEALTH,
AND CENTENNIAL MENTAL HEALTH

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STATEMENT OF INTENT

The clinical practice guidelines contained in this document were adopted to provide clinicians who are credentialed through Northeast Behavioral Health with practice parameters for evidence-based clinical practices. The intent of these guidelines is to assist in the delivery of high quality, strengths-based, culturally competent, clinical services; as well as to promote the delivery of consistent clinical care.

These practice guidelines should be considered guidelines only. They are aspirational in intent, and they are intended to facilitate the continued systematic development of client-directed and client-focused treatment interventions. These guidelines are not intended to be mandatory or exhaustive, they are not definitive, and they are not intended to take precedence over sound clinical judgment. They should not be viewed upon as including all effective treatment interventions, or as excluding other acceptable methods of treatment. Adherence to these guidelines does not ensure successful outcomes. The guidelines were not generated to limit the individualization of treatment or the ability of the clinician to provide treatment in the best interests of the client.

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision (DSM-IV-TR) was utilized in the development of these practice guidelines. It is recognized that problem/symptom presentation does not always meet clear DSM-IV-TR diagnostic criteria, and responses to interventions are not uniform. All clinical interventions require client input and client decision making, and all interventions require the clinician to adapt a treatment program individualized for each client.

The clinical practice guidelines contained in this document are based on evolving scientific research, the current knowledge base of mental health organizations, and the current consensus of clinical experts and seasoned clinicians. We expect that knowledge and practices in the area of mental health treatment will change over time; hence, these practice guidelines will be reviewed and updated periodically.

PRACTICE GUIDELINE DEVELOPMENT

Typically, clinical practice guidelines are systematically-developed consensus statements designed to assist health professionals in their decision-making about appropriate treatments for specific problems. They provide mental health practitioners, consumers and advocates with evidence-based information about particular mental illnesses and appropriate treatment options. NBH practice guidelines include the usual clinical practice guidelines and extend them to include all aspects of how consumers are treated - from their first contact with providers to the time they no longer need services.

Thus, NBH conceptualizes practice guidelines on two levels. The first level addresses how consumers are treated as they enter the NBH system and sets practice guidelines for the basic clinical and non-clinical services furnished to almost all consumers. The second level proposes specific services to meet the special needs of individual consumers and/or groups of consumers.

The NBH guidelines are not fixed protocols that must be followed, but rather descriptions of generally recommended courses of assessment and intervention. They present commonly accepted procedures for the treatment of various classes of mental illness against which service plans are compared during the authorization process.

Because clinical practice guidelines can neither address the unique needs of each consumer nor the combination of resources available to a particular consumer, community or mental health care professional, variations on clinical practice guidelines may be justified by individual circumstances.

The process followed by NBH in adopting practice guidelines is fully consistent with the requirements of the Mental Health Program contract and federal managed care regulations regarding this topic. As required, Practice Guidelines are:

1. Based on valid and reliable clinical evidence or a consensus of health care professionals in the field

The "References and Resources" pages for each guideline cite the empirical and expert-based sources. In addition, the acknowledgement page of this document identifies the professional and consumer/family contributors.

2. Consider the needs of NBH Members

The needs of NBH consumers as they relate to the clinical practice guidelines were considered by utilizing data to determine in the most commonly occurring diagnoses for the children/adolescent and adult populations.

3. Were adopted in consultation with NBH providers

The NBH QI and the Practice Guidelines committees include providers from the three of the comprising agencies (North Range Behavioral Health, Larimer Center for Mental Health, and Centennial Mental Health). Addition, the QI committees, clinical experts, external providers, and consumers from within each agency were given the opportunity to review the guidelines and provide input prior to adoption of the guidelines.

4. Are reviewed and updated as appropriate

- › The NBH QI Plan makes provision for the annual review of the clinical practice guidelines.
- › Practice guidelines are routinely disseminated to all affected Providers. They are available at no cost to enrolled consumers upon request and to the public at a minimal fee.
- › The Quality Improvement Committee monitors the activities of the Department of Utilization Management, the Office of Consumer and Family Affairs and reviews individual consumer charts to assure that practices are consistent with the guidelines.

GUIDELINES FOR MENTAL HEALTH TREATMENT

PHILOSOPHY OF TREATMENT

Northeast Behavioral Health endeavors to provide strengths-based culturally competent mental health services to reduce or eliminate the impact of mental illness and to restore or enhance the individual's functional capacity. These goals are achieved through a variety of treatment modalities which include but are not limited to psychological, physiological, and social interventions.

GENERAL GUIDELINES FOR MENTAL HEALTH TREATMENT

1. Treatment and services are respectful of client preferences, goals, rights, and safety.
2. Family members and significant others should be encouraged to participate in this process whenever appropriate and possible.
3. Services are recovery and empowerment based whenever appropriate and possible.
4. Education about the illness and treatment options is an important part of treatment. Information should be provided about the illness and treatment approach options, as well as opportunities to discuss the information.
5. The goals of interventions are to optimize functioning in roles of the client's choice within their family and community.

GUIDELINES FOR MENTAL HEALTH TREATMENT OF YOUTH

1. Treat youth where they live. Treatment of emotionally disturbed youth is most effectively accomplished within the youth's family and within the youth's home community when the necessary resources are available, or can be acquired, to achieve the goals of treatment. A key to effective treatment is the support and strengthening of the family and community in which the youth lives.
2. Involve all aspects of a youth's life in treatment. All systems in which the youth participates should be considered in assessment and treatment.
3. Adapt treatment to account for the individual differences among youth. The assessment and treatment of youth should be consistent with the unique characteristics of the youth and family.
4. Treat youth using a variety of interventions. These include individual and family psychotherapy and education; participation in therapeutic groups, normalizing life activities; the mobilization of community resources; and the involvement of a variety of support systems.

Inpatient/residential services are viable options for severely dysfunctional youth when family and community support/resources are exhausted.

5. A team is better. The treatment of youth is very complex and the clinical picture may change frequently. Therefore, a team approach to treatment is preferable, with the family as a full partner.
6. The goal of treatment is functionality. The goal of mental health treatment is for the youth to successfully function within a variety of age appropriate life roles.
7. Prevention is best. Since success in later life roles is supported by a foundation of success in earlier life roles, intervention at the earliest opportunity in a youth's life is the best treatment approach.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER

CHILDREN

ASSESSMENT GUIDELINES

Assessment Considerations

1. Diagnosis must be based upon established diagnostic criteria as detailed in the most current Diagnostic and Statistic Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
2. School performance is important to assess, including history of behavior, learning, attendance, grades, and test scores. Observation of the youth and teacher in the school environment may provide important information.
3. A medical evaluation may assist in determining the presence of physical factors that may be causing or contributing to ADHD symptoms, such as impaired vision or hearing, malnutrition, primary sleep disorder, seizures or head trauma, genetic disorders and toxic brain syndromes (e.g., in utero alcohol exposure).
4. Differential diagnosis is important because the symptoms of ADHD are similar to other disorders of childhood including responses to trauma, Anxiety Disorders, Oppositional Defiant Disorder, Bipolar Disorder, Autistic Spectrum and Pervasive Developmental Disorders, Mental Retardation, Brain Injuries and Central Nervous System Disorders. Environmental factors such as chronic family discord and/or inappropriate academic placement may also result in behaviors which mimic ADHD.
5. Substance abuse/dependence should be evaluated as a possible cause of ADHD symptomology or as a secondary diagnosis. Substance use/dependence should be re-assessed every 6-months.
6. The diagnosis of ADHD is based on current DSM criteria, with symptoms that occur in more than one setting and evidence of functional impairment in daily living.
7. The diagnosis of ADHD should come from a synthesis of information gathered from parents/primary caretakers, school reports, and an interview of the child.
8. The use of standardized rating scales from multiple informants is highly desirable.
9. Early onset mania or a bipolar mixed state may be hard to distinguish from ADHD, although ADHD is likely to have an earlier onset, sustained clinical course, and a family history of attention disorders.
10. Core symptoms of ADHD (inattention, impulsivity, and/or hyperactivity) must be evident before age seven; a careful history should be gathered to determine this.

Initial Assessment

The goal of the assessment is to clarify diagnosis and determine the severity of functional impairment (e.g., mild, moderate, or severe). The following should be helpful in determining appropriate treatment interventions.

1. Interview parents/guardians. During the interview:
 - establish the presence of the primary symptoms of the disorder,
 - determine the age of onset, and the relative stability of these symptoms over time and across at least two different settings,
 - assess developmental, family, academic, medical, and family psychiatric and substance abuse histories,
 - assess the impact of family stability and functioning on the child/adolescent (e.g., recent significant changes, trauma history, conflicts, and losses) and current behavioral, academic, and social functioning.

This assessment is particularly important if the child is a victim of, or witness to, domestic violence.

2. Prior to initial interview with the child/adolescent, it may be useful to have family members and collateral contacts (e.g., school, day care providers, or other significant parties) complete standardized behavioral rating scales.
3. Interview the child/adolescent. During this interview:
 - examine mental status,
 - obtain the child/adolescent's descriptions of the problems as well as his or her view of the family environment,
 - conduct interview with the family to observe the family's interaction.
4. Determine history and effectiveness of treatment and treatment-related interventions (medical, collateral contacts including school, day care providers, etc., family, and mental health).
5. Consult with the collateral contacts including school, day care providers, etc. (teachers, school psychologist) to:
 - verify the presence of primary symptoms in the school setting,
 - obtain school psychological testing results if available,
 - review subscore patterns if educational testing has been done.
6. Conduct psychological testing as indicated:
 - standardized parent, teacher, and self behavioral rating scales may be useful as screening devices,
 - occasionally, additional testing might be useful to establish the diagnosis if alternate diagnoses such as depression, adjustment

reaction, and family problems might exist.

7. Screen for co-occurring conditions such as substance abuse, learning disability, depression, oppositional/defiant disorder, post traumatic stress disorder, adjustment disorders, and organic conditions.

TREATMENT GUIDELINES

Indicators for Referral

Referrals for ancillary services (e.g., medical evaluation, special education) may be indicated if screening suggests possible co-occurring medical or organically-based disorders, or disorders such as substance abuse, learning disability, affective disorder, anxiety disorder, personality disorder, and organic conditions.

Treatment Intervention Considerations

1. Treatment of ADHD usually involves a combination of treatment modalities. Willing participation of the parent/guardians, the youth, and school personnel contributes to improved outcomes.
2. Ongoing collaboration with parents and teachers is an essential component of treatment for children and adolescents with ADHD. It is important to provide support and education about ADHD to the primary adults in the child's life as well as help to establish a management program that recognizes ADHD as a chronic condition, and provides consistency between home and school environments.
3. Parent and youth motivation, available resources, co-occurring disorders, specific target symptoms, and the strengths and weaknesses of the youth, family, school, and community enter into the choice of intervention strategies.
4. Treatment targets:
 - a. Behavioral symptoms are usually effectively addressed through behavioral and psychosocial interventions.
 - b. Interventions in the school setting typically involve ensuring appropriate class placement, behavior management and modification programs, and ongoing collaboration with school personnel.
 - c. Interventions with parent/guardians usually include behavior modification training. Parent/guardians may also be referred to a parent support group.
 - d. Family psychotherapy is indicated when family dysfunction is present.
 - e. Interventions with the youth include social skills training.
 - f. Individual therapy may be helpful in treating co-occurring disorders, but is not the treatment of choice to address core ADHD symptoms in isolation.
5. Coordination of services among the youth, parent/guardians, school, medical personnel, and others enhances the effectiveness of comprehensive treatment.

6. Medication may be an essential component in the treatment of ADHD. The core symptoms (inattention, impulsivity, and hyperactivity) usually respond to medication.

The Psychotherapeutic Component

For child/adolescent cases, the following may guide the therapist in developing an effective treatment approach.

For All Cases:

1. Educate parents/guardians and/or other significant family members about ADHD's neurological basis, symptoms, clinical course, prognosis, etc.,

Information should be provided to parents and teachers about the chronic nature of ADHD, its effects on learning, self-esteem, behavior, social skills, and family functioning. Parent groups can be an effective mode for this education, providing the added benefit of normalizing family experiences. Provide developmentally appropriate education for the child about ADHD, with updates as s/he matures. Educate families about support groups to families, such as Children and Adults with Attention/Deficit Hyperactivity Disorder (CHADD).

2. Educate the child/adolescent on the above topics in an age-appropriate manner.
3. Instruct parents/ guardians/family in behavior management techniques.

Parents and teachers of children with ADHD can be trained and supported in specific techniques for improving behavior, including increased structure, use of positive reinforcements and consequences, and limitations of distractions. The therapist can help establish communication methods between home and school, such as a daily report card. Realistic and measurable goals with clear plans for follow-up should be established.

4. Teach "self-talk" and "stop-think" strategies.
5. Refer to appropriate community supports (CHADD, etc.).
6. Coordinate treatment planning with collateral contacts including school, day care providers, etc. This may include educating the parents/guardians in working/ communicating with the school system.
7. Coordinate treatment planning with the primary healthcare provider.
8. Discuss with collateral contacts including school, day care providers, etc. some useful teaching methods for children with ADHD.

In Cases Involving Mild Impairment in Functioning

1. Consider referral for psychiatric medication evaluation.
2. Consider brief family therapy.

In Cases Involving Moderate to Severe Impairment in Functioning

1. A referral for a psychiatric medication evaluation is necessary.

2. Psychotherapy and/or psychosocial interventions are likely needed. This may involve family therapy and/or group or individual treatment of the child, focusing on impulse control, social skills, attention problems, and/or self-esteem.
3. The child/adolescent will likely need therapeutic interventions to address possible self-esteem problems and “failure identity” and/or depression that can emerge when child/adolescent has been identified as “different”.
4. Consult with parents/guardians and the school/day care providers on appropriate class or school placement, teaching interventions, and behavioral management approaches. Children/adolescents with ADHD respond better to interactive and experiential (hands-on) educational programs.
5. Interactive, as opposed to passive, therapeutic interventions are preferred, such as adventure-based therapies.
6. To prevent hospitalization/residential treatment and/or when family challenges are significant, utilize community based services, such as respite care, therapeutic case management, intensive family-based services, crisis beds, therapeutic foster care, or other individualized services as available.
7. When appropriate, include cognitive behavioral coping skills, self-regulation training, and behavioral self-monitoring, in addition to self-talk and stop-think strategies.

The Psychiatric Component

Once a referral to the psychiatric staff has been made, the following assessments and evaluations will occur.

Assess Medical Status

1. A thorough medical history should be taken from the client. If indicated, possible somatic causes of the presenting signs and symptoms (e.g., thyroid dysfunction, concurrent medication, or substance abuse) should be ruled out.
2. The psychiatric staff is encouraged to involve the primary healthcare provider in order to promote a complete and thorough medical evaluation.
3. Depending upon the particular medication chosen, baseline laboratory studies and/or EKG must be appropriately obtained before treatment is initiated.

Assess Mental Status

1. Assess current mental status
2. Confirm the diagnosis and the appropriate level of care.

Assess for Specialty Referrals

Determine if referrals for endocrinology, neurology, or laboratory

examinations are appropriate. Consult with other health professionals (primary therapist, primary healthcare provider).

Evaluate for Medication

1. Medication for children and adolescents with ADHD should be considered whenever the diagnosis is made.
2. Medications should be tailored to provide symptom relief in school, at home, and in other settings. Medication may be indicated during weekends and summer vacation periods, in addition to school, and is appropriate and safe to use continuously.
3. Stimulants are usually the medications of first choice, and these include methylphenidate and the amphetamine derivatives. (Pemoline or Cylert is no longer indicated or approved for use.) Children/adolescents who do not respond to stimulants, or who experience unacceptable side-effects, may be considered for alternative medications including atomoxetine (Strattera), modafinil, bupropion (Wellbutrin) and the tricyclic anti-depressants. The SSRI anti-depressants are ineffective in treating ADHD.
4. Relative contra-indications to the use of stimulants include children or adolescents with seizure disorders, severe anxiety disorders, and possibly tic disorders.
5. Alpha 2 adrenergic agonists (Clonidine, Tenex) may be indicated for adjunctive treatment of agitation, co-occurring conduct disorder, or oppositional defiant disorder, and for insomnia.
6. Atypical neuroleptics (e.g., Risperdal, others) may be considered for severe agitation and aggression. The potential risks of weight gain and development of the metabolic syndrome should be carefully explained to patients and their families, and periodic blood monitoring and observation for weight gain should be employed.
7. Baseline blood pressure and pulse should be recorded before initiation of tricyclic anti-depressants, and an EKG should be ordered if there is any history of relevant familial or personal heart disease. EKG monitoring and serum anti-depressant levels should be monitored if dosages exceed recommended guidelines.
8. When medication is recommended, inform parents/guardians of the risks/benefits associated with and without medication use. The information should include changes to expect, appropriate dose, course of administration, possible side effects, and moderation of side effects over time.
9. Periodically reassess the need for medication and dosage required. Extended school holidays, such as summer vacation, provide opportunities to observe the child while off medication. Advise parents/guardians that some children and adolescents may continue to benefit from medications well past childhood and adolescence, and into

adulthood.

10. Coordinate care with the primary healthcare provider.

Obtain Informed Consent

Treatment alternatives and their outcomes (trial of medications and side effects) should be discussed with the client.

TREATMENT EVALUATION

Indicators of Successful Treatment Response

The optimal outcome of treatment of ADHD is to achieve full functioning by minimizing the negative effects of ADHD symptoms on development.

As negative symptoms identified in the treatment plan approach resolution, begin to taper therapeutic interventions. Examples of successful treatment response might include the following:

1. Decrease in symptoms related to ADHD (inattentiveness, impulsiveness, restlessness, psychomotor agitation).
2. Improvement in academic/work performance as reflected in achievement level, grades, and specific skill areas.
3. Improved behavior at home is reported by parent/family. Decrease in other associated features of ADHD, such as obstinacy, stubbornness, negativism, mood lability, low frustration tolerance, temper outbursts, and low self esteem.
4. Improvement in personal relationships.

Considerations in the Event of Inadequate Treatment Response

1. In the event that the target symptoms don't improve, identify causal factors.
2. Reconsider appropriateness of diagnosis. Ongoing trauma, abuse, or violence can produce symptoms matching those of ADHD.
3. Evaluate treatment compliance and identify possible barriers to address.
4. Refer case to peer review process and/or obtain consultation.

ADULTS

ASSESSMENT GUIDELINES

Assessment Considerations

1. The diagnosis of ADHD is based on current DSM criteria, with symptoms that occur in more than one setting and evidence of functional impairment in daily living.
2. Adult assessment should include history and context of the development of ADHD symptoms, as well as history of school and work performance and social development. ADHD should be diagnosable in childhood, as adult-

- onset ADHD is contrary to the natural history of this disorder. Reports from parents or significant others can be helpful in determining core symptoms.
3. The use of standardized rating scales from multiple informants is highly desirable.
 4. A medical evaluation may assist in determining the presence of physical factors that may be causing or contributing to ADHD symptoms, such as impaired vision or hearing, malnutrition, primary sleep disorder, seizures or head trauma, genetic disorders and toxic brain syndromes (e.g., in utero alcohol exposure).
 5. Differential diagnosis is important because the symptoms of ADHD are similar to other disorders of childhood including responses to trauma, Anxiety Disorders, Oppositional Defiant Disorder, Bipolar Disorder, Autistic Spectrum and Pervasive Developmental Disorders, Mental Retardation, Brain Injuries and Central Nervous System Disorders.
 6. Substance abuse/dependence should be evaluated as a possible cause of ADHD symptomology or as a secondary diagnosis. Substance use/dependence should be re-assessed every 6-months.
 7. The diagnosis of ADHD is based on current DSM criteria, with symptoms that occur in more than one setting and evidence of functional impairment in daily living.
 8. Early onset mania or a bipolar mixed state may be hard to distinguish from ADHD, although ADHD is likely to have an earlier onset, sustained clinical course, and a family history of attention disorders.
 9. Core symptoms of ADHD (inattention, impulsivity, and/or hyperactivity) must be evident before age seven; a careful history should be gathered to determine this.

Initial Assessment

The goal of the assessment is to clarify the diagnosis and determine the severity of functional impairment (mild, moderate, or severe). The following approach should be helpful in determining an appropriate treatment intervention.

1. Interview client. During the interview:
 - examine mental status,
 - obtain the client's description of problems,
 - establish the age of onset and the relative stability of these symptoms over time and across settings,
 - obtain developmental, family, academic, medical, and family psychiatric and substance abuse histories,
 - establish current behavioral, occupational, academic, and social functioning.

2. Interview collateral resources if possible (e.g., partner, significant other, family member, co-worker, employer, long-time friend). During the interview, establish
 - presence of the primary symptoms of the disorder,
 - age of onset, and the relative stability of these symptoms over time and across settings,
 - developmental, family, academic, medical, and family psychiatric and substance abuse histories,
 - current behavioral, occupational, academic, and social functioning.
3. Determine history and effectiveness of treatment and treatment-related interventions (medical, academic settings, family, and mental health).
4. Conduct psychological testing as necessary to confirm diagnosis. Standardized adult behavioral rating scales may be useful as screening devices.
5. Screen for co-occurring conditions such as substance abuse, learning disability, affective disorder, anxiety disorder, personality disorder, and organic conditions.

TREATMENT GUIDELINES

Indicators for Referral

Referrals for ancillary services (e.g., medical evaluation, special education) may be indicated if screening suggests possible co-occurring medical or organically-based disorders, or disorders such as substance abuse, learning disability, affective disorder, anxiety disorder, personality disorder, and organic conditions.

Treatment Intervention Considerations

1. Symptoms of ADHD often persist into adulthood, as well as secondary difficulties such as problems with academic/vocational issues, relationships, poor self-esteem, anxiety, and depression. Along with appropriate medication, structured psychotherapy with clear attainable goals can be helpful. In addition, education, regarding the nature of ADHD, should be part of treatment.
2. Treatment of ADHD usually involves a combination of treatment modalities. Willing participation contributes to improved outcomes.
3. Client motivation, available resources, co-occurring disorders, specific target symptoms, and the strengths and weaknesses of the client, family, and community enter into the choice of intervention strategies.
4. Treatment targets:
 - a. Behavioral symptoms are usually effectively addressed through behavioral and psychosocial interventions.
 - b. Interventions may include social skills training.

- c. Individual therapy may be helpful in treating co-occurring disorders, but is not the treatment of choice to address core ADHD symptoms in isolation.
 - d. Family psychotherapy is indicated when family dysfunction is present.
5. Coordination of services among the client, family, medical personnel and other professional involved in the case enhances the effectiveness of comprehensive treatment.
 6. Medication may be an essential component in the treatment of ADHD. The core symptoms (inattention, impulsivity, and hyperactivity) usually respond to medication.

The Psychotherapeutic Component

In developing the treatment plan, interventions should target areas of difficulty identified during the assessment. Interventions to consider include the following:

For All Cases:

1. Educate the client and family members about ADHD's neurological basis, symptoms, clinical course, prognosis, etc.,
2. Utilize cognitive-behavioral interventions and teach strategies such as "self-talk" and "stop-think".
3. Refer to appropriate community supports (CHADD, etc.).
4. Coordinate treatment planning with the primary healthcare provider.

In Cases Involving Mild Impairment in Functioning

1. Consider referral for psychiatric medication evaluation.
2. Consider Individual therapy to address associated self-esteem problems.
3. Consider brief couples/family therapy.

In Cases Involving Moderate to Severe Impairment in Functioning

1. A referral for a psychiatric medication evaluation is necessary.
2. Psychotherapy and/or psychosocial interventions are likely needed. This may involve individual and/or couple/family therapy focusing on impulse control, social skills, attention problems, and/or self-esteem.
3. When appropriate, include cognitive behavioral coping skills, self-regulation training, and behavioral self-monitoring, in addition to self-talk and stop-think strategies.
4. Individual treatment will likely be needed to address possible self-esteem problems associated with "failure identity" and/or depression that can emerge as a result of being identified as "different".
5. Interactive, as opposed to passive, therapeutic interventions are preferred.
6. To prevent hospitalization/residential treatment and/or when family challenges

are significant, utilize community based services, such as therapeutic case management, intensive family-based services, crisis beds, or other individualized services as available.

The Psychiatric Component

Once a referral to the psychiatric staff has been made, the following assessments and evaluations will occur.

Assess Medical Status

1. A thorough medical history should be taken from the client. If indicated, possible somatic causes of the presenting signs and symptoms (e.g., thyroid dysfunction, concurrent medication, or substance abuse) should be ruled out.
2. The psychiatric staff is encouraged to involve the primary healthcare provider in order to promote a complete and thorough medical evaluation.
3. Depending upon the particular medication chosen, baseline laboratory studies and/or EKG must be appropriately obtained before treatment is initiated.

Assess Mental Status

1. Assess current mental status
2. Confirm the diagnosis and the appropriate level of care.

Assess for Specialty Referrals

Determine if referrals for endocrinology, neurology, or laboratory examinations are appropriate. Consult with other health professionals (primary therapist, primary healthcare provider).

Evaluate for Medication

1. Medication for adults with ADHD should be considered whenever the diagnosis is made.
2. To date, the US Food and Drug Administration has approved the following agents for adult-use: mixed amphetamine compounds, methylphenidate, and the noradrenergic specific reuptake inhibitor, atomoxetine (Strattera).
 - a. Placebo-controlled clinical trials with stimulants, atomoxetine, and the catecholaminergic antidepressants have demonstrated significant short-term improvement in ADHD symptoms.
 - b. The stimulants methylphenidate and amphetamine are the most commonly used and are highly effective in a dose-dependent manner for adults with ADHD. The stimulants have an immediate onset of action and may last from 4 to 12 hours depending on the formulation of the agent (immediate vs. extended release). Longer-term trials of methylphenidate use by adults support the ongoing effectiveness and tolerability of stimulants. The most common adverse effects with stimulants include edginess, insomnia, headache, and mild increases in heart rate and blood pressure, necessitating monitoring.

- c. Atomoxetine may be particularly useful when anxiety, mood, or tics occur with ADHD. Atomoxetine should be started slowly (0.5 mg/kg per day) and increased to therapeutic dosing (40-120 mg/d) over 1 month. Common adverse effects include gastrointestinal upset, mild increases in heart rate and blood pressure, and sexual dysfunction in men.
 - d. Other available medications shown to be effective for adults with ADHD include bupropion and desipramine, the latter requiring serum level (desipramine) monitoring. Also, for patients over 40, a baseline EKG should be obtained prior to initiation of desipramine or any of the other tricyclic anti-depressant medications.
 - e. Although taking medication is lifelong, periodic reappraisals of the need to continue therapy are recommended. The lack of current symptoms or impairments of ADHD in the unmedicated status is one signal, for example, that medication may not be necessary any longer.
3. Because of the potential for misuse of stimulant medications, particular caution is recommended in prescribing a stimulant medication for any patient with a co-occurring (past or present) substance use disorder, or in whom a potential for substance abuse exists (e.g., nicotine use). In these circumstances, initiation of medication with atomoxetine or desipramine may be preferable.
 4. Given that there are few established guidelines for use, and limited data as to efficacy, of the medications for ADHD in the adult population, it is also important to stress the use of adjunctive therapies, including cognitive-behavioral therapies.

Obtain Informed Consent

Treatment alternatives and their outcomes (trial of medications and side effects) should be discussed with the client.

TREATMENT EVALUATION

The optimal outcome of treatment of ADHD is to achieve full functioning by minimizing the negative effects of the ADHD symptoms on functioning abilities.

Indicators of Successful Treatment Response

As areas of difficulty identified in the treatment plan approach resolution, begin to taper therapeutic interventions. Examples of effective treatment response might include the following:

1. Symptoms related to ADHD lessen (inattentiveness, impulsiveness, restlessness, psychomotor agitation),
2. Improvement in work performance as reflected in work space organization, meeting deadlines, completion of projects, and specific skill areas, improve,
3. Family/significant others report improved behavior at home. Decrease of other associated features of ADHD, such as obstinacy, stubbornness,

negativism, mood lability, low frustration tolerance, temper outbursts, and low self-esteem.

4. Improvement in personal relationships.

Considerations in the Event of Inadequate Treatment Response

1. In the event that the target symptoms don't improve, identify causal factors.
2. Reconsider appropriateness of diagnosis. History of trauma, abuse, or violence and/or substance abuse can produce symptoms similar to those of ADHD.
3. Evaluate treatment compliance and identify possible barriers to address.
4. Refer case to peer review process and/or obtain consultation.

REFERENCES AND RESOURCES

The Clinical Practice Guidelines contained in this document are based upon a compilation of information obtained from the following resources, and the compilation of feedback from expert and consumer reviewers:

1. American Academy of Pediatrics: www.pediatrics.aappublications.org
 - American Academy of Pediatrics (2000). Clinical practice guidelines: Diagnosis and evaluation of the school-aged child with ADHD. *Pediatrics*, 105 (5), 1158-1170.
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2. The American Psychiatric Association Practice Guidelines and Guideline Watches, www.psych.org, www.appi.org
3. The American Psychological Association, Board of Professional Affairs, Committee on Professional Practice and Standards, www.apa.org
4. Cincinnati Children's Hospital Medical Center, Evidence Based Care Guidelines for Attention Deficit Hyperactivity Disorder, www.cincinnatichildrens.org/svc/alpha/h/health-policy/ev-based/adhd.htm
5. Colorado Work Group for Evidence Based Mental Health Practices, Colorado Department of Human Services, Division of Metal Health, www.cdhs.state.co.us/dmh
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13. Vermont, Preferred Clinical Practice Guidelines, produced by The National Council for Community Behavioral Healthcare (NCCBH) [formerly the National Community Mental Healthcare Council (NCMHC)] and The Behavioral Health Network of Vermont, www.nccbh.org.
14. Wyoming Public Mental Health System Clinical Practice Guidelines, produced by the Wyoming Division of Behavioral Health Through collaborative venture with the Wyoming Association of Mental Health and Substance Abuse Centers, www.bhswv.org

MOOD DISORDERS

MAJOR (UNIPOLAR) DEPRESSION, BIPOLAR (MANIC-DEPRESSIVE) DISORDER, DYSTHYMIA, CYCLOTHYMIA

ASSESSMENT GUIDELINES

Assessment Considerations

1. Diagnosis must be based upon established diagnostic criteria as detailed in the most current Diagnostic and Statistic Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
2. Clients with suspected Mood Disorders should be assessed at intake for possible dangerousness to self and/or others. A safety plan should be developed jointly with the client and supportive others.
3. A medical evaluation may assist in determining the presence of physical factors that may be contributing to symptom presentation, including various medications.
4. Differential diagnosis is important.
 - a. Substance abuse/dependence should be evaluated as a possible cause of a mood disturbance or as a secondary diagnosis. Substance use/dependence should be re-assessed every 6-months.
 - b. With adults, particularly older adults, it is important to consider co-occurring or undiagnosed medical conditions as well as medication interactions or effects in determining the presence of depression.
 - c. Mood disturbances are also frequently seen as associated features in other disorders such as Posttraumatic Stress Disorder, Anxiety Disorders, Attention Deficit Hyperactivity Disorder, Learning Disabilities, Mental Retardation, Brain Injuries, and Central Nervous System Disorders.
5. The degree of severity of the mood disorder may be evaluated through the administration of appropriate psychodiagnostic tools, such as structured interviews and standardized depression screens.
6. The development of manic-like episodes following pharmacological treatments for depression may place individuals at increased risk for the development of Bipolar Disorder.
7. Late life onset (after 60 years) of bipolar-like symptoms is inconsistent with the natural history of bipolar illness. Alternate etiologies for symptoms, e.g. medication side-effects or an organic brain disorder, should be carefully considered.

Initial Assessment

The goal of the assessment is to clarify diagnosis and determine the level of severity (mild, moderate, or severe) as described in the most current diagnostic manual (DSM). The following should be helpful in determining appropriate treatment interventions:

1. Evaluate the client with particular attention to the following:
 - The presence or history of severe mood swings including manic or depressive episodes,
 - The intensity and magnitude of the symptom presentation,
 - Duration of the current symptoms,
 - History of prior symptoms,
 - Cultural factors associated with symptom presentation/endorsement,
 - Family history, including medical history,
 - The possibility of co-occurring diagnoses,
 - Current events, including loss, trauma, or victimization,
 - History of or current substance abuse,
 - Frequency of cycling,
 - The presence of a seasonal pattern.
2. History from other, objective informants is important, as many persons with bipolar disorder may deny or may not recognize symptoms of their illness.
3. Medical screening (physical and laboratory assessment) may be necessary for ruling out a somatic basis (e.g., thyroid disorder, diabetes, and anemia) or to rule out a substance abuse disorder.
4. In manic as well as depressed clients, it is critical for the clinician to carefully assess current levels of functioning, judgment, and risk factors, including potential for harm to self and/or others.
5. In diagnosing depression in the older adult special caution should be used to differentiate depressive symptoms from similar symptoms in dementia.

TREATMENT GUIDELINES

Indicators for Referral

If the initial evaluation confirms a diagnosis of mood disorder, initiate psychotherapeutic treatment and/or refer for psychiatric treatment depending upon symptoms and severity level. Careful assessment of risk is critical. If the risk of manic behavior and/or suicide is high, hospitalization may be indicated.

1. Most clients will benefit from the combined use of psychotherapy and pharmacotherapy. Following evaluation, clients with the following characteristics should be considered for combined treatment:

- partial but incomplete response to an adequate trial of medication,
 - intermittent or continuous depression with maladaptive functioning,
 - mood disturbance with maladaptive response to psychosocial or environmental stressors,
 - continuing presence of marked cognitive distortions and interpersonal difficulties,
 - excessive medical risk associated with the use of medication (e.g., elderly, severe cardiac disease).
2. Moderate to severe depressive disorders are associated with alterations of brain function and they usually respond to pharmacology.
- Clients presenting with significant or severe neurovegetative signs characterized by (but not limited to) anergia (weakness, loss of energy), anhedonia (lack of emotional response in situations that normally elicit such responses), disturbances of appetite, weight changes, sleep disturbances, difficulty concentrating, slow thinking, libido changes, loss of interest, etc., should be seen by psychiatric staff for clinical evaluation.
 - Clients presenting with any of the following characteristics should be seen by psychiatric staff as soon as this can be arranged:
 - Signs and symptoms of psychosis (e.g., hallucinations, delusions, etc.),
 - Active suicidal or homicidal ideation/behavior,
 - Signs and symptoms of mania.
3. In addition, depending on severity of dysfunction, clients presenting with any of the following characteristics should be referred to the psychiatric staff for an evaluation:
- mild to moderate dysthymic or depressive symptoms for longer than six months with anhedonia, decreased libido, and/or impairments in normal role function,
 - past history of psychiatric hospitalization,
 - current use of prescribed, mood-altering medication (e.g., codeine, etc.),
 - age greater than 65,
 - co-occurring medical conditions (e.g., cardiac abnormalities, endocrine dysfunction, neurological disorders, etc.),
 - presence of significant coexisting psychiatric or substance abuse problems (e.g., schizophrenia, alcohol dependency, past history of manic episode, etc.),
 - tendency toward somatization.

Treatment Intervention Considerations

1. Establishing a therapeutic alliance, developing trust, and instilling a sense of hope that things will improve are crucial elements in engaging the client and impacting lasting change.
2. Individual and/or group psychotherapy may be appropriate.
3. Psychiatric evaluation and treatment for any individual with a long standing or moderate to severe mood disorder is appropriate.
4. Education about the illness, incidence and possible genetic factors, and treatment options are important parts of treatment. Family members and significant others may be included in this process whenever appropriate and possible.
5. Case management may be useful to coordinate treatment among care providers.
6. For clients with chronic functional deficits, psychosocial rehabilitation may be useful treatment.
7. Ongoing assessment of dangerousness to self or others is an important part of the treatment process.

The Psychotherapeutic Component

1. Time-sensitive or brief treatment therapeutic approaches are generally preferred.
2. Assessment may indicate individual, family, or group therapy depending on severity and length of presence of symptoms and presence or lack of support system.
3. Involve the client in developing an appropriate treatment plan focusing on strengths and specific behavioral goals. Establish measurable short-term goals with the consumer and family.
4. The following treatment considerations, especially for those with chronic and recurrent mood disorder, should be taken into account in formulating the treatment plan:
 - Incorporate all supports available to the client, such as family, friends, church, support groups, and community groups.
 - Recognize the client's particular strengths and areas of positive functioning.
 - Consider the interaction of the client's strengths and support systems with prevailing patterns of maladaptation and recurrence of illness.
5. The following evidence-based practices have been shown to be effective in treating mood disorders.
 - cognitive-behavioral therapy approaches
 - interpersonal therapy approaches

- strategic therapy.
 - Dialectical Behavioral Therapy (DBT)
 - psychiatric medication services
 - the recovery model
6. Collaborate with the consumer and family as partners in their recovery, focusing on their goals. Identify, with the consumer, effective ways they have used to cope with depression and support continued use of these methods. Provide consumer/family education on depression, its treatment, and steps they can take to assist their recovery.
 7. Consider the phase of the treatment episode, i.e. acute, continuation, and maintenance, as well as the severity of the depressive symptoms, in determining an approach. For example, cognitive or interpersonal therapy can be as effective as medication in mild or moderate depression, with medication and case management/support recommended for moderate/severe depression. In addition, cognitive or interpersonal therapy, during the continuation/maintenance phase has been shown to reduce incidents of relapse.
 8. Assist the consumer in maintaining a regular pattern of daily activities, including regular sleep-wake cycles, meal times, physical activity, and emotional stimulation. Disruption in these social rhythms, with disrupted sleep-wake cycles may trigger manic episodes.
 9. Treatment is most often successful when planned with a biopsychosocial perspective.
 10. Education about unipolar/bipolar illness and its treatment, teaching skills in coping with psychosocial stressors and attendant problems, facilitating compliance with treatment, and monitoring occurrence and severity of symptoms. Involve the family in education programs whenever possible.
 11. Use ancillary therapeutic approaches, such as bibliotherapy, behavioral change assignments, and self-help groups.

The Psychiatric Component

Once the client is referred to the psychiatric staff, the following assessments and evaluations will occur.

Assess Medical Status

1. A thorough medical history should be taken from the client. If indicated, possible somatic causes of the presenting signs and symptoms (e.g., thyroid dysfunction, concurrent medication, or substance abuse) should be ruled out.
2. The psychiatric staff is encouraged to involve the primary healthcare provider in order to promote a complete and thorough medical evaluation.

3. Depending upon the particular medication chosen, baseline laboratory studies and/or EKG must be appropriately obtained before treatment is initiated.

Assess Mental Status

1. Assess current mental status
2. Confirm the diagnosis and the appropriate level of care.

Assess for Specialty Referrals

Determine if referrals for endocrinology, neurology, or laboratory examinations are appropriate. Consult with other health professionals (primary therapist, primary healthcare provider).

Evaluate for Medication

1. Establish medical clearance for pharmacotherapy in collaboration with the primary healthcare provider if required in the judgment of the psychiatric staff. Include, as appropriate, a review of medical history, a physical examination, and relevant baseline laboratory examinations.
2. Estimate the likelihood of positive response to medications and discuss this with other involved clinicians, if any, and the client. Explore the client's attitude toward medications and possible problems in compliance. The following characteristics indicate the likelihood of a positive response to medication:
 - recent onset of significant mood disruption,
 - positive past response to medication,
 - presence of two or more vegetative signs that suggest mood disorder in the context of the client's history,
 - family history of mood disorders.
3. The following characteristics are predictive of a less positive response to medication, but in a specific case do not contraindicate a trial of medication:
 - history of poor response by client or close biological relative to antidepressants,
 - a long history of subjective complaints of depression without objective signs and symptoms,
 - presence of personality disorder or significant Axis II traits,
 - presence of a diagnosable somatization disorder,
 - history of illicit drug-seeking behavior or history of any substance abuse disorder.

Obtaining Informed Consent

Treatment alternatives and their outcomes (trial of medications, side effects,

and, in some cases, ECT) should be discussed with the client.

Prescribing Medication

After completing the evaluations outlined above and taking into consideration risks, side effects, and cost-effectiveness, the psychiatric staff may determine that medication is appropriate. The decision to use medication should always involve the client and/or the client's significant others. Choice of specific medication or other somatic interventions should be guided by the most recent American Psychiatric Association "Practice Guidelines for Major Depressive Disorder in Adults," and "Practice Guidelines for the Treatment of Patients with Bipolar Disorder," including "Guideline Watches" (updates).

Prescribing Medication for Acute Mania

Acute mania may present a psychiatric emergency based upon the risk to the client and others because of impaired judgment. Presentation of acute mania may be indistinguishable from other forms of acute psychosis; therefore, the initial treatment parallels treatment for acute psychosis unless signs, symptoms, and/or history point to a specific manic diagnosis. The following suggestions are specific to the treatment of acute mania, but are not meant to replace American Psychiatric Association treatment guidelines:

1. Consider lithium trial, especially if there is a positive history of lithium response in the client or a first-degree relative or if agitated psychosis or "depression" results from antidepressant treatment.
2. If mania is a likely diagnosis, benzodiazepines or neuroleptics, in combination with mood stabilizing drugs, are routinely used for control of agitated psychosis.
3. Avoid prolonged exposure to traditional neuroleptics for treatment of acute mania whenever possible.

Use of Anti-Epileptic Medication

Certain clients with manic episodes may not respond well to lithium monotherapy. These clients, who comprise nearly 50% of the current clinical population, experience manic episodes characterized by:

1. Extreme irritability or mixed states of rapidly shifting moods of euphoria, anger, anxiety, and depression.
2. Atypical pattern of illness course (stability, followed by depression leading abruptly to manic states).
3. Rapid cycling (more than four episodes of mania per year).

In such clients, the use of carbamazepine or valproic acid, used singly or in combination with lithium or each other, is indicated. Specific dosing regimens are dictated by clinical response and blood levels of each agent. Rapid response in acute manic states is often facilitated by the adjunctive use of new atypical anti-psychotic agents that can be tapered and discontinued once the client's condition has stabilized. Use of specific

agents is determined by the type of mania, the pattern of illness course, the nature of the client's response, and tolerability of side effects.

Prescribing Medication for Acute Depression

If Unipolar depression has been established and/or it has been determined that there is very little indication for bipolarity, then anti-depressant medication can be prescribed for acute depression. By ruling out bipolarity, the risk of inducing mania with an anti-depressant is minimized, though there remains the risk of unexpected induction. Therefore, patients who are started on anti-depressants should always be cautioned as to the potential activation of hypomania or mania, and they should be followed closely by the prescribing medical provider during the first weeks and months of treatment, and at any time anti-depressant medication is increased or changed. The choice of anti-depressant medication(s) should be based upon the most recent established guidelines provided by the American Psychiatric Association.

In cases of major depression complicating a bipolar illness, anti-depressants are indicated for the relief of depression. In these cases, the patient should first be well-established on a therapeutic dose of a mood stabilizer, in order to prevent induction of mania, rapid cycling, or "switching" of moods. Recent evidence points to the particular usefulness of lamictal in treating bipolar depression, as it is a mood stabilizer with mood-elevating properties.

TREATMENT EVALUATION

Indicators of Successful Treatment Response

The optimal outcome for the client that presents with a mood disorder is for the client to:

1. Attain symptom relief
2. Learn skills to prevent or manage future episodes of illness
3. Improve functioning in daily life

Use of standardized screening instruments may be useful to measure and monitor the response, or the failure to respond, to treatment. Consider treatment response adequate if target symptoms, especially vegetative signs and symptoms and/or negative cognitions, are reversed within four-to-six weeks.

Considerations in the Event of Inadequate Treatment Response

1. Consider the possibility of an undetected medical illness or substance abuse disorder.
2. Evaluate treatment compliance and identify possible barriers.
3. In clients on pharmacotherapy alone:
 - Evaluate the adequacy of medication dosage and evaluate client compliance.
 - Consider a second medication within the same class, or one with enhanced psychopharmacologic action. (e.g., substitute a

norepinephrine/serotonin re-uptake inhibitor for an SSRI. Or, if a TCA fails, switch to an SSRI. If it fails, try a different SSRI.)

- Consider an augmentation strategy (e.g., use of Li₂CO₃, thyroid, or psycho stimulant.)
 - If a depressed client has a negative response to three separate adequate medication trials, consider an MAO inhibitor.
 - In addition, consider if psychotherapy is indicated in these clients.
4. In clients being treated solely with psychotherapeutic intervention, consider referring for a medication trial.
 5. In clients being treated with a combination of psychotherapeutic intervention and medication, seek consultation with the medical director.

IMPORTANT CONSIDERATIONS FOR MOOD DISORDERS IN YOUTH

ASSESSMENT GUIDELINES

Assessment Considerations

1. Diagnosis must be based upon established diagnostic criteria as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
2. Youth with suspected Mood Disorders should be assessed at intake for possible dangerousness to self and/or others. A safety plan should be developed jointly with families.
3. Youth with Mood Disorders may be at increased risk for suicide. A thorough risk assessment is recommended.
4. A medical evaluation may assist in determining the presence of physical factors that may be contributing to symptom presentation, including various medications.
5. Differential diagnosis is important because the symptoms of Mood Disorders in youth can present quite differently than traditionally seen in adults.
 - a. When diagnosing depression in youth remember that, although the core symptoms are the same for children and adolescents, characteristic symptoms may vary with age. For example, somatic complaints, irritability, and social withdrawal are more common in children; psychomotor retardation, hypersomnia, and delusions are more common in adolescents. For all youth, mood may be irritable rather than sad.
 - b. In prepubertal children depressive episodes often occur in conjunction with another disorder, especially disruptive behavior disorders such as ADHD and anxiety disorders. In adolescents,

depressive episodes commonly co-occur with disruptive behavior disorders such as ADHD, anxiety disorders, substance-related disorders, and eating disorders.

- c. Special caution should be used to distinguish negativism, behavioral resistance, and impulsive irritability of a child with disruptive behavior disorders from irritability, sadness, or anhedonia of a child with depression.
 - d. Mood disturbances are also frequently seen as associated features in other disorders such as Posttraumatic Stress Disorder, Anxiety Disorders, Attention Deficit Hyperactivity Disorder, Learning Disabilities, Mental Retardation, Brain Injuries, and Central Nervous System Disorders. Environmental factors such as chronic family discord and/or inappropriate academic placement may also result in a mood disturbance.
6. The degree of severity of the mood disorder may be evaluated through the administration of appropriate psychodiagnostic tools, such as structured interviews and standardized depression screens.
 7. The parent/guardian interview is an integral part of the assessment process.
 8. School performance is important to assess, including history of behavior, learning, attendance, and grades.

Initial Assessment

The goal of the assessment is to clarify diagnosis and determine level of severity (mild, moderate, or severe) as described in the most current diagnostic manual (DSM). The following should be helpful in determining appropriate treatment interventions:

1. In assessing youth for a Mood Disorder, developmental factors impact the clinical presentation.
 - a. Younger children with Mood Disorders usually show more anxiety symptoms, somatic complaints, auditory hallucinations, temper tantrums, and behavioral problems.
 - b. In middle to late childhood, children with Mood Disorders may begin to report the cognitive components of dysphoric mood, low self-esteem, guilt, and hopelessness.
 - c. In adolescence, more sleep and appetite disturbances, delusions, suicidal ideation and attempts, irritability, anger, and impairment in functioning may appear.
2. It is recommended that information be gathered to assess subtypes of depression. Such information includes seasonality in symptoms, presence of psychotic features, mania or hypomania, and "mixed states" of depression and mania.

3. Many youth with Mood Disorders have co-occurring disorders, the most common being Anxiety Disorders, Disruptive Behavior Disorders, and Substance Use Disorders. In younger children, Separation Anxiety is a common co-morbidity.
4. Dysfunctional relationships within families of depressed youth may exacerbate symptoms. A history of depression in family members is also common. Family systems should be assessed for needs that can be met through case management and in-home services to improve environmental factors that may be contributing to the Mood Disorder.

TREATMENT GUIDELINES

Treatment Intervention Considerations

1. Treatment should be provided in the least restrictive setting. Initial considerations for determining level of care include availability of a safe environment, the severity of illness, and the severity of co-occurring psychiatric or medical factors.
2. Cognitive-behavioral treatment, interpersonal therapy, and insight-oriented psychotherapies are useful strategies for addressing cognitive distortions, role and relationship dynamics, self-understanding, and life skill deficits.
3. Individualized treatment approaches may be indicated which include community based psychosocial activities and recreational activities. For young children, play therapy may be an effective approach.
4. Family therapy is important in the treatment of children and adolescents with mood disorders.
5. Psychiatric referral for medications may be indicated, especially when psychotic features are present, when the symptoms are severe, or when the disorder is chronic. For more detailed information see the “Psychiatric Component” section of this guideline.
6. Interventions may need to involve others beyond the youth and family, such as school personnel.
7. If medical conditions are involved, coordination with medical providers is essential.
8. Work with the client and family to educate them on Mood Disorders, including the importance of continuing medication, on lessening environmental stressors, and on developing a preventive focus. These elements can assist recovery and prevent relapse.
9. Continuation of treatment after improvement with a first episode is appropriate to solidify gains.

10. Treatment may need to continue longer if the disorder is recurrent, chronic, has psychotic features, or when unremitting environmental stressors are present.
11. Special caution must be exercised in medication management in children and adolescents. Most psychoactive medications used in children will be for off-label indications. Dosing must be appropriate to the child's age and weight and consider long-term effects of medication. Polypharmacy should be avoided except when medically necessary based on symptomatology.
12. When prescribing antidepressant medications for children and adolescents caution must be exercised with regard to the FDA Black Box Warning and the potential that these medications might increase suicidal thoughts, especially early in the course of treatment. More frequent follow-up visits are recommended to monitor the response to these medications.

TREATMENT EVALUATION

Indicators of Successful Treatment Response

Optimal outcomes of the treatment of Mood Disorders in youth are:

1. For the youth to experience a remission of symptoms
2. For the youth and family to learn skills to cope with the psychosocial repercussions of the disorder
3. To address and lessen environmental stressors
4. To understand and recognize the early signs of relapse, and prevent the reoccurrence of symptoms
5. To improve functioning in daily life

As a result of treatment, the youth should be able to engage in, and make use of, age-appropriate activities leading to normal development.

IMPORTANT CONSIDERATIONS FOR BIPOLAR DISORDER IN YOUTH

ASSESSMENT GUIDELINES

Assessment Considerations

1. The presentation of Bipolar Disorder in youth often differs from the presentation in adults. Youth with mania frequently present with symptoms that are considered atypical. Changes in mood, mental excitement, and psychomotor agitation are often erratic. Irritability, belligerence, and mixed states are more common than euphoria. Reckless behaviors typical of Bipolar Disorder in adults may present as behavioral problems, school failure, fighting, dangerous play, and overly sexualized behaviors.

2. Discriminating between manic symptoms and normal childhood behavior may be difficult. Therefore, consideration of current and past history regarding symptom presentation, treatment response, and psychosocial stressors is important to gain a historical perspective on the youth's behavior. A family history of Bipolar Disorder should alert the clinician to consider that diagnosis.
3. History from other, objective informants is important, as many persons with bipolar disorder may deny or may not recognize symptoms of their illness. Information from a number of informants, such as family or teachers, is particularly important in assessing children and adolescents.
4. Although the core symptoms are the same for children and adolescents, their expression may be developmentally influenced. For example, manic episodes in adolescents are more likely to include psychotic features, which may be associated with school truancy, antisocial behavior, school failure, and/or substance use. In many youth, the behavior problems precede the development of frank manic episodes. Mixed episodes may be more common in younger individuals.
5. The development of manic-like episodes following somatic treatments for depression may place individuals at increased risk for the development of Bipolar Disorder. This may be an especially important consideration in children and adolescents.
6. Differentiating between Bipolar Disorder and ADHD is frequently difficult. ADHD usually has an onset before age 7 and is a consistent characteristic of the youth's behavioral pattern. Bipolar disorder is usually episodic. Most children with Bipolar Disorder meet the criteria for ADHD and both diagnoses can be made when appropriate.
7. Early onset Bipolar Disorder is at times accompanied by psychotic symptoms such as delusions and hallucinations. Differential diagnosis may be difficult.

TREATMENT GUIDELINES

Treatment Intervention Considerations

1. Acute mania and severe depression may require hospitalization to weather the acute stage of the disorder and to evaluate medication needs and levels.
2. Youth with Bipolar Disorder are at increased risk for suicide.
3. Areas which may require intervention include family life, school performance, co-occurring disorders, and lack of social supports.
4. Medication is valuable in the treatment of Bipolar Disorder in both the acute phase and in the prevention of relapse.
5. It is important that the youth's family be made aware of the nature of the illness and what to expect in the future. Both the family and youth need to

understand that Bipolar Disorder is generally a chronic condition which can be managed.

6. Management includes a treatment regimen of medication to prevent relapses. The benefits and the risks of medication should be thoroughly discussed with the youth and the family. Scheduled meetings with parent/guardians around behavioral concerns and treatment updates can alleviate premature termination of treatment and medication stoppage.
7. Because of the chronic nature of Bipolar Disorder, treatment is likely to be long term. The treatment plan may include medication management, psychoeducational services, psychotherapy, psychosocial therapies, family supports, vocational services and supports, and residential services.
8. A wide range of services which may be required to adequately treat Bipolar Disorder. Case management services may be helpful for coordination and family support and advocacy.
9. Prevention of relapse should be included in treatment planning for Bipolar Disorder. Most relapses occur as a result of lapses in medication regimes. Both the client and the family should know the signs of relapse and be educated regarding the need for consistent implementation of the treatment plan, and particularly cautioned against changing or discontinuing medications without psychiatric consultation.
10. Safety plans are needed to address relapses should they occur, including plans for addressing self care needs, prevention of suicide or violence, and for accessing inpatient care should it be required.

REFERENCES AND RESOURCES

The Clinical Practice Guidelines contained in this document are based upon a compilation of information obtained from the following resources, and the compilation of feedback from expert and consumer reviewers:

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