

Quality Assessment and Performance Improvement

The design of the Quality Assessment and Performance Improvement (QAPI) program is to evaluate and enhance the quality of services provided to consumers and other stakeholders. The program includes:

- Input from consumers and family members;
- Evaluation of the outcomes of the services provided, by determining whether the quality of consumer and families' lives have been maintained or improved as a result of receiving services;
- Evaluation to determine the extent to which NBH has identified and met the mental health care needs of the enrolled population, and to identify any unmet needs for mental health services;
- Determine through outcome measures benchmarks of clinical quality;
- Monitoring administrative process; and
- Planning the improvement of NBH administrative systems and clinical services.

Reports and other information produced by the Quality Assessment and Performance Improvement Program will be made available to: NBH management staff, NBH providers, the Department of Health Care Policy and Finance, consumers, family members, parents, advocacy groups and other interested stakeholders.

The purpose of reviewing information that relates to the quality of services is to improve performance and enhance the nature of services provided. All information and data regarding the provision of services to consumers is reviewed by the QAPI or other appropriate committees. The NBH Quality Improvement and Utilization Management Programs undertake a variety of studies to determine the quality of services and whether NBH systems are functioning in accordance with federal guidelines and state contracts as well as internal policies and procedures. This data/information, and data derived from other sources that show a positive impact of the services provided are shared with all appropriate parties. When data or findings indicate a problem, a corrective action plan is written and specific action steps and timelines are indicated. The QAPI monitors the process of all corrective action plans and determines the degree to which the corrective action plans have been implemented and the degree to which the action steps are successful in correcting identified problems. The QAPI determines if further action steps are necessary, and if those actions reached their goal. This is all part of the corrective action cycle.

Quality information regarding an individual center provider or non-center provider will be used in the re-credentialing process and/or annual performance evaluations.

NBH will maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program. NBH will submit an annual report to the Department detailing the findings of the program impact analysis which will describe techniques used to improve performance, the outcome of each

performance improvement project, and the overall impact and effectiveness of the quality assessment and improvement program. This report will provide sufficient detail for the Department of Health Care Policy and Finance to validate NBH's performance improvement projects.

This information will be made available to Providers and Members at no cost.

NBH will provide a quality improvement plan to the Department delineating current and future quality assessment and performance improvement activities and integrating findings and opportunities for improvement identified in studies, performance outcome measurement, Member satisfaction surveys, and other monitoring and quality activities. NBH understands that this plan is subject to the Department's approval.

NBH will monitor areas of consumer satisfaction and dissatisfaction with services through state determined surveys, NBH internally conducted surveys, and the grievances filed each year. The specific activities NBH will conduct to monitor areas of consumer satisfaction and dissatisfaction is:

- Report on areas of satisfaction and dissatisfaction based on the results of its internal satisfaction survey of consumers;
- Analyze areas of satisfaction and dissatisfaction based on the results of the State conducted surveys; and
- Analyze the number and content of grievances filed each year.

NBH will also evaluate access and adequacy of services through the NBH Adult Consumer Report Card and State conducted surveys (MHSIP and other designated surveys). NBH will evaluate access and adequacy based on appeal data, grievances, enrollment, and disenrollment information.

Upon request, the report evaluating the Quality Assessment and Improvement Program and the Program Impact Analysis and Evaluation Annual Report are made available to providers and members at no cost.

Practice Guidelines

Northeast Behavioral Health conceptualizes practice guidelines on two levels. The first level consists of how consumers are treated as they enter the NBH system, and the practice guidelines for the basic clinical and non-clinical services that almost all consumers receive. The second level consists of more specific practice guidelines that meet the special needs of the consumer(s). These practice guidelines are based on valid and reliable clinical evidence or consensus of health care professionals in the field.

NBH adopts Practice Guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the field;
- Consider the needs of the members;

- Have been evaluated in consultation with contracting health care professionals; and
- Are reviewed and updated periodically as appropriate.

NBH will ensure that decisions for Utilization Management, Member education, coverage of services and other areas to which the practice guidelines apply shall be consistent with the guidelines.

NBH's Practice Guidelines are Appendix A of this section.

Dissemination of Practice Guidelines

Practice guidelines are given to Providers in the Provider Manual, located on the NBH website, and, at their request, given to consumers, their advocates, and the public at large at no cost.

Quality of Care Concerns

Physician Quality of Care Issues

The work of physicians is reviewed through the quality monitoring process. Quality-of-care concerns regarding physicians are handled in the same manner as all other staff. The professional and personal behaviors of physicians are subject to the same expectations and rules as all other NBH providers.

When a quality of care issue is raised involving a physician that arises solely from medical practices, an initial investigation shall be conducted by the NBH Medical Director who will share the findings with the Executive Director of the NBH.

If it is determined that quality of care medical issues are involved, consistent with the requirements of C.R.S. 12-36.5-104, a professional review committee is assembled to review the issue(s) of concern. NBH will inform the Department of the referral to a peer review process.

The head of the professional review committee provides a written report of the committee's findings to the Executive Director, Director of Utilization Management, and Quality Improvement. The committee will compose a letter detailing a brief by clear description of the issue, the efforts taken to investigate the issue, and the outcome of the review. The outcome will include whether or not the issue was found to be a quality of care issue and what action NBH intends to take with the Provider involved. The letter will be sent to the Department within ten (10) business days of the Department's request.

If additional time for investigation and the peer review process is needed, the Department should be contacted for approval.

Based on the findings of the report, appropriate action steps will be taken, up to and including suspension or termination of the physician, and including reports to the National Practitioners Data Bank and other licensing boards.

Quality of Care Concerns Not Filed as Formal Grievances

If a consumer or consumer's designated representative registers a concern about the quality of care without filing a formal grievance, the Director of Consumer Affairs contacts the appropriate Program Director and follows the same steps detailed in the Procedures regarding disposition of a formal consumer grievance. A formal analysis will be conducted at the end of the year.

Quality of Care Concerns Regarding an Independent Provider

These concerns are reviewed by the Directors of QI, UM, and of Consumer Affairs. This includes formal grievances or informal complaints about quality of care furnished by private providers. Action steps involving private providers depend upon the nature of the grievance or concern

Quality of Care Concerns at Intensive Care Facilities

Quality of Care concerns that do not reach the level of critical incidents are monitored by the Intensive Care Coordinators at the Centers. Action steps will be taken as appropriate to the level of concerns and the degree of cooperation with the facility.

These are reviewed by the Directors of QI and UM for further investigation and response. Actions are taken appropriate to the level of concern, and can include removal of NBH consumers from the facility.

The Directors of Consumer and Family Affairs, UM and QI are authorized to act expeditiously to assure the safety of consumers, including immediate suspension of a provider or facility pending the results of an investigation into a grievance or complaint.

Critical Incident Reporting

All critical incidents involving NBH Medicaid consumers must be reported to the NBH Director of Clinical Services and the NBH Director of Quality Improvement. Critical incidents involve the following:

- Death by suicide or causing the death of another person;
- Consumer's effort to make a suicide attempt that requires medical attention;
- A homicide attempt;
- Other actions that posed a significant danger to self or others or involve the general public safety;
- Accidents that occur at any facility utilized by an NBH consumer resulting in injuries that require medical attention; and
- Physical or verbal abuse, neglect, or exploitation of consumers while at any facility utilized by an NBH consumer.

In the event that the critical incident results in the loss of life to the consumer and/or others, or posed a significant public safety risk, the NBH Clinical Director and the NBH Director of Quality Improvement shall be informed immediately upon determination of such an event. Appropriate and timely reporting shall also be made

to the police, if necessary, designated senior staff of the provider Center (if applicable), Division of Mental Health, and other appropriate agencies. Other, non-lethal events shall be verbally reported within one week of occurrence to the NBH Clinical Director and NBH Director of Quality Improvement.

After it is been determined that a critical incident involving an NBH consumer occurred, an initial written report summarizing the event(s) shall be sent within seven days of occurrence of the critical incident to the NBH Clinical Director and the NBH Director of Quality Improvement. If the critical incident occurs with a consumer being served by a member of the NBH Independent Provider Network, the Independent Provider shall conduct an identical review by working with the NBH Clinical Director. This report shall contain, at a minimum, the following:

- The date the report is being completed;
- The clinical care coordinator completing the report;
- The clinical or administrative supervisor of the clinical care coordinator completing the report;
- The name of the NBH consumer;
- The consumer's date of admission to NBH services;
- Risk factors identified at the time of admission of the consumer;
- Known medications taken by the consumer at the time of the critical incident.
- The events leading up to the critical incident;
- An explanation of how the NBH clinical staff learned of the critical incident;
- The specific nature of the critical incident, including the time, place, and other pertinent circumstances involved in the critical incident;
- Actions taken by NBH staff immediately following the critical incident;
- Current status of the NBH consumer at the time the report is being written; and
- This report shall be signed by the clinical coordinator and the appropriate supervisor.

Further Center Responsibilities

Within 30 days of the occurrence of the critical incident a formal review shall be undertaken by the Center provider responsible for the ongoing care of the consumer. The formal review will address the following issues.

- Brief description of consumer's prior treatment history;
- Description of all events involving danger to self or others or predisposition to such actions;
- A summary of the treatment history leading up to the time of the critical incident;
- Details of the circumstances leading to the critical incident;
- A description of the consumer's current mental and physical status as well as current location;

- Subsequent efforts taken to address psychiatric and psychological factors leading to the critical incident;
- Description of current service plan, including steps taken to address the nature of the critical incident;
- A description of any system issues that were involved in the critical incident and what was learned from the formal review; and
- This review will be signed by the clinical care coordinator, the appropriate supervisor, the Director of Quality Improvement for the Center provider, and the medical director for the provider Center.

The findings of the local provider Center review need to be sent to the NBH Clinical Director and the QI Director. If further investigation is deemed necessary by the aforementioned persons, they will assemble a professional NBH review committee of senior clinical staff to conduct a thorough assessment of the event. A written report of the findings of this assessment and its recommendations will be prepared and sent to the Executive Director of NBH.

Further Independent Provider Responsibilities

Although NBH performs the formal review of the critical incident, the Independent Provider will provide all clinical documentation needed at the request of NBH and will be available for interviews as needed.

Colorado Client Assessment Record

NBH will utilize the Colorado Client Assessment Record (CCAR) tool for all Members receiving Covered Services in the Community Mental Health Services Program and shall comply with established guidelines and instructions. CCARs will be completed for each Member as described in the State CCAR instructions. NBH will submit an electronic text file of all completed CCARs to the Department.

Completion of CCARs Responsibility

The responsibility of the Center staff or Independent Provider is defined in the charts on the next pages:

NBH CCAR Rules

MHC – Mental Health Center
IP – Independent Provider
IPN – Independent Provider Network

		Responsible for preparing the CCAR		Responsible for entering CCAR in appropriate electronic system			Explanation
		MHC	IP	MHC	IP	NBH	
Outpatient Admission	New Admit to NRBH, LCMH, or CMHC	X		MHC system			Admit CCAR prepared by Center clinician and entered into Center electronic medical record. Also responsible for update and discharge CCARs.
	New Admit to IPN		X		eCCAR system		Admit CCAR prepared by IP and entered into InNET eCCAR program. Also responsible for update and discharge CCARs.
	New Admit to IPN MHC		X		MHC system		Admit CCAR prepared by MHC and entered into that MHC CCAR system. Also responsible for update and discharge CCARS. Copy of CCAR must be sent to NBH as proof of completion. (NBH will enter those update and/or discharge CCARs for clients already entered in the InNET eCCAR program. For new admits the paper CCAR document will be placed in the client’s file and tracked in the NBH Operation Database.

		Responsible for preparing the CCAR		Responsible for entering CCAR in appropriate electronic system			Explanation
		MHC	IPN	MHC	IP	NBH	
Inpatient Admission	Not open at Admit for Inpatient services to NRBH, LCMH, or CMHC	X		eCCAR system			ICC responsible for obtaining CCAR from hospital or preparing CCAR. CCAR will be entered into InNET eCCAR program. Also responsible for discharge CCAR and entering it into InNET eCCAR program.
	Open at Admit for Inpatient services to NRBH, LCMH, or CMHC	X		MHC system			ICC responsible for obtaining CCAR from hospital or preparing CCAR. CCAR will be entered as an update into Center electronic medical record. Also responsible for update CCAR upon discharge of client.
	Open at Admit for Inpatient services to IPN	X		eCCAR system			ICC responsible for obtaining CCAR from hospital or preparing CCAR. CCAR will be entered into InNET eCCAR program. Also responsible for discharge CCAR and entering it into InNET eCCAR program.
	Managed by NBH					eCCAR system	NBH is responsible for obtaining both admit and discharge CCARs from hospital. NBH will enter the CCARs in the InNET eCCAR program

		Responsible for preparing the CCAR		Responsible for entering CCAR in appropriate electronic system			Explanation
		MHC	IP	MHC	IP	NBH	
Child Residential Admission	Open at Admit for Residential services to NRBH, LCMH, or CMHC <ul style="list-style-type: none"> Admit to TRCCF within same Center 	X		MHC system			TRCCF prepares update CCAR and enters it into Center electronic medical record. Also responsible for update and discharge CCARs and entering them into Center electronic medical record.
	<ul style="list-style-type: none"> Admit to other facility 	X		MHC system			<ul style="list-style-type: none"> Center prepares discharge CCAR and enters it into Center electronic medical record. Facility prepares admit CCAR and enters it into InNET eCCAR program. Also responsible for update and discharge CCARs and entering them into InNET eCCAR program.
	Open at Admit for Residential services to IPN		X		eCCAR system		

Medical Records

The documentation requirements of Northeast Behavioral Health are mandated by Statutes and Standards and Regulations promulgated by Health Care Policy and Finance (HCPF) and the Colorado Division of Mental Health (DMH or DHS). The maintenance of accurate client records is essential for insuring the delivery of quality, comprehensive treatment. Medical records document service delivery and continuity of care, provide information necessary for quality improvement reviews, are a source of statistical information and NBH, provide information necessary for billing purposes, and are essential in certain legal procedures. Consequently, it is important that all information be documented clearly and concisely so that it may be easily understood by those who review the record or provide continuing services to clients of NBH.

At a minimum, consumer medical records shall contain with identifying information (name, date of service, and time) on all records the following information:

- Intake Assessment;
- CCAR for admission, yearly updates if required, and discharge;
- Initial Service Plan (signed by all relevant parties);
- HIPAA Release of Information/Authorization (annually updated);
- Service Plan (updated prior to re-authorization and signed by all relevant parties);
- Individual and group progress notes;
- Mandatory Disclosure Form;
- Attendance contracts, treatment agreements, parental consent forms, other releases of information, progress notes;
- NBH authorizations, as appropriate/required;
- Copies of all documents sent to NBH, as appropriate/required;
- Copies of Medicaid and other insurance cards;
- Other clinical documentation;
- Discharge Summary; and
- Documentation of booklets given to the consumer:
 - Advance Directives brochure; and
 - Consumer Handbook.

Other information that may be required to be in a medical record:

- Other Facilities
 - Information from Schools
 - History and Physical by Physicians
 - Vocational Rehabilitation
 - Reports from Colorado Mental Health Institutes
 - Hospital Admission, Progress Notes, Discharge Summary
 - Medication Worksheet
 - Medication Order Sheet
- Medical

- Testing and Lab Reports
- Client Inventory Reports
- Test Protocols
- Psychological or Clinical Evaluation Report
- Lab Reports
- Medical Evaluation
- Voluntary Consent to Receive Psychotropic Medication
- Psychiatric Progress Note
- Vocational
 - Vocational Functional Assessment
 - Job Placement Record
 - Individual Written Rehabilitation Plan
 - Clubhouse Monthly Summary
 - Clubhouse & Vocational Services Referral Form
 - Vocational Services Referral
- Legal
 - Misc. Legal Papers (Divorce, Child Custody, etc.)
 - Protective Services Documentation Form
 - Subpoena
 - Certification Forms
 - › M-1 Emergency Mental Illness Report
 - › M-2 Rights of Patients
 - › M-2.1 Advisement to Person on 72-Hour Hold for Evaluation or Certified for Treatment
 - › Statement Letter from Professional Person to the Judge
 - › M-8 Notice of Certification and Short Term Treatment
 - › M-18 Motion and Order to Transport
 - › M-19 Application for Representation by Counsel
 - › M-20 Order Appointing Attorney
 - › M-12 Petition for Long-term Care and Treatment
 - › M-14 Petition for Extension of Long-term Care
 - › M-10 Notice of Termination
- Correspondence
 - Letters
 - Misc. notes from Clinical Staff
 - Misc. notes and letters from client, family, etc.
 - Letters to/from client
 - Letters to/from other agencies
 - Releases
 - › Authorization to Release/Request Information
 - › Information Released/Disclosed

Electronic Criteria for Determining Format

- Any form or document that requires a consumer's signature must be printed and filed in that medical record.

- All other staff documentation that does not require a consumer signature will not be printed and will be accessed electronically.
- Any documents obtained from other sources will be filed in the medical record.

Medical Records Security

Records are to be kept in secure, locked rooms or locked cabinets in the provider's offices. The confidentiality of medical records is protected by statutory requirements and ethical standards

At the mental health centers, all medical records are returned to the Medical Records Manager or the designated support staff for storage. No mental health center employee shall keep medical records in their desks nor may records be taken outside Center facilities without specific permission from the mental health center's Executive Director or his\her designee.

Medical records, forms, policies and procedures are in constant transition due to continuing changes in requirements for documentation. The mental health center Medical Records Department and the Quality Improvement/Assurance Committees are responsible for monitoring these changes and developing or revising existing policies and forms to maintain compliance with new requirements.

Time Frames for Paperwork

Billings and statistical reports need to be completed in a timely fashion. Moreover, good professional practice requires that client information be available in a timely fashion for continuity of care and supervision issues. There are time frames in which paperwork must be completed in order to satisfy these needs. Clinical providers are expected to complete all current and delinquent paperwork in a timely manner.

Retention/Archiving and Disposal of Medical Records

The provider shall preserve and maintain all treatment records for a minimum of ten (10) years from the last date of entry in the records, except in the case of minors whose records shall be maintained until the former consumer reaches his/her 25th birthday. A listing of the basic information is maintained before the chart is destroyed.

Intake Summary

Upon application for services, an Intake Summary form shall be completed for all individuals who are eligible for services. The initial assessment shall address the developmental, cultural and linguistic needs of the client.

Purpose:

- Identify client needs, strengths and desires so that the most appropriate mix of services will be provided through the appropriate human services

system.

- Obtain relevant information necessary to diagnose presenting problems and to develop appropriate treatment and case management plans based on the physical, emotional, behavioral, vocational and social needs of the client.
- The information provided on the Intake Summary form shall be congruent with information provided on the CCAR and with other information in the medical record.
- To identify need for further evaluation of one of the following areas: vocational; substance abuse, psychological testing; or psychiatric evaluation.
- To evaluate the whole person for making informed referrals using a collaborative approach with consumers, their families and community resources.

Process:

- An Intake is defined as an initial face-to-face interview between the provider and an individual eligible for services.
- In general, all parts of the Intake will be completed by the end of the first session. It is expected that the write-up for the intake will be completed within three business days of the actual date of the intake.
- Clients re-admitted within six months of the date of last contact require only an update of presenting problem, mental status, and any other information that changed in the interim.

Service Plan

A Service Plan is developed for each consumer. The Service Plan shall be developed in partnership with the consumer. The Service Plan shall be based upon the consumer's identified needs and be consistent with the results of the CCAR and the clinical assessment of the consumer. Service Plans will be strength based and will build upon the consumer's individual strengths.

Purpose:

- Describe the course of treatment, goals, objectives, modalities, and expected outcomes;
- Provide a link to the assessed needs, diagnosis and strengths identified in the initial assessment and the treatment being provided;
- Goals should be measurable, behavioral and quantifiable objectives related to each problem and related goals;
- Service plans should include the expected target date;
- Treatment modalities and strategies to be used, including best practices, to achieve the stated goals and objectives must be documented in the service plans; and
- Plan for the services to be delivered including but not limited to individual, group and family therapy; medication assessment and management;

psycho-education; psychological evaluation; skill development; vocational, residential and clubhouse and case management services. Case management services include advocacy, linkage, referral, monitoring and follow-up, service planning, and crisis management, in addition to the amount and frequency of services to be provided.

NBH service plans will be consistent with the following principles:

- Treatment will be holistic, focusing on the consumer's strengths;
- Consumers receiving services shall choose the outcomes (goals) they wish to achieve as well as the services they need to assist them in achieving those outcomes;
- Recovery model, health maintenance, and client education Will be incorporated into the service plans;
- Service planning shall reflect a thorough recognition and understanding of a consumer's or family's needs, desires, values, capabilities, life stages, living situation, and opportunities for greater independence in life activities;
- Services shall be tailored to the needs of consumers and families and not constrained by existing service delivery structures, program requirements or funding sources;
- Consumers receiving services shall be offered a range of options to accommodate their choices and needs;
- When desired services are not available, efforts will be made to locate or create them;
- NBH and private providers shall have the responsibility to be knowledgeable of and sensitive to cultural differences, and all service planning shall be culturally competent;
- Community-based supports, including personal support systems, shall be utilized to the greatest extent possible; and
- Consumers and families shall have opportunities to participate as advocates.

Process:

- In general, the Service Plan is begun at intake and is to be finalized no later than one week following the second session or within 30 days of the date of the initial assessment, whichever occurs first. An Interim Service Plan is developed as a part of the Intake Summary which will cover up to two sessions of treatment.
- Service Plans are to be updated, at a minimum, every six months and as the needs and treatment directions change through the course of treatment. The Rules and Regulations for the Colorado Public Mental Health System suggest that the following may constitute a major change in the consumer's condition:
 - Inability to live independently;
 - Inability to maintain safely in the community;

- Change in diagnosis;
 - Death or loss of a significant person, when level of functioning is affected;
 - Significant change in physical health status;
 - Change in substance use status;
 - Criminal justice involvement;
 - Violation of certification; and
 - Violation of Conditional Release requirements.
- If the consumer is certified for *involuntary treatment* under the Colorado statutes at any time during the treatment episode, the Plan will be reviewed every month by the attending professional person who shall confirm the appropriateness of the Plan by making a notation in a Progress Note.
 - All services delivered must be identified in the service plan.
 - All goals in the service plan are achievable within six months and are stated in measurable terms.
 - A Service Plan should be a ‘map of the treatment’ and used to guide the treatment, not written and forgotten until due again six months later. It should be available in sessions and reviewed with the consumer during the course of treatment to assist with the focus of treatment.

Clinical Progress Notes

A Progress note is required for every clinical contact a therapist has with a consumer. The progress note document includes, but is not limited to, client mental health issues and the type of care that was provided. Documentation of client contacts and progress towards treatment goals enhances continuity of care whether by the original therapist over time, or by a subsequent therapist of a care provider. Documentation is also required to demonstrate accountability of services rendered, to obtain payment for services, and to protect the care provider in high-risk situations. Progress notes should reflect treatment using best practices.

The Progress note shall be signed, dated, and placed in the consumer’s chart.

The following is a list of what is expected in a progress note:

- The progress note must be legible and include signatures and therapist’s credentials (print name if not legible);
- Identifying information (client name);
- Dates and time of service;
- Type of service (individual, group, family, etc.);
- All progress notes must follow the DAP or SOAP documentation format;
- Description of problem;
 - Client’s subjective report
 - Changes in circumstances
 - Treatment issues addressed

- Clinical impressions and/or diagnostic formulation. This should be linked with presenting problem and history, e.g., client continues to display symptoms of depression, continues to ruminate about the past, and continues to fear rejection by others or, e.g., client appears less depressed, reports decreased rumination about past, and seems to be more willing to take risks in making contact with other people.
- Assessment of functioning
 - Emotional state, mental status, coping abilities, motivation and risk assessment
 - Risk assessment should be conducted at each contact, including potential for harm to self or others (suicidal and homicidal ideation, plans, and/or intent, as well as abuse potential).
- Intervention and response to intervention-progress toward short/long term goals:
- Plans for future intervention. Next appointment and “check-in” notes (e.g., issues to be addressed, assessment to be done, and other follow-up notes).
- Progress notes **must** reflect the goals on the Service Plan.
- Progress/lack of progress toward goals is clearly documented in the record.
- Progress notes are current, with a minimum of 7 day entry. If no contact is made this should be indicated monthly.

Case Management Notes

Case Management contacts can occur with significant others, parents, guardians, and other service agencies that are necessary to help the client succeed in meeting treatment goals. All individuals who are receiving case management services must have an Individual Service Plan which includes the individuals or agencies with whom case management contacts will occur. Documentation of client contacts enhances coordination of care and is required to demonstrate accountability of services rendered, to obtain payment for services, and when appropriate to protect the care provider in high-risk situations.

A case management note is required for every case management encounter provided. It must include sufficient documentation of what has occurred. An abbreviated documentation formats are not acceptable. Case management services must be listed on the individual care plan. All types of case management to be used to assist in achieving the clients’ goals, which are related to the mental health diagnosis, must be identified. The note must identify the person(s) that were contacted and the agency they represent. Releases of information are required for all case management contacts and are to be placed in the clients’ chart. Case management does not include the following activities: social or recreational activities of a general nature, case finding, treatment services, and required documentation activities, activities provided on behalf of

an un-enrolled client or other administrative/supervisory activities. Case management activities include, but are not limited to: linkage, monitoring and follow-up, referral, advocacy, service planning, and crisis management. These inclusions are defined below:

- **Advocacy:** Advocacy to ensure that the consumer has access to needed services.
- **Monitoring/Follow-up:** Contacting the consumer or others to insure that the service plan is working for the consumer and/or monitoring the progress of the Service Plan.
- **Service Planning:** Activities with the consumer and/or with referral source, family or other collaterals, to develop a comprehensive plan.
- **Crisis Management:** Services performed to assist with or alleviate a crisis.
- **Referral:** Referring the consumer for needed services.
- **Linkage:** Working with the consumer and/or service agencies to secure needed services.

The following must be included on the case management note:

- Identifying information (client name, and ID number);
- Dates and times of contact;
- Type of service (modalities);
- Must reflect the medical necessity of the contact from the Service Plan;
- Must be legible, and signed with clinicians credentials;
- Must document services that were attempted, but were unable to be carried out, (e.g., phone calls, letters); and
- Must be filed in client's chart.

Missed Appointments and Services

When consumers unexpectedly miss appointments or discontinue treatment, an evaluation of the specific circumstances and an assessment of the risk factors involved in each case determine appropriate actions. Varied responses to consumers who "miss appointments" as opposed to consumers who are discontinuing treatment are made within the context of assessment of risk.

NBH recognizes that a single strategy does not work effectively with all populations. Clinician-care coordinators develop outreach plans that take into consideration these and other factors: diagnosis, severity of illness, cultural issues, age, cultural views of mental health services and stigma regarding mental illness.

Consumers who miss appointments and unexpectedly discontinue treatment are considered active cases until a definitive resolution is determined.

NBH appreciates that Providers can not continue to make appointments for clients who consistently "no show." Providers may have their own internal policies but they may not conflict with NBH policy. If a provider decides to discontinue care, the provider must contact the client in writing. If the client wishes to re-establish care but the Provider chooses not to

provide services for the client, the client should be directed to call NBH. NBH will assist the client in finding a new provider.

Risk Assessment

Primary factors considered in evaluation of risk include:

- Suicidal ideation or gestures
- Tendency toward violent behavior
- Known physical impairment that may prevent keeping appointments
- Mental status and/or judgment so seriously impaired the consumer could have been unable to remember the appointment (s)

Secondary factors considered include:

- Age of the consumer
- Severity of the illness
- Diagnosis
- Cultural issues
- Support network
- Past history of suicide attempts or other concerning behavior

Consumers who meet one or more of the primary factors are considered to have a high-risk status. The secondary factors determine the most appropriate means for contacting the consumer to promote continuation of needed mental health services. The procedures for contacting the consumers are detailed below. Consumers who do not meet any of the above criteria are considered to have low risk status.

High Risk Status

If a consumer is rated “high risk”, action is taken based on a single missed appointment not canceled in advance. When consumer’s risk status meets the criteria for a mental health hold, the Provider intervenes immediately.

When such a consumer unexpectedly misses a scheduled appointment, the assigned Provider attempts to make telephone contact with the consumer within one working day of the date of the appointment. When the consumer is a child, the Provider contacts the parent or legal guardian. Other outreach efforts, such as calling the consumer at work, calling available family members, school personnel, church and/or social supports, visiting the consumer’s home and initiating a welfare check, are pursued as indicated and appropriate for each individual consumer.

If the consumer is successfully contacted, the Provider determines if barriers exist to the consumer's ability to keep appointments (i.e. transportation barriers, need for home visits, consumer discomfort with the assigned provider, or disagreement with the service plan). Consumers and their families are given every support to voice their concerns and resolve issues that may have led to

reluctance to continue services. At this time, another appointment will be offered to the consumer.

If the Providers unable to contact the consumer, family member, significant other or others identified by the consumer on the first attempt within one working day, additional efforts to contact consumer are made. The type and frequency of additional contacts or other actions are based on the clinician-care coordinator's assessment of the individual consumer and the degree of risk involved. Part of the assessment involves determining whether the missed appointments are one of following:

- An isolated event
- Part of a pattern of missing appointments while remaining in treatment
- A prelude to a consumer discontinuing treatment

When appropriate, home visits are made by staff to re-connect with a consumer. Law-enforcement may be contacted for a wellness check based on the nature of the risk status. If the consumer is contacted, the aforementioned efforts to determine why the consumer did not keep the appointment (s) will be made. The Provider makes a concerted effort to set up another appointment with the consumer. In addition, the Provider attempts to maintain a connection with the consumer so, even if the consumer is not willing to come in for an appointment, ongoing telephone contacts can be continued. If appropriate, and when signed releases exist, family members, friends, or other community agencies with ongoing contact with the consumer are used to monitor the consumer's status.

Outreach efforts continue until the consumer is located and a decision is reached about ongoing mental health services, or until reasonable efforts have been exhausted. Consumers are not terminated from treatment until the clinical supervisor reviews the situation and agrees that this plan is appropriate.

The cases of consumers who meet high-risk criteria and choose to discontinue treatment are not terminated. At a minimum, they remain in inactive status for at least six months. In such incidents, consumers are asked if their clinician-care coordinators can make periodic telephone calls or contact the consumers' support networks to check on their status. At the end of six months, clinician-care coordinators meet with their clinical supervisors to determine whether a consumer's record will continue to remain open or be closed.

Low Risk Status

When a consumer does not appear for a scheduled appointment, the primary Provide reevaluates the need for follow-up. If follow-up efforts are deemed appropriate, and the consumer is successfully contacted, the Provider determines if barriers exist to the consumer's ability to keep appointments (i.e. transportation barriers, need for home visits). At this time, another appointment time is offered and identified barriers addressed. An appointment is made if the consumer wants to continue treatment. If the consumer is contacted and

declines to have any further appointments, no additional contacts are made. The case will be terminated and reasons for termination indicated.

When a consumer demonstrates a pattern of missing appointments, the Provider will address this issue with the consumer in the treatment planning process to determine if treatment is to be continued and at what level.

If telephone contact or home visits are not successful, or not appropriate for any reason, the following steps are followed:

- A letter is sent asking the consumer to contact the Provider within a specific time frame to schedule another appointment.
- If the consumer does not respond to the letter, the case is terminated and the reason for determination indicated.
- If the consumer responds to the letter by contacting the Provider and indicating a desire to continue treatment another appointment is made.

Consumers with Serious Mental Illness

During the course of treatment, consumers are encouraged to include family members and other support networks in their treatment. These individuals can provide a second line of communication with the consumer and about the consumer in the event that the consumer misses appointments or discontinues treatment. The consumer is asked to sign releases to contact these persons. If consumers express reluctance to provide contact names and telephone numbers, the clinician explains the benefits of the involvement of significant others in treatment. However, the consumer's wishes are honored. In addition, if the consumer is agreeable, the Provider attempts to maintain a connection with the consumer, so that even if the consumer is not willing to come in for an appointment, ongoing telephone contacts can be continued. Further out reach efforts include home visits, telephone calls, invitations to events at clubhouses and offering treatment at sites chosen by the consumer.

Minority Consumers

Providers take into consideration cultural, language and socioeconomic barriers when working with minority populations. Consumers who have a primary language other than English may have difficulty understanding the scheduling of appointments, their mental illness, the need for mental health treatment and/or medications, and the consequences of not continuing treatment and/or medications. Matching consumers with clinical staff who speak their language and understand their cultural issues is a priority for NBH

Consumers 60 years of Age and Older

Providers who work with the senior population understand that these consumers may be experiencing decreased levels of physical and cognitive functioning and that these factors may impact the ability to keep appointments. Stigma of mental health treatment is an additional obstacle to seniors face in getting and staying in treatment. Addressing the stigma through education about mental health and

counseling starts at the first contact. It is also essential that the Provider use the language of the individual being seen. This effort could include calling therapy sessions "counseling" or a "visit". Outreach to a senior in a residential facility is accomplished by contacting a staff member at the facility. Outreach to individuals living in their own homes may include telephone contact, home visits, and contact with the consumer's primary care physician, neighbors and family members or going to the senior center or senior lunch program.

Discontinued Treatment

When treatment is discontinued, the Provider makes a concerted effort to contact the consumer. The Provider then determines if barriers exist to the consumer's ability to keep appointments (i.e. transportation barriers, need for home visits, consumer discomfort with assigned provider, disagreement with the service plan). Consumers and their families are given every support to voice concerns and resolve issues that may have led to reluctance to continue services. At this time, another appointment is offered to the consumer. Consumers are offered the opportunity to plan for services that interest or will benefit them, as well as an opportunity to address difficulties or barriers that may have impacted the decision to discontinue treatment prematurely.

In addition, if the consumer is agreeable, the Provider attempts to maintain a connection with the consumer, so that even if the consumer is not willing to come in for an appointment, ongoing telephone contacts can be continued. If appropriate, and when signed releases exist, family members, friends, or other community agencies that have ongoing contact with the consumer are used to monitor the status of the consumer. This approach is designed to make it easier for consumers to decide to return for further services at some point in the future. Maintaining connection with consumers also facilitates future, needed emergency responses.

Provider Records Audit

Providers who may be audited include mental health centers, individual private providers (both single case and contracted), and treatment facilities. Individual providers who have no active clients and providers who are appropriately accredited are not audited.

Audits may be performed on- or off-site. Providers who will be audited include: individual providers, mental health centers, and facility providers. Providers who will not be audited include: individual providers with no active clients and facilities who are JHACO, CARF, or COA accredited.

Lists are compiled of active clients for each provider. These lists are mailed to providers along with a description of the upcoming audits. These materials are followed by telephone calls to schedule the audit and to clarify the audit process. For each provider, a subset of active clients is selected for audit, which consisted of

either 10% of the NBH caseload, or at least 2 audits. For providers with only one or two NBH clients, the entire NBH caseload is audited.

Quality of Practice Criteria:

Provider may be asked to demonstrate that he/she maintains patient health care records in a current, detailed, organized and comprehensive manner, and in accordance with applicable state and federal laws, which are consistent with the standards and the requirements of NBH. Records shall be legible and reflect all aspects of pertinent care. For each patient encountered, there shall be completed, dated and signed progress notes which, at a minimum, contain the chief complaint or purpose of the visit, diagnosis of findings and therapeutic plan. Where appropriate, there shall be evidence of follow-up of previous encounters.

Practitioner and facility practice patterns must reflect a general adherence to established practice protocols for associated treatments. Practitioners must provide a detailed description of treatment approach, as applicable, including:

- Clinical program components and structure;
- Treatment orientation, philosophies and approaches;
- Levels of professional clinical staff;
- Degree of physician involvement with patients;
- Levels of family and community involvement in the program;
- Frequency of clinical treatment planning and review sessions, including those who attend those sessions;
- Overall staffing levels;
- Education and experience requirements for the clinical staff, including credentials and treatment responsibilities;
- Patient populations best suited for the program; and
- Frequencies and types of clinical supervision provided.

Clinical records are audited on a regular basis by Quality Improvement staff. The reports are then reviewed by the NBH Quality Improvement Administrative Subcommittee. Charts are reviewed using the NBH Quality Improvement Standards, which are consistent with the standards set by the Colorado Department of Behavioral Health. Included in these standards are:

- › Intake summary present, complete, dated, and signed;
- › Medication information/care coordination;
- › CCAR complete as required;
- › Disclosure form complete;
- › Service Plan completed and signed as required;
- › Goals are strength based, in consumer's words, related to current issue, reflect diagnosis, specific, measurable, outcome based, and can be attained in a reasonable time period;
- › DSM-IV diagnosis is accurate and supported by documentation;

- Progress Notes correspond to claims billed, are in an appropriate format, include signature, title, date and time of service, and refer to progress on Service Plan goals;
- Case management contacts are clearly identified, are consistent with treatment;
- Release of Information is present.
- Availability of appointments; and
- Emergency availability
- Addresses the impact of culture on treatment

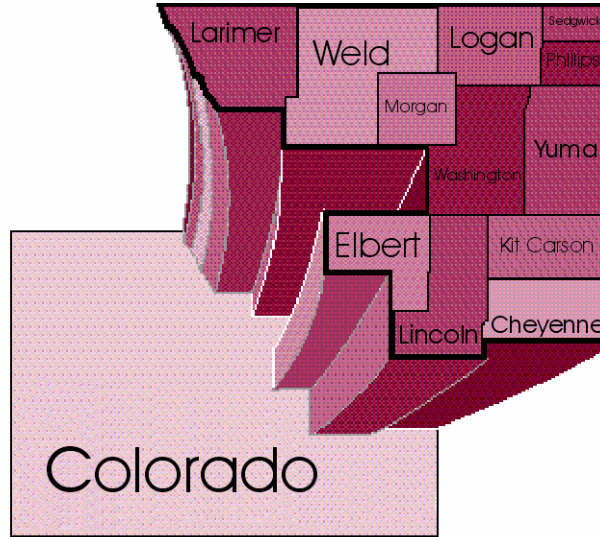
Other review items for on-site audit include: physical appearance and accessibility, waiting room space, treatment room space, and paid claims vs. clinical documentation. Please see attached clinical review forms for detailed information.

As extra level of oversight, an NBH evaluation team reviews randomly sampled service plans to certify that the appropriate mechanisms are in place to meet the identified treatment goals. If needed, the evaluation team provides technical assistance and clinical supervision with the provider. The evaluation team and staff involved in the authorization process monitor the provider and assure full compliance with all relevant performance requirements specified in the NBH contract.

Additionally, providers are monitored through responses to consumer satisfaction surveys sent to consumers periodically during the course of treatment and at termination of treatment.

The Quality Improvement Committee collect data and review overall service delivery and treatment outcomes on an ongoing basis. NBH providers are expected to participate actively in the overall quality improvement process and respond to all requests for information and quality improvements findings in a timely manner. The NBH Director of Quality Improvement will contact providers that fail to comply with expectation.

Appendix A



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

AUGUST, 2006

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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, Independent 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 antidepressant 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.
 - American Academy of Pediatrics (2001). Clinical Practice Guidelines: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder. *Pediatrics*, 108 (4), 1033-1044.
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 Mental Health, www.cdhs.state.co.us/dmh
6. The Expert Consensus Guideline Series, www.psychguides.com
7. Foothills Behavioral Health Care Organization, Colorado, www.fbhcolorado.org
8. Hawaii State Department of Health, Mental Health Division, Evidence Based Practice Services, www.hawaii.gov/health/mental-health
9. Medscape from WebMD: Psychiatry Practice Guidelines, www.medscape.com/pages/editorial/public/pguidelines/index-psychiatry
10. National Alliance on Mental Illness (NAMI), www.nami.org
11. The National Guideline Clearinghouse, www.guideline.gov, produced by the Agency for Healthcare Research and Quality (AHRQ) in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP) Foundation.
12. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, U.S. Department of Health and Human Services
 - www.samhsa.gov
 - Practice guidelines, www.mentalhealthpractices.org

- Evidence-Based Practices Implementation Toolkits, www.mentalhealth.samhsa.gov/cmhc/communitysupport/toolkits
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 indicator.
 - 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 Statistic 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:

1. The American Psychiatric Association Practice Guidelines and Guideline Watches, www.psych.org, www.appi.org
 - American Psychiatric Association (2002). *Practice Guidelines for the Treatment of Patients with Major Depressive Disorder*. Washington D.C.: Author.
 - American Psychiatric Association (2002). *Practice Guidelines for the Treatment of Patients with Bipolar Disorder (Second Edition)*. Washington D.C.: Author.
2. The American Psychological Association, Board of Professional Affairs, Committee on Professional Practice and Standards, www.apa.org
3. Colorado Work Group for Evidence Based Mental Health Practices, Colorado Department of Human Services, Division of Metal Health, www.cdhs.state.co.us/dmh
4. The Expert Consensus Guideline Series, www.psychguides.com
5. Foothills Behavioral Health Care Organization, Colorado, www.fbhcolorado.org
6. Hawaii State Department of Health, Mental Health Division, Evidence Based Practice Services, www.hawaii.gov/health/mental-health
7. Medscape from WebMD: Psychiatry Practice Guidelines, www.medscape.com/pages/editorial/public/pguidelines/index-psychiatry
8. National Alliance on Mental Illness (NAMI), www.nami.org
9. The National Guideline Clearinghouse, www.guideline.gov, produced by the Agency for Healthcare Research and Quality (AHRQ) in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP) Foundation.
10. The Royal Australian and New Zealand College of Psychiatrists, Clinical Practice Guidelines (Depression and Bipolar Disorder), www.ranzcp.org
11. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, U.S. Department of Health and Human Services
 - www.samhsa.gov
 - Practice guidelines, www.mentalhealthpractices.org
 - Evidence-Based Practices Implementation Toolkits, www.mentalhealth.samhsa.gov/cmhc/communitysupport/toolkits

12. 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.
13. 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