Behavioral Health Toolkit for Primary Care Providers

Aetna Better Health® of Kentucky

About this toolkit

Our primary care provider (PCP) serves as the cornerstone of our Aetna Better Health provider network. You play a vital role in ensuring that each of our members have a medical home and access to necessary health care, which provides continuity and coordination of care. Assuming this pivotal role, you are already aware of the growing numbers of your patients that present to you with both physical and behavioral health issues.

That is why Aetna Better Health of Kentucky has provided this toolkit to give our Primary Care Providers information and screening tools that they need to help them with early recognition and treatment of behavioral health disorders. Primary Care Providers need tools that are valid, reliable, brief, easy to administer and easily accessible. Aetna Better Health of Kentucky is committed to the integration of medical and behavioral health services with the end goal of achieving better outcomes for our members.

Confidentiality

It is essential for health care providers to respect an individual's autonomy and right to confidentiality if they are to be effective in developing a trusting relationship that will impact the quality of screening and proper follow-up interventions.

Health care providers need to be familiar with and abide by all applicable state and federal laws pertaining to the privacy of patient health information. Although state laws vary by state, the relevant federal laws include:

- Health Insurance Portability and Accountability Act (HIPAA).
- 42 CFR Part 2 (governs the confidentiality of alcohol and drug treatment information).

Table of Contents

Chapter One:
Anxiety Disorders

Overview

Anxiety disorders in children and adults

Anxiety disorders are the most common behavioral health condition that affects many people throughout the United States. An estimated 18 percent of adults have an anxiety disorder. The American Academy of Pediatrics indicates approximately 8 percent of children and adolescents experience some type of anxiety disorder that has a negative impact at school and home.

This overview intends to provide information on the diagnosis, types, symptoms, age of onset, treatment, Healthcare Effectiveness Data and Information Set (HEDIS®) standard, and a clinical practice guideline.

Diagnosis

The clinician should consult the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, to ensure the criteria are met. It is also advised that a thorough examination be completed to rule out any underlying medical and/or psychiatric conditions.

Indicators of an anxiety disorder may include:

- Feeling restless, wound-up, or on-edge
- Being easily fatigued
- Having difficulty concentrating; mind going blank
- Being irritable
- Having muscle tension
- Difficulty controlling feelings of worry
- Having sleep problems, such as difficulty falling or staying asleep, restlessness, or unsatisfying sleep
- Experiencing panic attacks which may include heart palpitations or accelerated heartrate, sweating, shaking, shortness of breath or feelings of impending doom or being out of control

Types

There are different types of anxiety disorders that have various symptoms and require individualized treatment plans for effective treatment to occur.

- **Generalized anxiety disorder (GAD)** is a common anxiety disorder in which an individual is almost continuously predicting, anticipating, or imagining “dangerous” (unpleasant) events.
- **Separation anxiety disorder:** The individual is fearful or anxious about separation from attachment figures to an extent that is developmentally inappropriate.

- Selective mutism: The individual consistently fails to speak in a social situation in which there is an expectation to speak, such as at school or work, even though the individual speaks in other situations.
- **Specific phobia:** The individual is fearful or anxious about or avoidant of certain objects or situations.
- **Social anxiety disorder:** The individual is fearful or anxious about one or more social situations in which the individual is exposed to possible scrutiny by others.
- **Panic disorder:** The individual experiences recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or discomfort accompanied by specific physical symptoms.
- **Agoraphobia:** The individual is fearful and anxious about two or more situations, such as using public transportation, being in open or enclosed spaces, standing in line or being in a crowd, or being outside of the home alone or in other situations.
- **Substance- or medication-induced anxiety disorder** pertains to anxiety that occurs during or soon after substance intoxication or withdrawal or after exposure to a medication.

Symptoms

Anxiety disorders last at least six months and can become worse if they are not appropriately treated. Symptoms vary for each individual and generally include:

- Excessive fears and worries.
- Continual nervousness or restlessness.
- Sleep disturbance.
- Extreme stress.
- Feelings of uneasiness.
- Extreme caution or hypervigilance.
- Withdrawal in social settings.
- Feeling keyed up or on edge.
- Difficulty concentrating or mind going blank.
- Irritability.
- Physical complaints (muscle aches or cramps, stomachaches, headaches, or other pain or discomfort).

Age of onset

Many of the anxiety disorders develop in childhood and persist to adulthood. Anxiety disorders can start as early as 6 years of age but are most prevalent among adolescents between the ages of 13 and 18. Women are more prone to experience an anxiety disorder than men.

Treatment

- Medication: antidepressants, anti-anxiety drugs, or beta blockers can be effective in treating these symptoms.
- Psychotherapy (talk therapy)

  - Cognitive behavioral therapy is an effective approach to help people address their fears by changing the way they think and respond to stressful events.
  - Exposure therapy uses a method to gradually expose a person to fearful situations that can lead to decreased anxiety.
- A combination of medication and psychotherapy has been an effective treatment for many people.
- Exercise and relaxation techniques, such as meditation, can help reduce overall stress and worry.

Clinical practice guidelines

The clinical practice guideline for treatment of patients with anxiety disorders is developed for use in a primary care setting.

Here are the major recommendations for adults with GAD, panic disorder (PD) with or without agoraphobia, and panic attacks:

- Cognitive behavioral therapy (CBT) is recommended as a treatment option due to its effectiveness in decreasing the symptoms of anxiety, worry, and sadness. It also improves panic symptoms and quality of life.
- CBT should include techniques such as cognitive restructuring, exposure, relaxation, breathing exercise, psychoeducation, and systematic desensitization.
- Anti-depressants are recommended as a medication option if:
  - Symptoms are severe or are not improving apart from medication. If optimal dosages are ineffective or medication is not well tolerated, consider switching to another selective serotonin reuptake inhibitor (SSRI).
  - There is no improvement after 8 – 12 weeks. In such cases, consider using another medication with a different mechanism of action such as a serotonin-norepinephrine reuptake inhibitor (SNRI).
- A combination of CBT and antidepressants is an effective treatment approach.
- Information about the symptoms, treatment options, and resources should be provided to the member and family as indicated to foster the self-management of the condition.

Additional information can be found at **www.guideline.gov/browse/by-topic.aspx.**

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.DSM5.org

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Committee for Quality Assurance (NCQA)
HEDIS® 2015 Technical Specifications for Health Plans, Volume 2

National Guideline Clearinghouse
www.guideline.gov/browse/by-topic.aspx

National Institute of Mental Health
www.nimh.nih.gov/health
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

Assessment, screening tools and follow-up for anxiety disorders

Assessment

The health care clinician should complete a comprehensive examination to include a medical, developmental, school history, and psychiatric history to rule out any underlying medical condition(s) and identify any other co-existing mental health condition(s). It is important to address these co-existing conditions that may affect one another. Anxiety disorders can co-exist with other mental health conditions that may include:

- Depression.
- Substance use disorders.
- ADHD.
- Eating disorders.
- Problems with sleeping.

Screening tools

There are several reliable screening tools to assess for anxiety disorders. These scales can be used to obtain baseline data on the severity of the symptoms and also be re-administered to monitor progress, which will guide the treatment plan. These can be found in Appendix A.

- Generalized Anxiety Disorder 7-Item (GAD-7) Scale.
- Screen for Child Anxiety Related Disorders (SCARED) Parent Version, to be completed by the parent.
- Spence Children's Anxiety Scale (SCAS).
- Hamilton Anxiety Rating Scale (HAM-A).

Follow-up interventions

The following interventions are based on the individual's needs and his or her agreement on the next steps. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool for anxiety disorder should be told the results of the screening.
- Individuals with positive results will need some type of intervention and will vary depending on the severity of the anxiety, such as:
  - Education on anxiety disorder(s).
  - Resource information on anxiety disorders.
  - Encouraging participation in a support group.
  - Discussing medication options if applicable.
  - Scheduling a follow-up appointment.
  - Referring to a behavioral health provider for therapy.
  - Referring to the health plan Integrated Health Care Management program.

    - For severe symptoms: Initiate a referral to a behavioral health provider who can further assess and provide a treatment plan.
- If the individual is in a crisis, call 911 and refer to the closest emergency room.

Resources for anxiety disorders

Member resources

Anxiety and Depression Association of America
www.adaa.org
Provides education to individuals and their families with anxiety disorders and helps them find treatment, resources, and support.

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease and Prevention
www.cdc.gov/tobacco/quit_smoking/Ocessation/quitlines/index.htm
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling 1-800-QUIT-NOW (1-800-784-8669) toll-free number.

Job Corps
www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, and earn a high school diploma or a GED.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Institute of Mental Health
www.nimh.nih.gov/health
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

National Suicide Prevention Lifeline
https://suicidepreventionlifeline.org
Trained counselors to help individuals with suicidal crisis and/or emotional distress.

Parent to Parent USA
www.p2pusa.org
Parent to Parent USA provides a support for parents/ grandparents/families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teen and young adult siblings who have a sister or brother with a mental illness.

Social Security Administration
www.ssa.gov/disability
Social Security and Supplemental Security Income disability programs may provide financial assistance to people with disabilities.

Provider resources

Anxiety and Depression Association of America
www.adaa.org/resources-professionals

American Academy of Child & Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/about-suicide

American Psychiatric Association
www.psychiatry.org/patients-families

Centers for Disease Control and Prevention
www.cdc.gov/mentalhealth

National Institute of Mental Health
www.nimh.nih.gov/health/topics/anxiety-disorders

Appendix A: Screeners for anxiety disorders


HAMILTON-ANXIETY.pdf


ScaredParent.pdf


scas-boys-8-11.pdf


scas-girls-12-15-scorer.pdf


scas-girls-8-11-scorer.pdf


scas-boys-12-15-scorer.pdf


GAD-7_Anxiety-updated_0.pdf

Chapter Two:
Attention Deficit Hyperactivity Disorder

Overview

Attention deficit hyperactivity disorder (ADHD) is a common neurobehavioral condition in children and adolescents that interferes with their performance in school, ability to maintain social relationships, and ability to complete tasks at home. Adults can also have ADHD, which can lead to problems at work, problems with relationships, and the inability to get organized with everyday activities. Both adults and adolescents with ADHD are at increased risk for school failure, multiple car accidents, cigarette smoking, and other substance use.

This overview intends to provide information and consideration about ADHD diagnosis, symptoms, age of onset, treatment, Healthcare Effectiveness Data and Information Set (HEDIS®) standard, and a clinical practice guideline.

Diagnosis

To diagnose ADHD for any child 4 through 18 years of age, the primary care clinician should determine that Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria have been met (including documentation of impairment in more than one major setting). It is also advised that a thorough examination be completed to rule out any underlying medical and/or psychiatric conditions.

Symptoms

Symptoms of ADHD interfere with an individual's routine activities, such as school, work, relationships, and household activities. Children with ADHD have symptoms that decrease their ability to function compared with other children the same age.

Symptoms must be present in more than one setting and persist for at least six months.

- **Inattentiveness**: easily distracted, trouble focusing, problems completing a task, trouble completing or turning in homework assignments, often losing things, not listening when spoken to, daydreaming, difficulty processing information, and struggling to follow instructions.
- **Hyperactivity or impulsivity**: excessive restlessness, fidgety, talks nonstop, trouble sitting still, constantly in motion, difficulty doing quiet activities, impatient, talks out of turn, blurts out inappropriate comments, difficulty taking turns or waiting for things, often interrupts conversations.
- **Combined type**: Some individuals with significant symptoms have both inattentive and hyperactive/impulsive symptoms.

Age of onset

The American Academy of Pediatrics has expanded its guidelines to recommend that any child between 4 – 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity and may need evaluation for ADHD.

The average age of onset is 7 years old. Boys are more frequently diagnosed than girls with ADHD by about three to one.

Treatment

For preschool-aged children (4 – 5 years of age), the primary care clinician may prescribe parent/teacher evidence-based behavior management training as the first-line treatment. Methylphenidate may be prescribed if the behavior interventions do not provide significant improvement and there is moderate to severe continuing disturbance in the child's function.

For elementary school-aged children (6 – 11 years of age), the primary care clinician may prescribe U.S. Food and Drug Administration-approved medications for ADHD or follow parent/teacher evidence-based behavior management training as treatment for ADHD, preferably both.

For adolescents (12 – 18 years of age), the primary care clinician may prescribe U.S. Food and Drug Administration-approved medications for ADHD with the assent of the adolescent and/or recommend behavioral therapy for ADHD, preferably both.

For adults (18 years and older), the primary care clinician may prescribe U.S. Food and Drug Administration-approved medications for ADHD and/or recommend counseling services, preferably both.

School-based services

Special education services: Children with ADHD may be eligible for special education services. They may qualify under the "Other Health Impairment" disability category for an individual education plan (IEP). If they do not qualify for special education services, they still might be eligible for a 504 plan.

Parents/caregivers can request for the public school to provide testing at no cost to the family to further evaluate the child's needs. The request must be submitted in writing to the school before testing can occur.

There are two main laws that ensure a child's rights to an appropriate public education. The Individuals with Disability Education Improvement Act (IDEA) is the nation's federal special education law. This law requires states to provide a free age-appropriate education in the least restrictive environment to meet the needs of children (ages 3 – 21) who have disabilities with varying degrees of severity.

- The IEP: This is the key document developed by the parent/caregiver and the child's teachers in a collaborative approach. The IEP serves as a road map that includes the child's academic achievement, annual goals, progress toward goals, and accommodations to help meet those goals. Conferences with the parent/caregiver, child, and schoolteachers/officials are required to occur at least annually.
- Section 504 of the Rehabilitation Act of 1973: This is the civil rights law that protects individuals with disabilities in any agency, school, or institution to eliminate barriers and provide the appropriate accommodations to allow the child to participate in the general curriculum. An individualized document (504 plan) is created that outlines the child's needs and accommodations, but not to the extent of an IEP. Conferences with the parent/caregiver, child, and schoolteachers/officials are required to occur at least annually.

Clinical practice guidelines

The following clinical practice guidelines include the major recommendations for the diagnosis and management of ADHD in children, young people, and adults.

Individuals with ADHD require integrated care that addresses a broad range of personal, social, educational, and occupational needs, and treatment by health care professionals who have adequate expertise in the diagnosis and management of ADHD.

Health care professionals should:

- Develop a trusting relationship with individuals with ADHD and their families by:
  - Respecting their knowledge and experience of ADHD.
  - Being sensitive to stigma in relation to mental illness.
- Provide individuals with ADHD and their families with age-appropriate information about ADHD regarding diagnosis, assessment, support options, treatment, and the use and potential side effects of medication.
- Allow individuals to provide their own explanation of their feelings, symptoms, and how it is impacting the different domains of their life.
- Involve the individual and family in treatment decisions.
- Become familiar with local and national resources pertaining to ADHD.
- Provide adults with ADHD written information about local and national support groups and voluntary organizations.
- Inquire about the impact of ADHD on patients and their families.
- Encourage participation in self-help and support groups when relevant.
- Discuss parent-training/education programs to optimize parenting skills and provide referrals.
- Determine the severity of the problems, how these affect the individual and family, and the impact on the different domains and settings.

Additional clinical practice guidelines:

- Parent training/education is the first line of treatment for parents of pre-school children.
- Following a diagnosis of ADHD, the health care professional with the parent/caregiver consent should contact the child's pre-school or teacher to explain the diagnosis and severity of symptoms, the care plan, and any special education needs.
- Drug treatment should be provided for school- age children with moderate to severe impairments.
- For older adolescents with ADHD and moderate impairment, cognitive behavioral therapy (CBT) or social skills training may be considered.
- Prior to starting a medication, it is important to document baseline measures on height and weight plotted on a growth chart, heart rate and blood pressure, mental health and social assessment, family history of cardiac disease, and risk for substance misuse.
- Antipsychotics are not recommended for the treatment of ADHD in children and young people.
- When starting medications, monitor side effects.

Additional information can be found at: **www.guideline.gov/content.aspx?id=36881&search=adhd**

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.DSM5.org

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Committee for Quality Assurance (NCQA)
HEDIS® 2015 Technical Specifications for Health Plans, Volume 2

National Guideline Clearinghouse
www.guideline.gov/browse/by-topic.aspx

National Institute of Mental Health
www.nimh.nih.gov/health
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

Assessment, screening tools and follow-up for attention deficit hyperactivity disorder (ADHD)

Assessment

The primary care clinician should include assessment for other conditions that might co-exist with ADHD, including emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders); developmental (e.g., learning and language disorders or other neurodevelopmental disorders); and physical (e.g., tics, sleep apnea) conditions.

Screening tools

Screening tools and checklists help clinicians obtain information from parents, teachers, and others about the individual's symptoms and functioning level in various settings. Symptoms must be present in more than one setting (e.g., home and school) to meet the DSM-5 criteria for the diagnosis of ADHD.

The following rating scales are often used to screen and evaluate children and adolescents for ADHD:

- SNAP IV Scale (created by Swanson, Nolan, and Pelham).
- SWAN Rating Scale (strengths and weaknesses of ADHD symptoms).
- Vanderbilt ADHD Parent Rating Scale.
- Vanderbilt Teacher Rating Scale.

For adults, the 18-question Adult ADHD Self-Report Scale (ASRS v1.1) can be utilized. There is an online version that can provide a quick score and indicate whether further testing by a health care professional is warranted.

Follow-up interventions

The following interventions are based on the individual's needs and his or her agreement on the next steps. It is ultimately the individual's choice to receive or decline the following recommended interventions.

All individuals who complete a screening tool for ADHD should be told the results of the screening. Individuals with positive results will need some type of intervention and will vary depending on the severity of the condition, such as:

- Provide education on ADHD.
- Provide resource information on ADHD.
- Encourage participation in a support group.
- Discuss medication options if applicable.
- Assess the concern for possible medication misuse before initiation of stimulant therapy.
- Prepare the individual and family to the initial medication process to include beginning with a low dose and incrementally increasing to the optimal dose to achieve maximum benefit and minimal side effects.
- Schedule a face-to-face follow-up appointment that is recommended within the first two – three weeks of initiation of the medication.

- For the first year of treatment, face-to-face visits are recommended every three months and then at least twice a year.
- Initiate a referral to a behavioral health provider for therapy if appropriate.
- Refer to the health plan Integrated Health Care Management program.
- Severe symptoms: Initiate a referral to a behavioral health provider who can further assess and provide a treatment plan.
- If the individual is in a crisis, call 911 and refer to the closest emergency room.

Resources for attention deficit hyperactivity disorder (ADHD)

Member resources

ADHD Directory and Resource
addresources.org
Provides education, support, resources, and networking opportunities for individuals with ADHD.

Attention-Deficit Disorder Association (ADDA)
www.add.org
Provides information, resources, and networking opportunities to assist adults with attention deficit disorder lead more productive lives.

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease and Prevention
www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling 1-800-QUIT-NOW (1-800-784-8669) toll-free number.

Children and Adults with Attention-Deficit/ Hyperactivity Disorder (CHADD)
www.chadd.org
Provides education, advocacy, and support for individuals with ADHD.

Job Corps
www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, earn a high school diploma, or a GED.

Kids Health
kidshealth.org/teen
Provides education and resources regarding children and teen's health and development.

Mental Health America
www.mentalhealthamerica.net
Promotes mental health as a critical part of overall wellness, which includes prevention, early identification and intervention for individuals.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources, and support for individuals with mental illness.

National Center for Learning Disabilities (NCLD)
www.ncld.org
Works to ensure that children, adolescents, and adults with learning disabilities have every opportunity to succeed in school, work, and life.

National Institute of Mental Health
www.nimh.nih.gov/health/index.shtml
Provides information on a variety of mental health conditions regarding diagnosis, treatment options, and resources.

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Trained counselors to help individuals with suicidal crisis and/or emotional distress.

PACER Center: Champions for Children with Disabilities
www.pacer.org
A parent training and information center on education, bullying, vocational, training, and employment for youth and young adults with disabilities.

Parent to Parent USA
www.p2pusa.org
Provides a support for parents/grandparents/families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teen and young adult siblings who have a sister or brother with a mental illness.

Social Security Administration
www.ssa.gov/disability
Social Security and Supplemental Security Income disability programs may provide financial assistance to people with disabilities.

Provider resources

American Academy of Child & Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/about-suicide

Attention-Deficit Disorder Association
www.add.org

American Psychiatric Association
www.psychiatry.org/patients-families

Attention Research Update Newsletter
www.helpforadd.com

Bright Futures
www.brightfutures.org

Centers for Disease Control and Prevention (CDC)
www.cdc.gov/ncbddd/adhd

Center for Mental Health Services Knowledge Exchange Network
www.mentalhealth.org

Children and Adults With Attention-Deficit/ Hyperactivity Disorder (CHADD)
www.chadd.org

Comprehensive Treatment for Attention-Deficit Disorder
www.ctadd.com

National Institute of Mental Health
www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd

Appendix B: Screeners for Attention Deficit Hyperactivity Disorder

NICHQ-Vanderbilt-Assessment-Scales.pdf

prevhealth_swan.pdf JMA_

Vanderbilt-Teacher-Informant.pdf

SNAPIV.pdf

Chapter Three:
Depressive Disorders

Overview

Depression is a potentially life-threatening disorder that affects approximately 14.8 million Americans 18 years of age or older in a given year. Depression also affects many people younger than age 18.

Depression is associated with substantial morbidity and disability for individuals. Yet, depression is a highly treatable condition. Primary care providers should be equipped to screen for depression and provide immediate treatment either in their own practices or by referring to a mental health professional for a more severe depressive episode.

This overview intends to provide information on the diagnosis, types, symptoms, age of onset, treatment, Healthcare Effectiveness Data and Information Set (HEDIS®) standard, and a clinical practice guideline.

Diagnosis

The clinician should consult the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, to ensure the criteria are met. It is also advised that a thorough examination be completed to rule out any underlying medical and/or psychiatric conditions.

- Members diagnosed with one or more chronic conditions are at increased risk for depression.
- Members may self-identify, or clinician may observe signs of depression during the interview or examination.
- Multiple somatic complaints may suggest underlying depression.
- Past history, substance use disorder, family history, history of abuse, presence of anxiety and acute or chronic psychosocial stressors are all risk factors for depression.

Types

There are several forms of depressive disorders that have various symptoms and require individualized treatment plans for effective treatment to occur.

- **Major depressive disorder or major depression**: The individual has a mixture of symptoms that interfere with the individual's ability to work, sleep, study, eat and enjoy once-enjoyable activities. Major depression can be disabling if not treated and stops an individual from doing his or her usual activities. Some individuals may have only a single episode within their lifetimes, but more often an individual may have multiple episodes.
- **Dysthymic disorder, or dysthymia**: The individual has a long-term (two years or longer) depression, but it may not be severe enough to disable an individual. Still, it can stop the individual from doing usual activities or from feeling well. Individuals with dysthymia may also experience one or more episodes of major depression during their lifetimes.
- **Postpartum depression**: The individual experiences symptoms more serious than the "baby blues" that many women have after giving birth, when hormone and physical changes occur and the new

duties of caring for a newborn can be overwhelming. It is estimated that 10 percent to 15 percent of women have postpartum depression after giving birth.
- **Seasonal affective disorder (SAD)**: The individual will experience depression during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be treated with light therapy.

Symptoms

For major depressive disorders, at least five of the following symptoms must be present most of the day for at least two weeks. Also, at least one of the first two symptoms must be present:

- Depressed mood.
- Marked diminished interest in usual activities.
- Significant increase or loss in appetite or weight.
- Insomnia or hypersomnia.
- Psychomotor agitation or retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or guilt.
- Difficulty with thinking, concentrating or making decisions.
- Recurrent thoughts of death or suicide.

Depression in teens can look very different from depression in adults. The following symptoms of depression are more common in teenagers than in their adult counterparts.

- Irritable or angry mood: Irritability, rather than sadness, is often the predominant mood in teens with depression. A teenager with depression may be grumpy, hostile, easily frustrated or prone to angry outbursts.
- Unexplained aches and pains: Teens with depression frequently complain about physical ailments such as headaches or stomachaches. If a thorough physical exam does not reveal a medical cause, these aches and pains may indicate depression.
- Extreme sensitivity to criticism: Teens with depression are plagued by feelings of worthlessness, making them extremely vulnerable to criticism, rejection and failure. This is a particular problem for "overachievers."
- Withdrawing from some people, but not all: While adults tend to isolate themselves when depressed, teenagers usually keep up at least some friendships. However, teens with depression may socialize less than before, pulling away from their parents, or start hanging out with a different crowd.

Age of onset

Although the average age of an individual with depression is 32, the STAR*D (Sequenced Treatment Alternatives to Relieve Depression) study found that nearly 40 percent of youth had their first depressive episode before the age of 18.

Treatment

- The Texas Medication Algorithm Project is a diagnostic tool that may be helpful for medication management of depression.
- Antidepressants from several subcategories have been found to be effective: SSRIs, SNRIs, atypical antidepressants, tricyclics and MAOIs.
- The most widely prescribed antidepressants are SSRIs.
- Psychotherapy (talk therapy).
- Combination of medication and psychotherapy have been an effective treatment for many people.
- Some simple things can lift mood, such as exercise, healthy eating, and getting a healthy amount of sleep.
- Depression is a disease of isolation, so finding ways to spend time with family and friends can be helpful.

Clinical practice guideline

The following clinical practice guidelines include the major recommendations for the treatment of individuals with major depressive disorder.

- Evaluation and management:
  - Complete a comprehensive assessment that will rule out any underlying medical and/or psychiatric conditions.
  - Complete a safety evaluation that includes a suicide risk level and risk of harm to others.
  - Coordinate care with other clinicians when appropriate.
  - Assess and acknowledge potential barriers to treatment.
  - Provide patient and family education.
- Treatment:
  - Common medications to consider:
    - Selective serotonin reuptake inhibitors (SSRIs).
    - Serotonin norepinephrine reuptake inhibitors (SNRIs).
    - Mirtazapine.
    - Bupropion.
    - Nonselective monoamine oxidase inhibitors (MAOIs).
  - Refer to psychotherapy:
    - Cognitive behavioral therapy.
    - Interpersonal psychotherapy.
    - Psychodynamic.
    - Marital and family therapy.
    - Problem-solving therapy in individual and group sessions.
  - Combination of medications and psychotherapy is an effective approach.

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

American Psychiatric Association
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013)
www.DSM5.org

American College of Preventive Medicine (2009, October 6): Primary Care Urged to Have Systems in Place for Screening and Treating Depression. ScienceDaily.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Committee for Quality Assurance (NCQA)
HEDIS® 2015 Technical Specifications for Health Plans, Volume 2

National Guideline Clearinghouse
www.guideline.gov/browse/by-topic.aspx

National Institute of Mental Health
www.nimh.nih.gov/health
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

Assessment, screening tools and follow-up for Depressive Disorders

Assessment

When initially assessing the member, the clinician should consider other conditions that may appear with depressive-like symptoms:

- Medication side effects.
- Antihypertensive drugs, cardiovascular drugs, sedatives.
- Analgesics, narcotics, anti-inflammatory agents.
- Hormones can influence mood.
- Use of alcohol and street drugs can influence presentation.
- Adolescents with depression are often excessively critical of themselves and feel they are a failure, yet do not recognize their feelings and symptoms as depression.

Screening tools

The screening process starts with the Patient Health Questionnaire (PHQ-9), a well-known and valid tool. See Appendix C for the PHQ-9.

- The PHQ-9 and the PHQ-9A for adolescents are part of most electronic health records system.
- The PHQ-9 can be self-administered before or during the office visit.
- Translations into other languages are available by going to www.phqscreeners.com.
- Scoring of the PHQ-9 is done by the provider.

Follow-up interventions

PHQ-9 proposed treatment actions:

- 0 – 4: No or minimal severity; no action proposed
- 5 – 9: Mild severity, watchful waiting and repeat PHQ-9
- 10 – 14: Moderate – treatment plan, and consider counseling, follow-up and/or pharmacotherapy
- 15 – 19: Moderately severe – active treatment with pharmacotherapy and/or psychotherapy
- 20 – 27: Severe – immediate initiation of pharmacotherapy and if the member shows severe impairment or poor response to therapy, initiate an expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Resources for depressive disorders

Member resources

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents and families in crisis.

Centers for Disease Control and Prevention
www.cdc.gov/tobacco/quit_smoking
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling 1-800-QUIT-NOW (1-800-784-8669) toll-free number.

Depression and Bipolar Support Alliance
www.dbsalliance.org
National organization that provides peer support groups and training, education, and support for parents and guardians for individuals who have mood disorders.

Job Corps
www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, or earn a high school diploma or a GED.

Kids Health
www.kidshealth.org/teen
Provides education and resources regarding children and teen's health and development.

Mental Health America
www.mentalhealthamerica.net
Promotes mental health as a critical part of overall wellness that includes prevention, early identification and intervention for individuals.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates and offers resources, and support for individuals with mental illness.

National Institute of Mental Health
www.nimh.nih.gov/health
Provides information on a variety of mental health conditions regarding diagnosis, treatment options and resources.

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Trained counselors to help individuals with suicidal crisis and/or emotional distress.

Parent to Parent USA
www.p2pusa.org
Provides a support for parents, grandparents and families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teen and young adult siblings who have a sister or brother with a mental illness.

Social Security Administration
www.ssa.gov/disability
Social Security and Supplemental Security Income disability programs may provide financial assistance to people with disabilities.

Provider resources

American Academy of Child & Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/about-suicide

American Psychiatric Association
www.psychiatry.org/mental-health

Centers for Disease Control and Prevention
www.cdc.gov/mentalhealth

Depression and Bipolar Support Alliance
www.dbsalliance.org

National Institute of Mental Health
www.nimh.nih.gov/health

Appendix C: Screeners for depressive disorders

phq9-patient-health-questionnaire.pdf

Chapter Four:
Substance Use Disorders

Overview

Since substance use disorders are frequently a chronic condition that can progress slowly, the primary care clinician is in an optimal position to screen for alcohol and drug problems. Research has shown that primary care clinicians can help individuals reduce alcohol consumption through office-based interventions that only take 10 or 15 minutes.

Alcohol-related disorders are present in up to 26 percent of primary care patients, which is a prevalence rate similar to those for other chronic conditions, such as hypertension and diabetes.

This overview intends to provide information on the diagnosis, types, symptoms, age of onset, treatment, and a clinical practice guideline.

Diagnosis

Substance use disorders are present when an individual has a recurrent use of alcohol and/or drugs that results in problems with overall health and significant functional impairment regarding school, work, and responsibilities. Many mental health experts no longer refer to this condition as substance abuse/dependence. Substance use disorders is the most recent term used, which further describes this condition as mild, moderate, or severe.

The clinician should consult the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, to ensure the criteria are met. It is also advised that a thorough examination be completed to rule out any underlying medical condition(s) and/or psychiatric condition(s). Each specific substance is addressed as a separate disorder, but most substances are diagnosed based on the same primary criteria.

Types

The most common types of substance use disorders include:

- **Alcohol use disorder** (AUD) is characterized by problems controlling alcohol intake, continued use of alcohol despite serious consequences, involvement in risky situations, development of substance tolerance, withdrawal symptoms occur.
- **Tobacco use disorder** (TUD) often leads to significant health conditions, such as lung cancer, respiratory disorders, heart disease, stroke, and in many instances, death.
- **Cannabis use disorder** (CUD): Marijuana use can lead to distorted perception, problems with thinking and problem solving, impaired motor coordination, respiratory infection, decreased memory, and exposure to cancer causing compounds.
- **Stimulant use disorder** (SUD) often leads to increased alertness, attention, energy, blood pressure and heart rate; amphetamines are the most abused type of stimulant.
- **Hallucinogen use disorder** (HUD): The use of these drugs can result in hallucinations, feelings of detachment from one's body and environment, and discrepancies with time and perception.

- **Opioid use disorder** (OUD): The use of these drugs reduces the perception of pain; there are illegal opioids such as heroin and legal opioids such as prescription pain killers. Both types can lead to misuse, which often results in an overdose.

Symptoms

It is important for primary care clinicians to be aware of the signs and symptoms of an individual's substance use to be able to intervene effectively.

Physical signs:

- Dental cavities.
- Swollen hands or feet.
- Swollen parotid glands.
- Leukoplakia in mouth.
- Gingivitis.
- Perforated septum.
- Needle track marks.
- Skin abscesses, burns on inside of lips.
- Disrupted menstrual cycle.
- Dilated or constricted pupils.
- Slurred, incoherent, or too rapid speech.
- Inability to concentrate.
- Unsteady gait.
- Nodding off.
- Blackouts or memory loss.
- Insomnia or other sleep disturbances.
- Withdrawal symptoms.
- Agitation.

Psychiatric or behavioral signs:

- Depression.
- Anxiety.
- Low self-esteem.
- Feelings of desperation and/or loss of control.
- Impulsive and risk-taking behavior.
- Alienation and rebellious behavior.
- Academic and behavior problems at school.
- Involvement with the criminal justice system.
- Poor interpersonal relationships.

Age of onset

Unfortunately, substance use disorders are starting in our youth aged 12 and up who are engaging in alcohol, tobacco, cannabis, and stimulant misuse.

The use and abuse of alcohol and drugs is a common occurrence by teens and can lead to dire consequences.

Treatment

The treatment for substance use disorders will vary depending on the individual's age, severity, and type of substance use. There are several components that can be a part of the treatment plan for a successful recovery based on the member's needs, which may include:

- Individual and group counseling: The goal is to reduce or stop substance use, build skills, develop a recovery plan, and to provide social support and mentors (e.g., cognitive behavioral therapy).
- Intensive outpatient program offers intensive and regular treatment sessions three times a week for several hours per day.
- Partial hospital program offers intensive and regular treatment sessions four times a week for several hours per day.
- Inpatient hospitalization involves a brief hospitalization to address withdrawal symptoms, medication adjustment, individual/group sessions, and facilitate a recovery plan.
- Residential treatment facility offers a highly structured setting with the goal of intensive treatment and preparation for the return to community outpatient programs.
- Medication: The goal is to help reduce the symptoms of withdrawal so the person can better participate in treatment sessions.
- Case management services provide community- based support, resources, and referrals.
- Recovery support services provide individuals with additional supports to help them be successful in their treatment, such as transportation services, support groups (e.g., AA meetings), employment or educational supports, peer-to-peer mentoring/ coaching/sponsors, faith-based support, and education about wellness and recovery.

Clinical practice guidelines

Individuals with substance use disorders vary regarding many clinically prominent features and areas of functioning. Therefore, health care providers will need to use a multimodal approach to treatment for the most effective outcomes. The main interventions in assisting individuals with substance use disorders are the following:

- Conduct a thorough assessment.
- Treat intoxication and withdrawal symptoms when needed.
- Address co-existing psychiatric and medical conditions.
- Develop and implement an overall treatment plan.
- Refer to specialists when needed.

Assessment, screening tools and follow-up for substance use disorders

Assessment

Discussing sensitive questions about substance use in the context of other behavioral lifestyle questions may be less threatening than just asking about substance use to individuals. There are a variety of screening instruments that assess for substance use in adolescents and adults that can become part of your overall screening protocols and tools.

Screening tools

There are several reliable screening instruments to assess for substance use disorders. See Appendix D for the full instruments.

- CAGE-AID: a brief screening tool to use for individuals ages 18 and older. Asking the following questions of every adult routinely is an efficient way of screening and identifying substance use problems at an early stage in his or her development.
- AUDIT (Alcohol Use Disorders Identification Test) Questionnaire: a brief instrument that can be incorporated into a general health interview, lifestyle questionnaire, or medical history.
- CRAFFT: identifies adolescent alcohol and drug use and associated behaviors and is incorporated into the American Association of Pediatric Policy Statement on Substance Use Screening, Brief Intervention, and Referral to Treatment for pediatricians.

Follow-up interventions

The following interventions are based on the individual's needs and agreement on the next steps. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool for alcohol or drug use should be told the results of the screening.
- For individuals who do not appear to have any substance use problems, no further intervention is required.
- Individuals with positive results will need some type of intervention and will vary depending on the severity of the use, such as:
  - Provide education on the hazards of alcohol and drug use.
  - Provide resource information on substance use disorders.
  - Encourage participation in AA and Al-Anon support groups.
  - Discuss medication options if applicable.
  - Schedule a follow-up appointment.
  - Initiate a referral to a behavioral health and/ or substance use provider for therapy.
  - Refer to the health plan: Integrated Health Care Management program.
  - Severe symptoms: Initiate a referral to a behavioral health and/or substance use provider who can further assess and provide a treatment plan.
  - If the individual is showing signs of withdrawal and/or is in a crisis, call 911 and refer to the closest emergency room.

Resources for substance use disorders

Member resources

Alcoholics Anonymous
www.aa.org
Mutual support group dedicated to individuals with substance use disorders.

Boys Town National Hotline
www.boystown.org
Provides trained counselors to help teens, parents, and families in crisis.

Centers for Disease and Prevention
www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm
Provides support to quit smoking that includes the following free services: coaching, quit plan, educational materials, and a referral to local resources by calling 1-800-QUIT-NOW (1-800-784-8669) toll-free number.

Job Corps
www.jobcorps.gov
Provides education and training programs that help young individuals (at least 16 years old) develop a career, find a job, earn a high school diploma, or a GED.

Kids Health
kidshealth.org/teen
Provides education and resources regarding children and teen's health and development.

Mental Health America
www.mentalhealthamerica.net
Promotes mental health as a critical part of overall wellness, which includes prevention, early identification and intervention for individuals.

Narcotics Anonymous
www.na.org
Provides support groups that provide each member with the opportunity to share and hear the experiences of others who are learning to live without the use of drugs.

National Alliance on Mental Illness (NAMI)
www.nami.org
Educates, advocates, and offers resources and support for individuals with mental illness.

National Council on Alcoholism and Drug Dependence Inc.
www.ncadd.org
Provides a resource for individuals who are struggling with alcoholism and addiction.

National Institute of Mental Health
www.nimh.nih.gov/health
Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
Trained counselors to help individuals with suicidal crisis and/or emotional distress.

Parent to Parent USA
www.p2pusa.org
Provides a support for parents/grandparents/families with children with special health care needs and mental illness.

Sibling Support Project
www.siblingsupport.org
Provides support for teen and young adult siblings who have a sister/brother with a mental illness.

Social Security Administration
www.ssa.gov/disability
Social Security and Supplemental Security Income disability programs may provide financial assistance to people with disabilities.

Provider resources

Alcoholics Anonymous
www.aa.org

American Academy of Child & Adolescent Psychiatry
www.aacap.org

American Academy of Family Physicians
www.aafp.org

American Academy of Pediatrics
www.aap.org

American Foundation for Suicide Prevention
www.afsp.org/about-suicide

American Psychiatric Association
www.psychiatry.org/patients-families

Centers for Disease Control and Prevention
www.cdc.gov/mentalhealth

Narcotics Anonymous
www.na.org

National Council on Alcoholism and Drug Dependence Inc.
www.ncadd.org

National Institute of Mental Health
www.nimh.nih.gov/health

Provides information on a variety of mental health conditions in regard to diagnosis, treatment options, and resources.

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Appendix D: Screeners for substance use disorders


CAGE Substance Screening Tool.pdf


COMBINED-CRAFFT-2.1-Self-Admin_Clinic


audit.pdf

Chapter Five:
Post-Traumatic Stress Disorder

Overview

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape, or who have been threatened with death, sexual violence, or severe injury.

Diagnosis

For a diagnosis of PTSD, symptoms must last more than one month, and typically manifest within three months after experiencing a traumatic event although occasionally symptoms may emerge years later. Symptoms of depression, anxiety or substance use often accompany PTSD.

Symptoms fall into four categories. Specific symptoms can vary in severity:

- Intrusion or re-experiencing: includes repeated involuntary memories, distressing dreams, or flashbacks of the traumatic event
- Avoidance: staying away from reminders of the trauma, such as people, places, activities, or objects connected to the traumatic event. The person may avoid thinking or talking about the event and how they feel about it.
- Alterations in cognition and mood: difficulty remembering the traumatic event, negative thoughts or feelings that lead to persistent distorted beliefs about the self or others; ongoing feelings of fear, horror, anger, guilt or shame, as well as feeling detached from others or that the world is "not real" in some instances
- Alterations in arousal and reactivity: may include irritableness or angry outbursts, reckless or self-destructive behavior, trouble sleeping or concentrating, being easily startled or overly watchful of surroundings

Young children often exhibit different symptoms as they may be unable to fully communicate their experiences. Children may experience time skew, where trauma-related events are mis-sequenced when recalling the memory, as well as omen formation, a belief that if they are alert enough, they will recognize warning signs and avoid future trauma. These two symptoms are not typically seen in adults. School-aged children may also exhibit posttraumatic play in which they compulsively repeat an aspect of the trauma and unlike reenactment does not typically alleviate anxiety. An example might be an increase in shooting games after exposure to a school shooting.

Adolescent symptoms may be more similar to adult PTSD symptoms but are more likely to engage in traumatic reenactment or exhibit impulsive and aggressive behaviors.

Types

These subtypes are all considered part of the PTSD illness, but those who have these subtypes might need different treatments or therapies in order to get better. Authors writing for Current Psychiatry suggest that there are five different PTSD subtypes:

- Victim-related trauma: Includes witnesses of a criminal attack, or they were the victims of the attack involving physical violence or sexual abuse, including rape.
- Natural-disaster trauma: Found in survivors of earthquakes, tornadoes, hurricanes, and flooding - events rarely caused by human intervention.
- Survivor trauma: Sometimes, only one person survives the incident and might have a very specific form of PTSD that is tied to the fact that they lived through the event while others did not.
- Perpetrator guilt: Most forms of PTSD involve the thoughts and feelings of a person who was helpless in the face of fear, but people in this subtype had at least something to do with the event. They may have planned it and participated in it, while realizing that they made a terrible mistake. Or they may have been caught up in the moment, and then realized the error days or months later.
- PTSD not otherwise specified: Includes those who were affected by the aftermath of traumatic events without having been a direct witness, such as those who clean up after tornadoes or collect bodies from crime scenes.

Age of Onset

PTSD can occur at any age and is directly associated with exposure to trauma. Adults and children who have PTSD represent a relatively small portion of those who have been exposed to trauma. This difference is not yet well understood but we do know that there are risk factors that can increase a person's likelihood of developing PTSD. Risk factors can include prior experiences of trauma, and factors that may promote resilience, such as social support.

Treatment

PTSD can be treated and managed in several ways.

- Psychotherapy, including Cognitive Processing Therapy (CPT) or Eye Movement Desensitization and Reprocessing (EMDR)
- Medications
- Self-management strategies, such as self-soothing and mindfulness, are helpful to ground a person and bring her back to reality after a flashback
- Service animals, especially dogs, can help soothe some of the symptoms of PTSD

Clinical Practice Guidelines

Implementing trauma-informed care principles is fundamental to successfully engaging patients in their care. This includes:

- Creating a safe physical and social-emotional environment.
- Training both clinical and non-clinical staff in trauma-specific treatment approaches.
- Involving patients in the treatment process
- Screening for trauma
- Engaging referral sources and partnering organizations to address the complex medical, behavioral health, and social service needs of individuals who have experienced trauma.

Assessment, screening tools and follow-up for PTSD

Assessment

Careful assessment is an important part of evidence-based practice. Initial assessments can help determine possible treatment options, and periodic assessment throughout care can guide treatment and gauge progress. The following instruments (or earlier versions that corresponded to DSM-IV) were used in the studies that served as the evidence base of the systematic review that undergirds the guideline recommendations. Each instrument has evidence of reliability and validity, and several are available at no cost. These instruments include both interview and self-report measures. Potential uses include screening, diagnosis, and tracking of treatment outcomes.

Screening Tools

See Appendix E for full copies of the following screening tools:

- Primary Care PTSD Screen for DSM-5: 5-item screen designed for use in primary care settings
- PTSD Checklist for DSM-5 (PCL-5): a 20-item self-report measure assessing the 20 DSM-5 symptoms of PTSD; also used to monitor symptom change during and after treatment

Follow-up Interventions

All individuals who complete a screening tool should be told the results of the screening, and frequent re-screening should be avoided to avoid re-traumatization from revisiting traumatic experiences. For

For adults, the U.S. Department of Veterans Affairs recommends engaging patients in shared decision making, including educating patients about effective treatment options along with collaborative care interventions to actively engage in evidence-based treatments.

- Individual, manualized trauma-focused psychotherapy over other pharmacologic or non-pharmacologic interventions as primary treatment
- If individual trauma-focused psychotherapy is not available or preferred, pharmacotherapy or non-trauma-focused psychotherapy
- Psychotherapies that have a primary component of exposure and/or cognitive restructuring, such as EMDR or CPT
- Manualized group therapy over no treatment

For children and adolescents, the following treatments are recommended:

- Cognitive-behavioral therapy (CBT)
- Play therapy
- Psychological First Aid
- EMDR
- Specialized interventions for particularly problematic symptoms or behaviors

Although SSRIs have been approved for use in children and adolescents with depression and OCD, there is currently insufficient evidence to support the use of SSIRs to treat PTSD in children.

Resources for PTSD

Anxiety and Depression Association of America
https://adaa.org/understanding-anxiety/posttraumatic-stress-disorder-ptsd/treatment

American Psychiatric Association
www.psychiatry.org/ patients-families/ptsd/what-is-ptsd
https://www.apa.org/ptsd-guideline/assessment

Current Psychiatry. 2009 September;8(9):37-41; Ashley Benjamin, MD, MA

National Alliance of Mental Health Illness
https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Posttraumatic-Stress-Disorder

National Center for Biotechnology Information
https://www.ncbi.nlm.nih.gov/books/NBK83241/

The National Child Traumatic Stress Networks
https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions?search=&modality=1&page=2

Key Ingredients for Successful Trauma-informed Care Implementation,
SAMHSA
https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Appendix E: Screeners for PTSD


pc-ptsd5-screen.pdf


PCL5_Standard_form.PDF

Chapter Six:
Eating Disorders

Overview

People with eating disorders can show a broad range of symptoms often occurring along a continuum between Anorexia Nervosa and Bulimia Nervosa. Eating disorders are more commonly seen among females; however, males do suffer from these disorders too. The ratio of female to male prevalence is estimated from 6:1 to 10:1. Weight preoccupation is a primary symptom in both anorexia and bulimia. Some patients who initially present with Bulimia Nervosa may subsequently develop anorexic symptoms. Regardless of the origin of their weight loss, patients who are significantly underweight will require a medically monitored, nutritional rehabilitation program.

Diagnosis

Eating disorders often are long-term illnesses that may require long-term treatment. In addition, eating disorders frequently occur with other mental disorders such as depression, substance abuse, and anxiety disorder. Signs may include:

- Feeling distressed, ashamed, or guilty about eating
- Frequently dieting, possibly without weight loss
- Refusal to eat certain foods or whole categories of food
- Withdrawal from usual friends and activities
- Extreme concern with body size, shape; frequent checking for perceived flaws in appearance
- Noticeable fluctuations in weight, up and down
- Stomach cramps or other gastrointestinal complaints
- Maintaining an excessive, rigid exercise regime despite weather, fatigue, illness, or injury
- Mild anemia and muscle wasting and weakness
- Drinking excessive amounts of water/non-caloric beverages and/or using excessive mouthwash, mints, or gum
- Worn tooth enamel and increasingly sensitive and decaying teeth
- Feelings of disgust, depression, or guilt after overeating
- Hoarding food in strange places
- Brittle hair and nails; dry and yellowish skin; growth of fine hair all over the body
- Drop in internal body temperature, causing a person to feel cold all the time
- Lethargy, sluggishness, or feeling tired all the time
- Chronically inflamed and sore throat; swollen salivary glands in the neck and jaw area
- Eating even when full, not hungry or until uncomfortably full
- Eating alone or in secret to avoid embarrassment

Types and Symptoms

- **Anorexia nervosa**: People with anorexia nervosa avoid food, severely restrict food, or eat very small quantities of only certain foods. Even when they are dangerously underweight, they may

see themselves as overweight. They may also weigh themselves repeatedly. There are two subtypes:
    - Restrictive: place severe restrictions on amount and type of food they consume
    - Binge-purge: in addition to restricting the amount and type of food they consume, they may have binge eating and purging behaviors (such as vomiting, use of laxatives and diuretics, etc.).
- **Bulimia nervosa**: People with bulimia nervosa have recurrent episodes of eating unusually large amounts of food and feeling a lack of control over these episodes. This binge-eating is followed by behaviors that compensate for overeating, such as forced vomiting, excessive use of laxatives or diuretics, fasting, excessive exercise, or a combination of these behaviors. Unlike those with anorexia nervosa, people with bulimia nervosa may maintain a normal weight or be overweight.
- **Binge-eating disorder**: People with binge-eating disorder lose control over their eating. Unlike bulimia nervosa, periods of binge-eating are not followed by purging, excessive exercise, or fasting. As a result, people with binge-eating disorder are often overweight or obese.

Onset

Young people between the ages of 14 and 25 are most at risk. The average age of onset of Anorexia Nervosa is 16 - 17 yet the number of cases of children affected and cases of early onset continues to rise. The average age of onset of Bulimia Nervosa is 18 or 19 years.

Treatment

Typical treatments include:

- Individual Counseling/therapy helps a person to learn more about eating disorders and examine some of the difficult feelings that lie underneath. They will work on improving their self-esteem and developing new coping strategies. Therapy or counselling also helps a child to become motivated over time to recover from an eating disorder.
- Family therapy focuses on education about eating disorders, and helping parents develop the tools and strategies needed to support their child's recovery. Once the eating disorder behaviors have improved, family work may also focus on reducing any other stress in the family, and on adolescent issues in general.
- Medications can be used to help reduce binge-eating and purging in bulimia nervosa. There are no medications proven to treat anorexia nervosa. Medications, however, may be looked at to treat overwhelming anxiety and depression, or when a patient is very stuck and not getting better with other supports.
- Hospitalization may be required if a patient is medically unwell and needs intensive care and monitoring. Hospitalization can also be helpful when a person is not getting better outside of the hospital despite support from their family and professionals.

Clinical Practice Guidelines

According to the American Psychiatric Association, treatments for eating disorders include:

- Nutritional Rehabilitation
- Psychosocial treatments including:

  - Structured inpatient and partial hospitalization programs - Most inpatient programs use one of many behaviorally formulated interventions, individual and family psychotherapy, empathic nursing approaches, nutritional counseling, and several group therapies designed to improve the patient's knowledge about and attitude toward eating, exercise, and body image.
  - Individual and family psychotherapy
  - Psychosocial interventions based on addiction models (such as 12 step programs, with medical model using CBT interventions).
  - Support groups
  - Group psychotherapy using psychodynamic and cognitive behavioral approaches,
  - Self-help approaches in conjunction with pharmacology.
- Medications, including:
  - Antidepressants
  - Antipsychotics
  - Other medications (including antianxiety medications)
  - Combinations of psychosocial and medication treatments

Assessment, screening tools and follow-up for Eating Disorders

Assessment

A comprehensive assessment of a child or adolescent suspected of having an eating disorder includes a thorough medical, nutritional, and psychiatric history, followed by a detailed physical examination.

A full psychosocial assessment, including a home, education, activities, drugs/diet, sexuality, suicidality/depression (HEADSS) assessment is vital. This evaluation includes screening for physical or sexual abuse by using the principles of trauma-informed care and responding according to American Academy of Pediatrics guidance on suspected physical or sexual abuse or sexual assault73–75 as well as state laws. Vital to the HEADSS assessment is an evaluation for symptoms of other potential psychiatric diagnoses, including suicidal thinking, which may have been unrecognized previously.

A comprehensive physical examination, including close attention to growth parameters and vital signs, allows the pediatrician to assess for signs of medical compromise and for signs and symptoms of eating disorder behaviors; findings may be subtle and, thus, overlooked without careful notice. For accuracy, weights are best obtained after the patient has voided and in an examination gown without shoes. Weight, height, and BMI can be evaluated by using appropriate growth charts.

Screening Tools

- Eating Attitudes Test (EAT-26) ©: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation.
- SCOFF: consists of five questions to help identify potential eating disorders. This is not to be used as a diagnostic tool.

Follow-up Interventions

The following interventions are based on the individual's needs and agreement on the next steps. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool should be told the results of the screening.
- Individuals with positive results will need some type of intervention and will vary depending on the severity of the use, such as:
  - Check CBC, CMP, and electrocardiogram (ECG)
  - Selective use of the following tests: leptin level, TSH and T4, amylase and lipase, gonadotropins (LH, FSH) and sex steroids (estradiol, testosterone), Dual Energy X-ray Absorptiometry (DEXA).
  - Consider performing a longer diagnostic evaluation using the Eating Disorders Examination (EDE)
  - Consider hospitalization and/or referral to a multidisciplinary eating disorders program; these usually include some or all of the following: psychiatrist, family therapist, psychologist, pediatrician, nurse, dietician, and other therapists.
  - Evaluate for comorbid conditions such as depression, anxiety, or obsessive-compulsive disorder.

- Consider symptom-based referrals to a pediatric cardiologist, endocrinologist, psychiatrist, behavioral health specialist, and/or pediatric gynecologist.
- For adolescents with anorexia nervosa, consider referral for family-based treatment; these patients may be less responsive to antidepressants.
- For adolescents with bulimia nervosa, refer for short-term psychotherapy (e.g., cognitive behavior therapy) and consider antidepressant medications.

Resources for Eating Disorders

EMental Health Canada
https://www.ementalhealth.ca/Toronto/Eating-Disorders-in-Children-and-Youth-Guide-for-Parents-and-Caregivers/index.php?m=article&ID=8874

SAMHSA
https://ncsacw.samhsa.gov/files/TrainingPackage/MOD3/EatingDisorders.pdf

National Institute of Mental Health
https://www.nimh.nih.gov/health/publications/eating-disorders/index.shtml

American Academy of Pediatrics
https://pediatrics.aappublications.org/content/147/1/e2020040279

National Center of Excellence for Eating Disorders
https://www.nceedus.org/wp-content/uploads/2020/05/Part-1_-Intro-to-Eating-Disorders.pdf

National Eating Disorders Association Helpline
Call, chat, or text for support, resources, and treatment options for yourself or a loved one.
(800) 931-2237
https://www.nationaleatingdisorders.org/help-support/contact-helpline

Appendix F: Screeners for Eating Disorders


SCOFF-Questions.pdf


eat-26-rating-scale.pdf

Chapter Seven:
Autism Spectrum Disorder (ASD)

Overview

Diagnosis

The clinician should consult the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, to ensure the criteria are met. It is also advised that a thorough examination be completed to rule out any underlying medical condition(s) and/or psychiatric condition(s).

The number of people diagnosed with ASD has increased; this is believed to be due to a broader definition of ASD alongside better screening and diagnosis efforts, although a true increase cannot be ruled out. Although African American and Hispanic children are diagnosed at a later age on average, race, ethnicity, and socioeconomic status did not affect the accuracy of routine screening tests for ASD in low-risk toddlers, suggesting that screening with appropriate supports for follow-up care can lower the age at diagnosis in diverse populations. It has also been suggested that girls may have lesser intensity of symptoms and fewer externalizing behaviors, which may contribute to a lower rate of diagnosis in girls.

Although the cause of ASD is unknown, some risk factors include having a sibling with ASD, older parents or certain genetic conditions (such as Down syndrome, fragile X syndrome, and Rett syndrome) are more likely than others to have ASD. Frequently comorbid disorders with ASD include seizure disorder, gastrointestinal problems and sleep disturbance, as well as intellectual disability and one or more psychiatric disorders, especially anxiety spectrum disorders and/or obsessive-compulsive disorder.

Types

Using the previous version of the DSM, people could be diagnosed with one of several separate conditions:

- Autistic disorder
- Asperger's' syndrome
- Pervasive developmental disorder not otherwise specified (PDD-NOS)

In the current revised version of the DSM (the DSM-5), these separate conditions have been combined into one diagnosis called "autism spectrum disorder." Using the DSM-5, for example, people who were previously diagnosed as having Asperger's syndrome would now be diagnosed as having autism spectrum disorder.

Symptoms

Symptoms of ASD fall in the categories of social communication and interaction as well as restricted, repetitive patterns of behaviors, interests, or activities. These may include:

- Unusual body language, such as avoidance of eye contact
- Difficulty interpreting others' feelings and body language
- Difficulty understanding or following non-autistic social rules
- Strong interests/hyperfixations

- Importance of routine and difficulty dealing with changes in routines
- Stimming - repetitive movements, often as a self-soothing technique
- Echolalia
- Sensitivity to sensory input (such as bright light, loud sounds)
- Difficulty with fine motor skills or coordination
- Difficulty controlling volume

Age of Onset

ASD can usually be reliably diagnosed by the age of two. Language delay can be identified by using the Infant and Toddler Checklist in low-risk infants and toddlers between 12 and 18 months of age.

ASD symptoms in older children and adolescents who attend school are often first recognized by parents and teachers and then evaluated by the school's special education team. Older children may have subtle communication issues, such as problems understanding tone of voice, facial expressions, or body language. Older children and adolescents may have trouble understanding figures of speech, humor, or sarcasm. Parents may also find that their child has trouble forming friendships with peers.

Children with milder symptoms and/or average or above-average intelligence may not be identified with symptoms until school age, when differences in social language or personal rigidities affect function. Some children who are later diagnosed with ASD are initially believed to have precocious language, reading, or math skills, and it is not until the social demands of school or college that the social language symptoms become problematic.

Treatment

People with ASD may be referred to doctors who specialize in providing behavioral, psychological, educational, or skill-building interventions. These programs are typically highly structured and intensive and may involve parents, siblings, and other family members. Programs may help people with ASD:

- Learn life-skills necessary to live independently
- Reduce challenging behaviors
- Increase or build upon strengths
- Learn social, communication, and language skills

Medication may be used to treat certain symptoms such as irritability, aggression, attention problems, or anxiety and depression.

Clinical Practice Guidelines

The early identification of developmental problems should lead to further developmental and medical evaluation, diagnosis, and treatment, including early developmental intervention. If a child is diagnosed with a developmental disorder through the evaluation and diagnostic process, they should be identified as a child with special health care needs, and chronic-condition management should be initiated.

- Screen for developmental problems during well-child visits of young children
- Discuss results of screening and consider feedback around additional concerns
- Provide education to parents around ASD and developmental disabilities (i.e., ASD is not caused by vaccines)

- Include multi-disciplinary assessment during evaluation process

Assessment, screening tools and follow-up for ASD

Assessment

The American Academy of Pediatrics recommends that developmental surveillance be incorporated at every health supervision visit. Any concerns raised during surveillance should be addressed promptly with standardized developmental screening tests. In addition, screening tests should be administered regularly at the 9-, 18-, and 24- or 30-month visits.

For adults, there are no verified screening tools, but adults may be referred to a neuropsychologist, psychologist or psychiatrist specializing in ASD. The specialist will discuss concerns such as those around social interaction, sensory issues, repetitive behaviors, and restricted interests. They will examine information about the adult's developmental history, which may include speaking with parents or other family members.

Screening Tools

It is important for doctors to screen all children for developmental delays, but especially to monitor those who are at a higher risk for developmental problems due to preterm birth, low birth weight, or having a sibling or parent with an ASD.

- Modified Checklist for Autism in Toddlers (MCHAT): Parent-completed questionnaire designed to identify children at risk for autism in the general population.
- Ages and Stages Questionnaires (ASQ): This is a general developmental screening tool. Parent-completed questionnaire; series of 19 age-specific questionnaires screening communication, gross motor, fine motor, problem-solving, and personal adaptive skills; results in a pass/fail score for domains.
- Parents' Evaluation of Developmental Status (PEDS): This is a general developmental screening tool. Parent-interview form; screens for developmental and behavioral problems needing further evaluation; single response form used for all ages; may be useful as a surveillance tool.

Follow-up Interventions

The CDC recommends the following interventions after a pediatric developmental screening depending on the results and any additional concerns following discussion of the results:

- Negative screening, no concerns: Discuss results and provide anticipatory guidance; no immediate action required, but re-screen at next well-child visit
- Negative screening, some concerns: Provide anticipatory guidance; monitor development and re-screen at next well-child visit
- Positive screening: discuss results and concerns; perform more specific medical and developmental assessment and/or refer for further assessment; refer to appropriate early intervention services if child is under 3 years old, or special education program if 3 years or older

Adults who notice the signs and symptoms of ASD should talk with a doctor and ask for a referral for an ASD evaluation. While testing for ASD in adults is still being refined, adults can be referred to a neuropsychologist, psychologist, or psychiatrist who has experience with ASD.

References

Autistic Self-Advocacy Network
https://autisticadvocacy.org/about-asan/about-autism/

University of Louisville, Kentucky Autism Center
https://www.uoflautism.org/

ASD support groups and resources from the University of Kentucky
https://libguides.uky.edu/Information_Portal/Autism_Resources/Intro
https://ukhealthcare.uky.edu/kentucky-childrens-hospital/services/developmental-behavioral-pediatrics/autism-resources

National Institute for Mental Health
https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/

Center for Disease Control
https://www.cdc.gov/ncbddd/autism/hcp-screening.html

Social Security Administration
www.ssa.gov/disability
Social Security and Supplemental Security Income disability programs may provide financial assistance to people with disabilities.

Appendix G: Screeners for Autism Spectrum Disorder


form_PEDSQuestionnaire.pdf


3-year-ASQ-ENGLISH.pdf


M-CHAT-R_F_1.pdf

Chapter Eight:
Screening, Brief Intervention and Referral to Treatment (SBIRT)

Overview

SBIRT is a comprehensive, integrated public health approach that leads to the early identification of and intervention for individuals with one or more substance use disorders and also those who are at risk for developing these types of disorders.

The SBIRT process can help primary care providers and other health care specialists detect the severity of substance use disorders, depression, and other behavioral issues, and identify the appropriate level of treatment. Early intervention and treatment are vital to achieve positive outcomes and an improved quality of life for individuals with both substance use disorders and mental illness.

Importance of SBIRT

Recent studies have shown that individuals with serious mental illness die as much as 25 years earlier than the general population due to medical causes rather than suicides. It also shows many of these deaths may have been avoidable with routine preventive services and proper follow-up care for chronic medical diseases. Substance use disorders is a high comorbidity with individuals with serious mental illness.

Untreated chronic disease is a major reason in the overall higher cost of care for individuals with mental illness and/or substance use disorders.

Many individuals with these disorders are seeking treatment from their primary care provider rather than a behavioral health provider.

Core components

There are three main components to delivering the SBIRT process:

- Screening: brief process that effectively assesses the severity of substance use and/or mental illness and identifies the appropriate level of treatment.
- Brief intervention: focuses on raising awareness and increasing motivation toward behavioral change that supports overall health.
- Referral to treatment: critical component that facilitates a clear pathway for follow-up with individuals that have been identified with substance use disorder and/or mental illness that are in need of specialized treatment.

Refer for treatment

Referral to treatment is a vital component of the SBIRT process. This involves establishing a follow-up with the individuals who need more

intensive and specialized treatment services. This can be a complex process, and many individuals will need assistance in several areas:

- Obtaining access to specialized treatment.

- Selecting treatment facilities.
- Resolving barriers such as transportation.
- Understanding the cost and insurance reimbursement.
- Making the initial appointment.
- Completing forms.

Assessment, screening tools and follow-up for SBIRT

Assessment

Many individuals continue to be underdiagnosed for mental health and substance use disorder conditions and as a result do not receive treatment. Routine screenings in primary care and other health care settings facilitates the early identification of mental health conditions and substance use disorders that leads to earlier care. Screenings should be provided to individuals of all ages.

Screening tools

There are several reliable screening tools to assess for both substance use disorders and mental health

conditions. Here are some examples of brief screening tools that provide valuable clinical information:

- AUDIT (Alcohol Use Disorders Identification Test) is a 10-item questionnaire that assesses for dangerous alcohol consumption. This was developed by the World Health Organization and has been used with various populations and cultural groups. The questionnaire was primarily designed to be administered in primary care settings.
- AUDIT-C is a three-item questionnaire that assesses for dangerous alcohol consumption. This can be a separate screener or included as part of a general health history questionnaire.
- DAST-10 (Drug Abuse Screen Test) is a 10-item self-report scale to provide a brief assessment of drug abuse. It can be used with adults and older youth for screening and treatment purposes.

These tools can be found at: www.integration.samhsa.gov/clinical-practice/screening-tools

(See other chapters for further screening assessments.)

Follow-up interventions

The following interventions are based on the individual's needs and willingness to take the next steps in intervention. It is ultimately the individual's choice to receive or decline the following recommended interventions:

- All individuals who complete a screening tool for alcohol or drug use should be told the results of the screening.
- Individuals who do not appear to have any substance use disorder problems require no further intervention.
- Individuals with positive results will need some type of intervention and will vary depending on the severity of the use and symptoms, such as:
  - Providing education on the hazards of alcohol and drug use or other mental health comorbidities.
  - Providing resource information on substance use disorders or other mental health comorbidities.
  - Encouraging participation in Alcoholics Anonymous and/or other mental health support groups.
  - Discussing medication options if applicable.
  - Scheduling a follow-up appointment.
  - Initiating a referral to a behavioral health and/ or substance use provider for therapy.
  - Referring to the health plan: Integrated Health Care Management program.

- In the presence of severe symptoms: initiating a referral to a behavioral health and/ or substance use provider who can further assess and provide a treatment plan.
- Calling 911 and referring to the closest emergency room if the individual is showing signs of withdrawal and/or is in a crisis.

Motivational Interviewing

Evidence-based practice

Motivational interviewing (MI) is a clinical approach that engages individuals with mental health conditions, substance use disorders, and other chronic conditions such as diabetes, asthma, and cardiovascular disease to make positive behavioral changes to support better health.

MI techniques are an effective way to engage individuals when assessing for any conditions and stressors that impact an individual's functioning.

Core components

The approach consists of four components:

- Expressing empathy and avoiding arguing.
- Developing discrepancy.
- Rolling with resistance.
- Supporting self-efficacy (an individual's belief that one can successfully make a change).

Techniques

MI is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach to help individuals express their own desires for change, plan for and begin the process of change, and increase their confidence and commitment to changes. There are many effective techniques. Here are a few examples:

- Ask permission
  - Rationale: shows respect for individuals, which may lead to better results when discussing change.
  - Example: "I appreciate you answering the screening questions. Could we take a minute to discuss your results?"
- Use open-ended questions
  - Rationale: When individuals are asked open-ended questions, it allows for a collaborative dialogue.
  - Example: "Tell me what you like about your risky behavior?"
- Elicit change talk
  - Rationale: Change talk is more prone to successful outcomes. This technique elicits reasons for changing that are a priority to the individual.
  - Example: "What would you like to see different about your current situation?"
- Reflective listening
  - Rationale: This is the primary way of responding to individuals and building empathy; it involves carefully listening to individuals and responding to what they are saying.
  - Example: "It sounds like you recently became concerned about your drinking."

References

American Academy of Child and Adolescent Psychiatry
www.aacap.org

American Academy of Pediatrics
www.aap.org

National Institute on Alcohol Abuse and Alcoholism
www.niaaa.nih.gov/Publications/ EducationTrainingMaterials/Pages/ YouthGuide.aspx

Substance Abuse and Mental Health Services Administration
www.samhsa.gov/health-care-health-systems- integration/screening-referral

SAMHSA-HRSA Center for Integrated Health Solutions
www.samhsa.gov/health-care-health-systems-integration/ screening-referral

Motivational Interviewing Strategies and Techniques
www.nova.edu/gsc/ forms/mi_rationale_techniques.pdf

Motivational Interviewing from the Center for Evidence-Based Practice
www.centerforebp.case.edu/practices/mi

Appendix H: Screeners for SBIRT


DrugAbuseScreening Test_2014Mar24.pdf


audit.pdf


Audit-C.pdf

Chapter Nine:
Suicide Prevention Practices

Overview

Suicide is a public health issue that impacts everyone: patients, families, health care providers, school personnel, faith communities, friends, and the government. Suicide is the 10th-leading cause of death in the United States. Every 12 minutes someone takes their own life. The risk of suicide is highest within the first 30 days after an individual is discharged from the emergency room or an inpatient psychiatric hospitalization.1

Research shows that many individuals who died by suicide were undiagnosed with a mental health condition even though most had seen a primary care provider. Suicide is often preventable. Health care providers can have a critical role in preventing suicides by identifying individuals at risk and referring them for appropriate treatment.

Suicide is the 10th-leading cause of death in Florida. It is the second-leading cause of death for individuals ages 25 to 34. On average, one person dies by suicide every three hours in the state, and nearly twice as many people die by suicide annually in Florida as by homicide.

Risk and protective factors for suicide

Warning signs of immediate risk

- Putting affairs in order and giving away possessions.
- Saying goodbye to family and friends.
- Mood shifting from despair to calm.
- Planning to buy, steal, or borrow what is needed to complete suicide.
- If an individual is at immediate risk, call 911 for help to transfer to the nearest emergency room.

Risk factors for suicide

According to the National Alliance on Mental Illness, research shows that more than half of people (54 percent) who died by suicide did not have a known mental health condition.3 Risk factors include:

- Family history of suicide.
- Risky substance use — drugs and alcohol can cause mood swings that can increase suicidal thoughts.
- Intoxication — more than one in three people who die from suicide are found to be under the influence.
- Access to firearms.
- Serious or chronic medical illness.
- Gender — more women attempt suicide, but men are four times more likely to die by suicide.
- A history of trauma or abuse.
- Prolonged stress.
- Isolation.
- Age — people under 24 or over 65 are at a higher risk for suicide.
- A recent tragedy or loss, especially if the loss was a family member or close friend.
- Agitation or sleep deprivation.

High-risk populations

Risk factors can vary among cultures, age groups, and genders. The following groups of people are at a higher risk for suicidal thoughts and behavior than the general population:4

- People who have attempted suicide.
- LGBTQ individuals — due to stress resulting from prejudice and discrimination.
- American Indians and Alaska Natives — due to historical trauma endured by this population.
- Individuals who have lost someone close to suicide.
- People with chronic or painful medical conditions.
- People with mental health or substance use disorders.
- Members of the armed forces and veterans.
- Men in their midlife or older years — due to stress resulting from unemployment, divorce, and isolation.

Trauma is highly prevalent and a major risk factor for suicide. It is important for health care professionals to be aware of and understand the impact of trauma on an individual's health and overall well-being. A referral to a behavioral health provider who uses trauma-informed practices can help individuals in the recovery and healing process.

Precipitating events that can trigger suicidal behavior

- End of a relationship or marriage.
- Death of a loved one.
- An arrest.
- Serious financial problems.

Protective factors

Protective factors are personal or environmental characteristics that help guard people from suicide.

- Connections to individuals, family, friends, community, and social organizations.
- Effective behavioral health care.
- Life skills such as problem-solving, coping mechanisms, and the ability to adapt to change.
- Self-esteem and a sense of purpose or meaning in life.
- Cultural, religious, or personal beliefs that discourage suicide.

Screening and assessment tools

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends the following screening tools that can be integrated into primary care and other health care settings and foster earlier identification of suicide risk and other potential mental health disorders.

- Columbia-Suicide Severity Rating Scale (C-SSRS):
- www.integration.samhsa.gov/clinical-practice/ Columbia_Suicide_Severity_Rating_Scale.pdf.
- Patient Health Questionnaire (PHQ-9):
- www.integration.samhsa.gov/images/res/PHQ
- %20-%20Questions.pdf.
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): www.integration.samhsa.gov/images/res/ SAFE_T.pdf.

Prevention and treatment

There are psychotherapies that can help a person with thoughts of suicide recognize unhealthy patterns of thinking and behavior, validate feelings, and learn new coping skills:6

- Cognitive behavioral therapy (CBT).
- Dialectical behavioral therapy (DBT).

Medication can be used to help treat underlying depression and anxiety and can decrease a person's risk of hurting themselves.7 A combination of medication and psychotherapy has been an effective treatment for many people.

Resources for suicide prevention

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems that incorporates a set of resources and tools. The project is supported by the Suicide Prevention Resource Center. There are seven main elements of Zero Suicide:

1. Lead: Promote a system-wide culture change committed to reducing suicides.
2. Train: Provide training that creates a competent, confident, and caring workforce.
3. Identify: Use validated screening tools to identify patients with suicide risk.
4. Engage: Create a suicide care management plan for all individuals at risk of suicide.
5. Treat: Use evidence-based treatments for individuals who show suicidal thoughts and behaviors.
6. Transition: Provide warm hand-offs for individuals who need further evaluation and treatment follow-up.
7. Improve: Continue to review policies and procedures through quality improvement processes.8

Visit the Zero Suicide website at zerosuicide.sprc.org to learn more about available resources and technical assistance.

Suicide Prevention Resources

National Alliance on Mental Illness (NAMI) Florida
www.namiflorida.org.

Suicide Prevention Resource Center
www.sprc.org/states/florida.

Statewide Office of Suicide Prevention (Florida Department of Children and Families)
www.myflfamilies.com/service-programs/ mental-health/suicide-prevention.

Florida Initiative for Suicide Prevention
www.fisponline.org.

Member resources

(free and confidential help)

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
Available 24 hours a day, seven days a week; national network of local crisis centers that provide free emotional support to individuals in suicidal crisis or emotional distress.
https://suicidepreventionlifeline.org

Veterans Crisis Line
1-800-273-8255 and press 1, or text 838255
www.veteranscrisisline.net
Serves all veterans and service members; available 24 hours a day, seven days a week.

Crisis Text Line
Text 741741
Connect to a trained crisis counselor anywhere in the United States. Available 24 hours a day, seven days a week.

Teen Link
1-866-TEENLINK (833-6546)
https://866teenlink.org/chat-now/
Available evenings from 6 p.m. to 10 p.m.; help line for teens (ages 13 to 20) to call about issues such as relationships, problems at school, drugs and alcohol, self-harm, family problems, and suicidal thoughts; help line is staffed by trained volunteers ranging in age from 15 to 20.

The Trevor Project
1-866-488-7386
www.thetrevorproject.org
Available 24 hours a day, seven days a week; national organization that provides crisis and suicide prevention among LGBT youth.

National Alliance on Mental Illness (NAMI)
1-800-950-6264, Monday through Friday, 10 a.m. to 6 p.m.

Provider resources

American Foundation for Suicide Prevention
https://afsp.org

National Action Alliance for Suicide Prevention
http://actionallianceforsuicideprevention.org

National Alliance on Mental Illness (NAMI)
www.nami.org/Learn-More/Mental-Health- Conditions/Related-Conditions/Suicide

National Institute of Mental Health
www.nimh.nih.gov/health/topics/suicide- prevention/index.shtml

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.integration.samhsa.gov/clinical-practice/suicide-prevention-update#Resources_for_Providers

Suicide Prevention Resource Center
www.sprc.org

Suicide Prevention Resource Center: Risk and Protective Factors
www.sprc.org/about-suicide/ risk-protective-factors

Trauma-Informed Approaches
www.integration.samhsa.gov/clinical-practice/trauma-informed

Chapter Ten:
HEDIS Measures

Follow-up after hospitalization for mental illness (FUH)

This HEDIS measure looks at the percentage of members age 6 and older who were discharged from an inpatient setting. These members had a mental health diagnosis and attended a qualifying outpatient follow-up appointment with a mental health practitioner within 7 days and 30 days of discharge.

Effective discharge planning and ongoing outpatient provider support is essential to helping members after an acute care episode. Members who get prompt follow-up after hospitalization are more likely to engage in outpatient treatment. This may avoid hospitalization and emergency department visits. And these patients may have a better opportunity to return to baseline functioning.

To help support our members after hospitalization, we recommend these best practices:

- **Know that discharge planning starts on admission.** Our utilization managers and case management staff work with hospitals to ensure members have access to outpatient providers within 7 days of their discharge. If discharge planners can't make appointments within 7 days, they must tell our team so they can help make these appointments.
- **Understand that we offer case management to all members.** Our staff will reach out to each member who is discharged from an acute inpatient setting. Hospital staff can help us by alerting members that we will be calling and also offer support or services.
- **Have a discharge consultation.** On the day of discharge, it is important for the member to get and understand their discharge plan. They should also know the importance of following through with that plan.
- **Tell us about access issues.** We encourage our provider network to work closely with us. This includes letting our utilization management or case management staff know when discharge planners cannot make a follow-up appointment within 7 days of discharge with a network provider or practitioner.
- **Work together so everyone gets a reminder.** Our case management staff work hard to make sure our members have appointments within 7 days. And they call our members to remind them about the upcoming appointment. But often, it is most effective when the actual servicing provider makes the outreach. So we encourage you to also call members before their scheduled appointment. If you need help contacting our members and want to connect, just call us at **1-855-300-5528 (TTY: 711).**

Initiation and engagement of alcohol and other drug dependence treatment (IET)

This HEDIS measure looks at the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who receive:

- **Initiation of treatment** – the percentage of members who start treatment through an inpatient AOD admission, outpatient visit, intensive outpatient visit, or partial hospitalization within 14 days of the diagnosis.
- **Engagement of AOD treatment** – the percentage of members who started treatment and who had two or more other services with a diagnosis of AOD within 30 days of the first visit.

Be part of the solution and assess substance use in your patients

Early identification of substance use issues can help members avoid future drug-related illnesses and deaths and can improve their quality of life. It can also help curb the overuse of health care services related to substance dependence. We recommend these best practices for substance use:

- **Screen** – Make sure to include substance use questions or tools during intake and yearly treatment plan review, at a minimum. Many times, substance use goes undetected, simply due to not asking the right questions. People may want to minimize their substance use, so it's important to be persistent when raising the topic and keeping it at the forefront of treatment.
- **Document** – If your patient openly talks about their struggles with substances and you identify a concern, be sure to document it and code it on any claims you submit. Because there is sometimes a perceived stigma associated with a substance use diagnosis, practitioners may be reluctant to document it. But the lack of naming it may prevent other clinicians from working with the patient in a coordinated manner, and this can ultimately result in less effective care.
- **Follow up** – When you identify a substance-use concern, it's important to schedule appropriate follow-up treatment. For newly diagnosed members specifically, we recommend scheduling three follow-up appointments within the first 30 days. Increased intensity of contact in preliminary stages of treatment will help address the concerns as soon as possible. And it can help keep the member connected and motivated for treatment.
- **Educate** – It is important to educate members on the effects of substance use and the treatment choices in their community. Also, substance use often occurs with other behavioral health problems, like major depression or anxiety disorders. This can make treating substance use or diagnosing a behavioral health disorder more difficult. In these cases, it is helpful to refer to a behavioral health provider. If you need help finding resources, just call us at **1-866-329-4701 (TTY: 711)**.

Chapter Eleven:
Psychotropic Polypharmacy

Overview

Trends in Antipsychotic Prescribing Among Youth

- Medicaid-insured youth are three times as likely to be prescribed antipsychotic medications as compared to those commercially insured.
- Youth in foster care were prescribed antipsychotic medications at twice the rate of other Medicaid-insured youth

Experiences of Families and Youth related to Psychotropic Medications

- Uneasiness about giving antipsychotic medications to their children, especially young children.
- Concern about the side effects, particularly weight gain, and long-term consequences of use on their children's health.
- Stressed the secondary effect of stigma and bullying children may experience as a result of the side effects.
- Need for availability of comprehensive information on antipsychotic medications in lay terms that families can easily understand.
- Need for prescribing clinicians to provide more information about alternatives to antipsychotic medication treatment, and additional information about the various medication treatment options, including the anticipated benefits, risks, and potential side effects.
- Concerns around access to accessible educational materials around antipsychotic medication and treatment alternatives have also been expressed by young adults and transition-age youth.

Professional organizations and consensus statements endorse specific practice parameters for antipsychotic medication treatment among youth such as the following:

- The American Academy of Child and Adolescent Psychiatry (AACAP) endorsed practice parameters for antipsychotic medications that provide recommendations to start "low and go slow," with routine monitoring of side effects for metabolic conditions, such as body mass index, fasting blood glucose, hemoglobin A1c [HbA1c], and fasting lipid profiles.
- Recommendations also emphasize the limited safety and efficacy data available in prescribing two or more antipsychotic medication concomitantly and recommends avoiding such use. Other available consensus statements also emphasize the use of psychosocial treatments as a first line of treatment, use of structured rating scales to gauge treatment response, monitoring of abnormal involuntary movements, and other clinical parameters.
- The American Academy of Pediatrics published guidance on treatment for specific antipsychotic medications (e.g., risperidone).[1]

---

[1] Substance Abuse and Mental Health Services Administration: Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents. HHS Publication No. PEP19- ANTIPSYCHOTIC-BP. Rockville, MD: Office of Chief Medical Officer. Substance Abuse and Mental Health Services Administration, 2019
https://store.samhsa.gov/sites/default/files/d7/priv/pep19-antipsychotic-bp_508.pdf

AACAP Recommendations to promote safety and quality in mental health treatment, with particular attention to the appropriate use of psychotropic medication in children and adolescents in child-serving systems include the following:[2]

- Prescribers of psychotropic medication for children and adolescents, and others working with them and their families should adhere to a developmentally-informed biopsychosocial approach, trauma-informed care principles, and system of care principles.
- When psychotropic medication is being considered, children and adolescents should receive a comprehensive behavioral health assessment.
- Prescribers of psychotropic medication should actively engage and collaborate with children and adolescents and their families when they are referred for potential use of such medication.
- Prescribers should actively engage and collaborate with other professionals and systems involved with the child and family.
- All youth with complex behavioral needs, including youth in foster care, should receive a combination of evidence-based psychosocial interventions and psychotropic medication when indicated, not just psychotropic medication alone.
- Clinical guidelines identified in the 2009 AACAP Practice Parameter, "Prescribing Psychotropic Medication to Children" should be implemented.
- Prescribers should promote awareness of potential adverse effects and consistently monitor for such side effects over time.

Definitions of Psychotropic Polypharmacy[3]

- High-level psychotropic polypharmacy defined as the concurrent use of at least four classes of psychotropic medications for at least 30 days during the calendar year.
- Psychotropic polypharmacy defined as the concurrent use of at least 2 classes of psychotropic medications

Deprescribing[4]

What is Deprescribing? A structured approach to evaluating medications for indications, risks, and benefits with a goal of a minimum effective dose and number of medications. It can be thought of as rational prescribing.

Why Deprescribe? Some youth take more psychotropic medications (PM) than necessary. Youth are generally at higher risk of medication adverse effects and much is unknown about long-term effects of PM on the developing brain.

---

[2] American Academy of Child and Adolescent Psychiatry (AACAP). Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf

[3] Davis, D.W., Lohr, W.D., Feygin, Y. *et al.* High-level psychotropic polypharmacy: a retrospective comparison of children in foster care to their peers on Medicaid. *BMC Psychiatry* **21,** 303 (2021). https://doi.org/10.1186/s12888-021-03309-9

[4]University of Louisville Department of Pediatrics. Kentucky SafeMed. Resources for Providers. Accessed January 11, 2022 via https://louisville.edu/medicine/departments/pediatrics/research/cahrds/safemed/KYsafemed

When to Consider Deprescribing?

• Condition improved

• Polypharmacy

• Age <6 years old

• Youth or family request

• Lack of evidence to support use

• Medication side effects or non-compliance

• Dosing outside of accepted guidelines (too high/low)

• Medication use to treat side effects of another medication

• Extended trial without attempt to taper

How to Deprescribe?

- Step 1 - Review factors related to the youth which might favor deprescribing
    - Assess for psychosocial stability and level of function
    - How long has the youth been doing well?
    - Assess the natural course of condition treated
    - Evaluate medications
        - 4 or more medications
        - More than 1 medication per drug class
    - Consider the age of the youth
        - Under 6 years old
    - Is psychosocial therapy available and helpful?
    - Assess for other health conditions
        - Pregnancy, drug abuse, illness, etc.
    - Youth/family request see shared decision guide in resources below.
- Step 2 - Review medication history
    - Using the *Deprescribing Medication History Tool* in resources below, list all current medications and information
- Step 3 - Assess each medication for risk/benefit
    - Possible reasons to taper/discontinue:
        - Lack of indication or target symptoms
        - Lack of benefit – target symptoms have not improved
        - Low quality evidence to support the use
        - Redundant medication class
        - Adverse effects
        - Non-compliance
        - Dosing outside of accepted guidelines (too high/low)
        - Medication is being used to treat side effects of another medication
        - Extended trial of medication without an attempt to taper

- Step 4 - Prioritize a medication to deprescribe
- Step 5 - Implement taper and monitor
    - See specific drug class algorithms for guidance
    - Include deprescribing as part of an overall treatment plan which includes therapy and crisis planning (for more information, access https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychotherapies-For-Children-And-Adolescents-086.aspx)

Resources

American Academy of Child and Adolescent Psychiatry (AACAP). Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems. **https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf**

Bellonci, et al. "Deprescribing and Its Application to Child Psychiatry", Child & Adol Psychopharm News. 2016; 21 (6): 1-9.

Center for Health Care Strategies, Inc. (n.d) Improving the Appropriate Use of Psychotropic Medications for Children in Foster Care: A Resource Center. **https://www.chcs.org/resource/improving-appropriate-use-psychotropic-medication-children-foster-care-resource-center/**

Child Welfare Information Gateway. (n.d) Understanding Psychotropic Medications. **https://www.childwelfare.gov/topics/systemwide/bhw/medications/**

Children's Bureau et al. (2012). Making healthy choices: A guide on psychotropic medications for youth in foster care. Washington, DC: Author. **https://www.childwelfare.gov/pubPDFs/makinghealthychoices.pdf**

Children's Bureau et al. (2015). Supporting youth in foster care in making healthy choices: A guide for caregivers and caseworkers on trauma, treatment, and psychotropic medications. Washington, DC: Author. **https://www.childwelfare.gov/pubs/mhc-caregivers.**

Grudnikoff and Bellonci,"Deprescribing in Child and Adolescent Psychiatry-A Sorely Needed Intervention." Am J Ther 2017; 24 (1):e1-e2.

Gupta and Cahill, 2016. "A Prescription for 'Deprescribing' in Psychiatry." Psych Serv 2016; 67:904 -907.

Ohio Minds Matter (2015). Personal Decision Guide. **http://ohiomindsmatter.org/sites/ohiomindsmatter/files/2018-10/personal-decision-guide-2-2015.pdf**

Substance Abuse and Mental Health Services Administration: Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents. HHS Publication No. PEP19-ANTIPSYCHOTIC-BP. Rockville, MD: Office of Chief Medical Officer. Substance Abuse and Mental Health Services Administration, 2019 **https://store.samhsa.gov/sites/default/files/d7/priv/pep19-antipsychotic-bp_508.pdf**

University of Louisville Department of Pediatrics. Kentucky SafeMed Tools. Accessed January 11, 2022. https://louisville.edu/medicine/departments/pediatrics/research/cahrds/safemed/KYsafemed

- Deprescribing Information for Parents and Caregivers. **https://louisville.edu/medicine/departments/pediatrics/research/cahrds/safemed/deprescribing-information-for-parents-caregivers**
- De-Prescribing Medication History Tool **https://louisville.edu/medicine/departments/pediatrics/research/cahrds/safemed/safemed-medication-history-tool**
- Deprescribing Information for Providers. **https://louisville.edu/medicine/departments/pediatrics/research/cahrds/safemed/deprescribing-information-for-providers**

Chapter Twelve:
Aetna Better Health of Kentucky
SKY Resources and Support

Nurse Call Line (24 hours)
1-855-620-3924

Care Coordination Teams
1-855-300-5528

Provider Services
1-855-300-5528 (Available 7 am- 7pm EST, Monday through Friday)

Behavioral Health Crisis Hotline (24 hours)
1-888-604-6106

For additional resources and supports, please visit our website:
https://www.aetnabetterhealth.com/kentucky/providers/