



CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

INTRODUCTION

Psychcare has developed the guidelines in order to provide a concise version of treatment recommendations related to the top inpatient and outpatient mental health diagnoses. The diagnoses were based on our member demographic data.

The resources used to develop the guidelines were evidence-based clinical practice guidelines from recognized sources. Each guideline was reviewed and approved by our Clinical Standards Committee. The members of the committee include our network practitioners.

The review criteria included:

- Current applicability based on the annual high risk/high volume demographic data
- Consistency with Psychcare Clinical Criteria, and member education materials
- Current applicability for all behavioral healthcare disciplines

The Clinical Standards Committee reviews each Psychcare Clinical Management Guideline at least every two (2) years from the date of the last review.

When new scientific evidence or nationally recognized standards are published before the two-year review date, the Clinical Standards Committee reviews the guideline at the time the new scientific evidence and/or nationally recognized resource is published and revises the Psychcare Clinical Management Guideline when indicated.

ATTENTION-DEFICIT DISORDERS

CHILDHOOD ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

Diagnostic Criteria

The essential features are a persistent pattern, occurring for at least six months, of inattention and/or hyperactivity that is more frequent and severe than typically observed in individuals at a comparable level of development.

Symptoms of Inattention: poor attention to details, careless mistakes on tasks, does not seem to listen, difficulty following directions, deficient organizational skills, easily distracted, loses things, distractibility, and forgetfulness

Symptoms of Hyperactivity/Impulsivity: fidgets, leaves seat frequently, runs about excessively, difficulty playing quietly, talks excessively, blurts out answers, difficulty awaiting turn, and interrupts others.

Etiology

- ADHD is a highly heritable disorder
 - If a parent has ADHD, there is a greater than 50% chance of having a child with ADHD.
 - 25% of children with ADHD have parents who meet diagnostic criteria for ADHD.
 - It is unlikely that a single gene will be linked to ADHD. It is probably caused by an interaction of several different genes.



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- Environmental factors that disrupt normal brain growth before, during and after birth may contribute to the pathogenesis of ADHD.
- Risk factors include: Fetal alcohol syndrome, Maternal diabetes, Pre- or postnatal hypoxia, brain injury to prefrontal-subcortical circuits, maternal psychopathology, food sensitivities, maternal smoking, Maternal PKU, hyperbilirubinemia, early deprivation, poverty, and paternal criminality
- The risk is proportional to the number of adverse factors present.
- ADHD is a disorder of normal neurotransmitter function, mainly dopamine and norepinephrine.

Specific Features

- Appears in various cultures
- 4 to 9 times more common in males than females. Boys tend to be more disruptive, but girls have higher social impairment and distress.
- Prevalence is 5% in school age children
- Diagnosis is generally based on clinical criteria.

Differential Diagnosis

- Rule out Early Onset Bipolar Disorder (ADHD is commonly confused with this disorder which is difficult to diagnose in children), Mental Retardation, and/or Oppositional Defiant Disorder, Substance Abuse.

Treatment

Treatment of ADHD involves a multidisciplinary approach.

- Behavior Modification: Include behavioral techniques in the school setting.
- Structured Cognitive Behavior modification: Social and coping skills training. Self-instruction self-evaluation and anger management.
- Family Involvement: Include parent training and referral to support groups in the community as well as parenting skills training.
- Contact with school, teachers and school psychologist/counselor.
- Pharmacological intervention with a psychiatrist.
- Referral to specialized therapeutic classroom/school.
- Substance Abuse Assessment and Treatment as needed.

Treatment Intensity

- The mainstay of treatment for ADHD involves psychopharmacological management with a psychiatrist.
- According to the HEDIS Measure, *Follow-up Care for Children Prescribed ADHD Medication (ADD)* it is recommended that children 6 – 12 years old with an ambulatory prescription dispensed for ADHD medication have one follow-up visit with the practitioner with prescribing authority during the 30-day initiation phase; and as part of the continuation and maintenance phase of treatment, those children 6 – 12 years old that remained on the medication for at least 210 days, should have, in addition to the visit during the initiation phase, have at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation period ended.
- Patients seen by a Psychiatrist with minimal improvement after 6 sessions should refer the patient to a clinician in conjunction with psychotropic medication.



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- There are currently 3 medications FDA approved for the treatment of ADHD in childhood
 - Dextroamphetamine, (adderall, adderall XR, Dexedrine, dextrostat, dexedrine spansules, and vyvanse)
 - *d* and *d,l* methylphenidate (focalin, focalin XR methylin, Ritalin, Ritalin CD, LA, concerta, daytrana, metadate ER, CD mixed salts amphetamine and
 - atomoxetine (strattera).
- Individual psychotherapy can be useful in actively engaging the child in a positive therapeutic alliance, addressing low self-esteem and demoralization, and facilitating compliance with medication treatment.
- Behavior therapy helps the child develop more effective ways to work on immediate issues.
- Generally, a neurological examination and workup or psychological or neuropsychological evaluation is not necessary to establish the diagnosis of ADHD.

Prognosis

- Symptoms usually decrease by late adolescence, but the symptoms can persist into adulthood 60% of the time

ADULT ATTENTION-DEFICIT HYPERACTIVITY DISORDER

Etiology

There is strong evidence supporting a neurobiological and genetic basis for Attention-Deficit/Hyperactivity Disorder (ADHD). Abnormalities in the frontostriatal network, primarily in the noradrenergic and dopaminergic systems, appear to be central to the ADHD pathophysiology. Structural and functional magnetic resonance imaging (MRI) studies have also shown neurologic differences between those diagnosed with ADHD and those without. The MRI data show that the circuits controlling attention, mainly the pre-frontal cortex, are less active and smaller in individuals diagnosed with ADHD.

Diagnostic Criteria

The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development. The symptoms must be persistently present for at least six months, and must cause significant impairment in at least two settings.

Under the current guidelines described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, the child or adult must meet the criteria as set forth in the Manual. The symptoms must have persisted for at least six months to a degree that is maladaptive and inconsistent with the individual's developmental level. Six or more of the symptoms from either group of criteria (inattention or hyperactivity-impulsivity), and at least six in each group for the combined subtype must be present to meet criteria for the disorder. In addition, some hyperactive-impulsive or inattentive symptoms that caused impairment must have been present since before age seven, some impairment must have been present in two or more settings, there must be clear evidence of clinically significant impairment in social, academic, or occupational functioning, and the symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and not better accounted for by another mental disorder.

Symptoms of inattention include failing to give close attention to details and making careless mistakes, difficulty sustaining attention to tasks, not listening when spoken to directly, not following through on instructions, difficulty organizing tasks, avoiding or disliking engaging in tasks that require mental effort, being easily distracted by



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extraneous details, and forgetfulness in daily activities. **Symptoms of hyperactivity** include fidgeting or squirming in seat, leaving seat in classroom, running or climbing when inappropriate, difficulty playing or engaging in leisure activities, often being “on the go”, or talking excessively. **Symptoms of impulsivity** include blurting out answers before questions have been completed, difficulty awaiting a turn, or often interrupting or intruding on others.

Three (3) subtypes of the syndrome are currently recognized: predominantly inattentive, hyperactive-impulsive, and the combined type, which is the most common and most debilitating.

Historically, Attention-Deficit/Hyperactivity Disorder was considered to be primarily a childhood condition. However, recent data suggests that approximately 50% of children with childhood ADHD will continue to exhibit symptoms into adulthood. Adults with ADHD must have childhood onset, with persistent and current symptoms, although adolescents and adults who no longer meet the full criteria are considered “In Partial Remission”.

Diagnosing ADHD in adults requires a thorough evaluation by the clinician and involves careful identification of symptoms concerning childhood onset, persistence, and current presence of symptoms. In the absence of treatment, symptoms should have been consistently present without remission. While a longstanding history is often difficult to elicit in adults, it is key to an accurate diagnosis.

ASSESSMENT OF ADHD IN ADULTS

- Obtain a developmental history from the patient and other sources such as parents, report cards, and spouse (when available). Symptoms should be present since early childhood.
- Inquire about the impact of core ADHD symptoms on current areas of functioning (occupational, school, relationship).
- Assess concentration, attention, and short-term memory by having patient perform screening tasks (mental status exam) in the office setting.
- Assess for co-morbid disorders such as depressive disorders or substance use disorders.
- Refer for psychological/neurological testing if results are uncertain.

Specific Adult Features

Recent studies show that beginning in adolescence, ADHD symptoms decline and change their presentation. Most ADHD youth show a decline in symptoms of hyperactivity/impulsivity, while maintaining most symptoms of inattention. Hyperactivity in children becomes restlessness in adolescence and adults, with predominant symptoms becoming poor concentration, daydreaming, and forgetfulness. It is estimated that approximately 4% of college students and adults have ADHD. Adults with ADHD typically have difficulty prioritizing, keeping appointments, deadlines and commitments, while demonstrating poor self-discipline and follow-through. Impulsivity is often exhibited by socially inappropriate behavior, such as blurting out thoughts which may be rude or insulting.

ADHD: CLINICAL PRESENTATION IN ADULTHOOD

- Inattention/concentration problems
- Disorganized, fails to plan ahead
- Forgetful, loses things
- Difficulty in initiating and finishing projects or tasks
- Shifts activities prematurely



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- Misjudges available time
- Makes impulsive decisions related to spending money, travel, jobs, or social plans
- May have job instability and marital difficulties
- May exhibit difficulties with “Executive Functioning” (EF) such as time management, organization, sequential and hierarchical thinking

Pharmacological Treatment

Medications are the mainstay of ADHD treatment. The stimulants, antihypertensives, and antidepressants comprise the available treatments. In adults only amphetamine compounds and atomoxetine are approved by the FDA.

Psychostimulants, among the first-line agents for children and adults, work primarily in the mesocortical and frontostriatal pathways on both dopaminergic and noradrenergic neurons. Increased norepinephrine and dopamine concentrations in the brain stem, midbrain, or frontal cortex have been postulated to be responsible for the increased attention span and concentration that occurs with the use of stimulants. Methylphenidate (Ritalin) and dextroamphetamine (Dexedrine) are effective in improving attention and concentration, and in reducing impulsivity in adults with ADHD. Methylphenidate and the amphetamines (Adderall, Adderall XR, and Cylert) appear to affect the noradrenergic and/or dopaminergic systems, although the extent to which each works in these areas is still under investigation. Atomoxetine (Strattera), tricyclic antidepressants (Norpramin, Tofranil, Pamelor,) appear to work predominantly through the noradrenergic system. Bupropion (Wellbutrin and Wellbutrin SR-XL) has mixed noradrenergic and dopaminergic effects.

According to recent literature, each of the available stimulants appears to be equally effective in the management of symptoms of ADHD, but they differ in their dose response and time course of action. The side effects of stimulants are generally mild and can be managed by adjusting medication dosage and timing. Common side effects include sleep disturbance (delayed onset), diminished appetite, mood disturbance, headaches and gastrointestinal distress. Cardiovascular effects, specifically mild increase in heart rate and blood pressure, have also been noted and should be closely monitored. Treatment considerations should take into account the high comorbidity of other disorders with ADHD. These disorders include tics, depression and anxiety disorders, and substance abuse. Stimulant use should also be avoided or used with caution in patients with a history of substance abuse. Because methylphenidate and dextroamphetamine are C-II controlled substances, most states limit prescriptions to a 30-day supply and do not authorize refills. In addition, written copies of the prescription are usually required.

Antidepressant therapy in adults has also been found to be effective in treating adults with ADHD, especially with patients with affective instability and co-existing mood disturbance. Bupropion (Wellbutrin and Wellbutrin SR-XL) may be useful in treating complex cases of ADHD accompanied by mood instability, substance abuse, or bipolar disorder. Tricyclic antidepressants appear to be effective for all age groups and for ADHD with tic disorders. Common side effects include dry mouth, constipation, tachycardia, headache, nightmares, and weight fluctuation. These adverse effects have limited their use. Selective serotonin reuptake inhibitors (SSRIs) have not shown efficacy for ADHD, but are often used to treat patients with coexisting depressive disorders.

Psychosocial Treatment

Adults with ADHD may require collateral therapies aimed at increasing their understanding of ADHD and developing additional coping strategies. They may require modifications in their academic and/or work settings. These include learning cognitive strategies and utilizing organizational tools such as list making, time management programs, and calendars. Breaking projects into smaller, easy to manage pieces and establishing deadlines can also help with clarifying objectives and improving organizational skills.



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Individual and marital therapies have also been found to be valuable adjuncts to pharmacotherapy in addressing self-esteem and relational problems. Focused therapies incorporating cognitive-behavioral strategies have been reported to be most effective, while traditional insight-oriented psychotherapies have not been found to be helpful. Finally, self-help organizations such as Children and Adults with Attention Deficit Disorder (CHADD) may be useful in providing information about the disorder.

MOOD DISORDERS

MAJOR DEPRESSIVE DISORDER

Diagnostic Criteria

The essential features are a clinical course that is characterized by one or more major depressive episodes, and the lack of a history in which the patient has experienced manic, mixed, or hypomanic episodes.

Symptoms Major Depressive Episode: depressed or irritable mood, markedly diminished interest in life, changes in appetite, insomnia/ hypersomnia, psychomotor agitation/retardation, loss of energy, feelings of worthlessness/guilt, diminished concentration, recurrent thoughts of death, psychotic features. Significant decline or impairment in social, home or workplace environments. Symptoms must be present for at least 2 weeks.

Dysthymia: 2 years of depressed mood, most of the day, for more days than not, in the absence of a full-blown major depressive episode.

Specific Features

- The patient's presentation and their complaints can vary depending on their culture
- Onset can occur at any age, the average age of onset are those in their mid 20's
- Prepubescent boys and girls are equally affected; twice as common in adolescent and adult females than males; rates in men and women are highest between 25 to 44 years old age, whereas rates are lower for both men and women over age 65;
- Lifetime prevalence is 10% to 25% for women, and 5% to 12% for men
- Up to 15% of all individuals with this disorder commit suicide
- The disorder is 1.5 to 3 times more common in a first degree biological relative of a person diagnosed with a Mood Disorder, than in general population
- Contributing etiological factors may be low norepinephrine and serotonin levels, genetics, and/or psychosocial stressors and maladaptive thinking patterns (learned helplessness)
- Medical factors could include: Post Partum, Thyroiditis, Thyroid Disease, and Anemia.

Differential Diagnosis

- Rule out Bipolar Disorder, Dysthymic Disorder, disorders due to a general medical condition, substance use, Schizoaffective Disorder, Schizophrenia/ psychotic disorders, and dementia in older adults
- Numerous medical conditions, medications, and substances can cause depression. A thorough evaluation to rule out those possibilities is of paramount importance.

Psychcare Clinical Management Guidelines, Reviewed 5/01; Revised 5/02; Reviewed 5/03; Reviewed 9/03; Revised 11/03; Revised 2/04; Revised 9/04; Revised 5/05; Revised 8/05; Revised 11/05; Revised 7/06; Revised 10/06; Revised 6/07; Revised 8/07; Revised 5/08; Revised 3/09; Revised 12/09; Revised 3/10; Reviewed 5/10; Revised 6/10; Revised 12/10; Revised 1/11; Reviewed 3/11; Reviewed Compendium 5/12; MDD Guideline 6/12;



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Psychiatric Management

- Establish and maintain a therapeutic alliance, by collaborating with the patient in decision making and attending to the patient's preferences and concerns about treatment. Depressive symptoms may make it harder to develop a therapeutic alliance.
- A complete psychiatric assessment should include a history of present illness and current symptoms, psychiatric history, general medical history, medications, history of substance use and treatment for substance use, personal history, including social, occupational and family history.
- A mental status exam, review of systems assessment as well as appropriate diagnostic tests to rule out medical causes of depression may be indicated.
- Patient safety and suicide risk is essential.
- Establish an appropriate treatment setting that is least restrictive, yet addresses safety and promotes improvement in the patient's condition is the
- Address functional impairments and quality of life.
- Help the patient to set goals appropriate to his or her level of functioning and symptom severity.
- Coordinate the patient's care with other clinicians, provided that the patient gives written consent for this.
- Carefully monitor the patient's response to treatment and match the treatment plan to the needs of the patient by systematically addressing symptoms. Clinician or patient administered rating scales may be utilized to assist in this process.
- Patient education regarding expectations with regard to medications, and need for adherence to treatment recommendations
- Promote healthy behaviors such as exercise, good sleep hygiene, good nutrition and decreased use of tobacco and alcohol.

Treatment

- According to the HEDIS Measure, *Antidepressant Medication Management*, it is recommended that during the effective acute phase of treatment members newly diagnosed and treated should remain on an antidepressant medication for at least 84 days (12 weeks); and during the continuation phase of treatment it is recommended that those members newly diagnosed and treated remain on an antidepressant medication for at least 180 days (6 months).
- If substance abuse/dependence is present, this must be treated first
- The most effective treatment for patients with severe to moderate symptoms is medication management combined with brief psychotherapy (cognitive therapy most empirical support to date- Challenge negative patterns and thoughts, development of coping skills to deal with stressors).
- An initial evaluation will determine whether patients with moderate to mild symptoms may be treated with brief psychotherapy alone, however if within 6 sessions of psychotherapy with minimal to no improvement, the patient should be referred for a psychiatric evaluation and medication management. Ideally, patients should be seen in ongoing psychotherapy and medication management within the same time period for the most efficacious treatment.
- In women who are pregnant or breastfeeding, a depression focused psychotherapy alone is recommended, and depending on the severity of symptoms, should be considered as an initial option.



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- The effectiveness of antidepressant medications is generally comparable between and within classes for medication including selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), bupropion, tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs.)
 - ✓ MAOIs should be restricted to patients who do not respond to other treatments.
 - ✓ When an MAOI is used, a washout period is essential to avoid serotonin syndrome.
- Therefore medication choice should be based on patient preference, prior response, safety, tolerability and anticipated side effects, co-occurring psychiatric or general medical conditions, pharmacological properties of the medication, and cost
- ECT (electroconvulsive therapy) has the highest rates of response and remission of any form of antidepressant treatment, and can be particularly helpful in treatment refractory patients or in those patients who cannot tolerate adequate pharmacotherapy.
- Medication should be continued at full dose a minimum of sixteen to twenty weeks after remission. Patients with recurring depression may need to be maintained indefinitely on antidepressant medication. Patients with psychotic symptoms may require neuroleptic medication.

Response

- Ensure that the treatment has been administered for a sufficient duration and at a sufficient frequency of dose. Generally 4-8 weeks are needed before a response can be determined.
 - ✓ No treatment should continue unmodified if there has been no improvement after one month.
 - ✓ Optimizing the dose is a reasonable first step if side effect burden is tolerable, and the maximum does has not yet been reached.
 - ✓ For less than moderate response, reassess the following: diagnosis, side effects, co-occurring disorders, psychosocial factors and treatment adherence.
 - ✓ For patients in therapy, assess the frequency of session and whether the specific approach is adequately addressing the patient's needs.
 - ✓ After an additional 4-8 weeks, if the patient shows slow or minimal improvement, conduct another thorough review and make additional changes. Consider consultation.
- For patients with a partial response, a common strategy is to change to a different antidepressant in the same class or in a different class.
- Adding Lithium, thyroid hormone, or a second generation antipsychotic has a modest amount of evidence to support use.
- Adding an anticonvulsant, omega-3 fatty acid, folate and stimulants have less supporting evidence.
- For patients receiving an antidepressant, continue the medication for 4-9 months, generally at the same dose used in the acute phase.
- Patients who responded to an acute phase of ECT treatment, will require continued antidepressant management, and may respond to maintenance ECT.

Discontinuation of Treatment

- Factors to consider in discontinuing treatment is the risk of recurrence, frequency and severity of past episodes, persistence of symptoms after remission, presence of co-occurring disorders, and patient preference.



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- Tapering of the medication over several weeks allows for the detection of recurring symptoms and a return to treatment if needed. Tapering can also minimize discontinuation syndromes.
- The patient should be informed about the potential for relapse, and a plan for resuming treatment if symptoms return should be established.

Prognosis

- MDD tends to have a chronic, recurrent course, with probability of recurrence increasing with each subsequent episode
- 50% to 60% of all individuals who experience a single episode of depression will have more episodes within a two year period; 60% of all patients treated with antidepressants improve; of those treated with antidepressants, approximately 1/2 relapse within one year of terminating treatment

BIPOLAR I DISORDER

BIPOLAR DISORDER I IN THE ADULT POPULATION

Diagnostic Criteria

The essential feature is a clinical course that is characterized by the occurrence of one or more manic or mixed episodes. In addition, the individual may have had one or more Major Depressive Episodes.

Symptoms Manic Episode: inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, racing thoughts, flight of ideas, distractibility, increased goal directed activities, excessive involvement in pleasurable activities with a high potential for painful consequences

Specific Features

- There is a lack of evidence that this disorder is ethnically based, however African Americans and Hispanic patients tend to be misdiagnosed with Schizophrenia.
- The disorder is equally common in men and women. Men are more likely than women to be initially manic, but both are more likely to have a first episode of depression.
- Lifetime prevalence varies between 0.4% to 1.6%
- Twin and adoption studies provide strong evidence that there is a genetic influence. Etiology may be a result of an imbalance of norepinephrine and serotonin levels;
- The rate of alcohol abuse or dependence is evident in 46% of patients with bipolar disorder as compared to 13% for the general population.
- The rate of drug abuse or dependence is evident in 41% of patients with bipolar disorder as compared to 6% for the general population.

Differential Diagnosis

- Rule out Major Depressive Disorder, disorders due to a general medical condition, substance use, Bipolar II Disorder, Cyclothymia, and psychotic disorders
- There are numerous medical conditions, medications, and substances that can cause depressive or manic symptoms. A thorough medical evaluation to rule out those possibilities is of paramount importance.



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Treatment

- Comorbid substance abuse may be overlooked in patients with Bipolar Disorder, being one of the precipitants for mood episodes. Treatment of substance abuse and bipolar disorder should proceed concurrently.
- The risk for suicide is very high in this population. A detailed evaluation of the individual patient is necessary to assess suicidal potential. Based on the SADPERSONS suicide risk assessment, the mental status examination should include the following:
 - affect
 - speech
 - mood
 - thought content
 - judgment
 - insight
 - attention/concentration
 - memory
 - impulse control

Additional factors that assess suicide potential include the following:

- Were there previous suicide attempts?
- Is there an evaluation of suicidal ideation?
- Does the member use alcohol or drugs (prescribed, illicit, or over the counter)?
- Does the member have support from their family, friends, or significant other(s)?
- Is there a concurrent medical illness?
- Is there an assessment of rapid mood cycling within a depressive turmoil?
- Is there an assessment of shifting from one mood state to another?
- It is recommended that newly diagnosed patients treated in an outpatient setting be monitored carefully, with a minimum of three outpatient medication management visits within six months of their initial psychiatric evaluation.
- Emphasis is placed on recognizing early signs of relapse so that patients may seek treatment before a full-blown illness episode develops.
- Lithium is the primary mood stabilizer. Blood levels should be checked 12 hours after the first dose, twice weekly until the patient is stable, and then every two to three months. For patients with a single episode, medication should be considered for at least six months and then gradually tapered off over several months. Lifetime medication is needed for those with more than two episodes. A high concentration of Lithium in the blood may be very toxic and can produce symptoms such as lethargy, unsteady balance, GI symptoms, hand tremors, somnolence, gross confusion, urinary incontinence, random muscle twitching or coma. If these symptoms are reported or seen, instruct the patient to contact their psychiatrist immediately.
- Hypothyroidism is more common in women, who may be more susceptible to the anti-thyroid effects of Lithium.
- The identification of appropriate lab testing, based on the mood stabilizer, was obtained from the American Psychiatric Association Practice Guideline for the Treatment of Patients with Bipolar Disorder. Evidence of lab testing for the following mood stabilizers are:

Lithium:

- BUN; creatinine levels; thyroid function tests; an EKG for those members over 40 years; CBC and Lithium level after each dose adjustment; or if on maintenance, Lithium levels no less than every 6 months;

Depakote:

- liver functions; hematologic tests; and once on maintenance Depakote, hematologic monitoring and hepatic functions assessed and monitored, at a minimum, every 6 months;



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Tegretol:

- CBC with differential platelet count; liver profile, including LDH, SGOT, SGPT, bilirubin, and alkaline phosphatase; renal functions; CBC every 2 weeks during the first 2 months of treatment; and once on maintenance, liver functions and CBC every 3 months;
- If the patient has not significantly improved within a two to three week period, a second mood stabilizer should be added; antipsychotic medication may be necessary to control agitation or psychotic symptoms, but should be tapered off as soon as possible since patients with Bipolar Disorder are at higher risk for movement disorders;
- The first-line pharmacological treatment for acute and more severe manic or mixed episodes is the initiation of either lithium plus an antipsychotic, or valproate plus an antipsychotic.
- For less ill patients experiencing an acute manic or mixed episode, monotherapy with lithium, valproate, or an antipsychotic such as olanzapine may be sufficient. Short-term adjunctive treatment with benzodiazepines may also be helpful.
- For acute mixed episodes, atypical antipsychotics may be preferred over typical antipsychotics because of their more benign side effect profile.
- During an acute manic or mixed episode, antidepressants should be tapered and discontinued.
- The initial treatment for patients who experience rapid cycling episodes of illness should include lithium or valproate; an alternative treatment is lamotrigine. In many instances combinations of medications are required.
- For patients who, despite receiving maintenance medication treatment, suffer a breakthrough depressive episode, the first-line intervention should be to optimize the dose of maintenance medication. Optimization of dosage entails ensuring that the serum drug level is in the therapeutic range, and in some cases achieving a higher serum level (although still within the therapeutic range).
- For patients who do not respond to optimal maintenance treatment, next steps include adding another mood stabilizer or atypical neuroleptic.
- The most efficacious treatment of Bipolar Disorder is the combination of medication management and psychotherapy concomitantly, to assist the member and their family in identifying mood cycling, and prevent relapse.
- Following remission of an acute episode, patients may be particularly at high risk for relapse for a period of up to 6 months; this phase of treatment, sometimes referred to as continuation treatment is considered to be part of the maintenance phase. Optimally, patients newly diagnosed with Bipolar Disorder in an outpatient setting should have at a minimum three outpatient medication management within six months of their initial psychiatric evaluation.
- The high rate of relapse appears preventable with pharmacological maintenance treatment.
- Evidence suggests that patients with bipolar disorder are likely to gain some additional benefit during the maintenance phase from concomitant psychosocial intervention, including psychotherapy that addresses illness management and interpersonal difficulties.
- Brief psychotherapy dealing with medication compliance, setting limits on impulsive behaviors, warning signs of relapse, managing stress, rest, hygiene, and dietary issues may be beneficial particularly for newly diagnosed patients. Cognitive therapy may be helpful in assisting patients to understand the antecedents of the disease, and identify the symptoms of mania, depression, and mixed episodes while distinguishing these from a normal range of emotions.
- Establishing and maintaining a supportive and therapeutic relationship is critical to the proper understanding and management of the individual patient. A crucial element is the knowledge gained about the course of the patient's illness that allows new episodes to be identified as early as possible.
- Patients, family members, and significant others can benefit from education and feedback regarding the illness, prognosis, and treatment. Education should be an ongoing collaborative process.



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- Hospitalize the patient for purposes of safety due to harm to self or others, or when their thoughts and behavior become grossly disturbed and functioning becomes impaired.
- ECT is reserved for severe cases that fail to respond to medication, or when the patient cannot safely wait for the therapeutic effects of medication to take effect.

Prognosis

- Bipolar I is a recurrent disorder; over 90% of the individuals who have had 1 manic episode go on to have future episodes; most individuals return to a fully functional level between mood episodes; 20% to 30% continue to display mood lability and impaired functioning;
- When 4 or more episodes occur during a one year period (“rapid cycling”) the prognosis is poor.

BIPOLAR II DISORDER

BIPOLAR DISORDER II IN THE ADULT POPULATION

Diagnostic Criteria

The essential feature is a clinical course characterized by the occurrence of one or more major depressive episodes accompanied by at least one hypomanic episode.

Symptoms Hypomanic Episode: inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, racing thoughts or flight of ideas, distractibility, increased goal directed activities, excessive involvement in pleasurable activities with high potential for painful consequences

Specific Features

- More common in women
- Lifetime prevalence is 0.5%
- First degree biological relatives of individuals with Bipolar II Disorder have elevated rates of Bipolar II, Bipolar I, and Major Depressive Disorders
- Etiology may be a genetic predisposition

Differential Diagnosis

- Rule out Mood Disorders due to a general medical condition, substance use, Bipolar I Disorder, Cyclothymia, and Borderline Personality Disorder

Treatment

- Comorbid substance abuse may be overlooked in patients with Bipolar Disorder, being one of the precipitants for mood episodes. Treatment of substance abuse and bipolar disorder should proceed concurrently.



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- When initial treatment strategies are unsuccessful, treatment with antidepressant medication must be approached cautiously because it can precipitate a manic episode
- Medication strategies used for Bipolar I disorder may warrant a trial, especially when treatment with antidepressants alone has not been successful.
- Evidence suggests that patients with bipolar disorder are likely to gain some additional benefit during the maintenance phase from concomitant psychosocial intervention, including psychotherapy that addresses illness management and interpersonal difficulties.
- Cognitive therapy for depression may be necessary (psychoeducation on management of the disorder, warning signs of relapse, managing stress, and rest, and dietary issues).
- Cognitive therapy may be helpful in assisting patients to understand the antecedents of the disease, and identify the symptoms of mania, depression, and mixed episodes while distinguishing these from a normal range of emotions.
- Establishing and maintaining a supportive and therapeutic relationship is critical to the proper understanding and management of the individual patient. A crucial element is the knowledge gained about the course of the patient's illness that allows new episodes to be identified as early as possible.
- Patients, family members, and significant others can benefit from education and feedback regarding the illness, prognosis, and treatment. Education should be an ongoing collaborative process.
- Emphasis is placed on recognizing early signs of relapse so that patients may seek treatment before a full-blown illness episode develops.
- Following remission of an acute episode, patients may be particularly high risk for relapse for a period of up to 6 months; this phase of treatment, sometimes referred to as continuation treatment is considered to be part of the maintenance phase.
- The high rate of relapse appears preventable with pharmacological maintenance treatment.

Prognosis

- Approximately 60% to 70% of patients diagnosed with this disorder experience a hypomanic episode immediately before or after a major depressive episode.
- Approximately 5% to 15% of patients with this disorder have 4 or more mood episodes that occur within one year; 85% return to full functioning between mood episodes;
- 5% to 15% of individuals diagnosed with a Bipolar II Disorder will develop a manic episode five or more years after being diagnosed

BIPOLAR DISORDER IN THE CHILD AND ADOLESCENT POPULATION

Diagnostic Criteria

The presentation of bipolar disorder in youth, especially in children, is often considered atypical compared with that of the classic adult disorder. Children who receive a diagnosis of bipolar disorder typically present with rapid fluctuations in mood and behavior, often associated the attention deficit-hyperactivity disorder and disruptive behavior disorders.

Specific Features

- Epidemiological surveys of childhood psychiatric disorders have generally not addressed the illness. As the definition of bipolarity has broadened in both juveniles and adults, some experts suggest that the disorder may be as prevalent as 1% in youths.
- Overall bipolar disorder affects both sexes equally, early onset cases are predominantly male, especially in cases with age of onset before age 13.

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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- The adult literature supports a strong genetic component, with a four- to six fold increased risk of disorder in first degree relatives of affected individuals. The degree of familiarity appears even higher in early onset, highly comorbid cases.
- Offspring of parents with bipolar disorder display more symptoms suggestive of risk for the disorder than normal controls, including, mood lability, anxiety, attention difficulties, hyperarousal, depression, somatic complaints and school problems.
- Premorbid psychiatric problems are common in early onset bipolar disorder, especially difficulties with disruptive behaviors, irritability and behavioral dyscontrol.
- Most childhood cases are associated with attention-deficit hyperactivity disorder. Follow up studies of youths with ADHD have not shown that they have an increased rate of classic bipolar disorder as adults.
- Premorbid anxiety and dysphoria are common. Approximately 20% of youths with major depression go on to experience manic episodes by adulthood.
- Marked sleep disturbance is a hallmark sign. Mania in adolescents is frequently associated with psychotic symptoms.

Differential Diagnosis

- Rule out ADHD, major depressive disorder, substance use, conduct disorders, behavioral disorders and disorders due to a general medical condition.
- The DSM-IV-TR criteria including the duration criteria should be followed when making a diagnosis of mania or hypomania in children and adolescents.
- Bipolar disorder NOS should be used to describe youth with manic symptoms lasting hours to less than 4 days or for those with chronic manic-like symptoms representing their baseline level of functioning.
- Youths with suspected bipolar disorder must also be carefully evaluated for other associated problems, including suicidality and psychosocial stressors.
- The diagnostic validity of bipolar disorder in young children has yet to be established. Caution must be taken before applying this diagnosis in preschool children.

Treatment

- For mania in well-defined DSM-IV-TR bipolar 1 disorder, pharmacotherapy is the primary treatment.
- Standard therapy, based on the adult literature, typically includes, lithium, valproate, and/or atypical antipsychotic agents with other adjunctive medications used as indicated.
- The choice of medications should be made based on evidence of efficacy, the phase of illness, the presence of confounding symptoms, the agent's side effect spectrum and safety, the history of medication response and the preferences of the patient and the family.
- Lithium is approved down to age 12 years for acute mania and maintenance therapy.
- Aripiprazole, valproate, olanzapine, and ziprasidone are approved for acute mania in adults. Chlorpromazine is approved for acute mania in adults, but is generally not used first line.
- Both lamotrigine and olanzapine are approved for maintenance therapy in adults.
- The combination of olanzapine and fluoxetine is approved for bipolar depression in adults.
- Controlled studies in adults have not found gabapentin or topiramate to be helpful.
- Benzodiazepines may cause disinhibition in younger children.
- Antidepressants may be useful adjuncts for depression as long as the patient is taking at least one mood stabilizer. Use caution as this may destabilize the patient's mood.
- For patients with clearly defined bipolar disorder, stimulant medications may be helpful for addressing ADHD symptoms once the mood symptoms are adequately



CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- controlled.
- Most youths with bipolar 1 disorder will require ongoing medication therapy to prevent relapse; some individuals will need lifelong treatment.
- Current evidence suggests that the regimen needed to stabilize acute mania should be maintained for 12 to 24 months.
- The clinician must balance the potential deleterious impact of symptom reoccurrence versus that of the side effects of the medication.
- Psychopharmacological interventions require baseline and follow-up symptoms, side effect and lab monitoring as indicated.
- For severely impaired adolescents with manic or depressive episodes in bipolar 1 disorder, ECT may be used if medications are not helpful or cannot be tolerated.
- Psychotherapeutic interventions are an important component of a comprehensive treatment plan for early onset bipolar disorder. This includes, education relapse prevention, individual therapy, evaluation of social and family functioning, and evaluation of academic and occupational functioning.
- The treatment of bipolar disorder NOS generally involves the combination of psychopharmacology with behavioral/psychosocial interventions.

Prognosis

- With regards to long term outcomes, although symptoms of early onset bipolar disorder appears stable over time, juvenile mania has not yet been shown to progress onto the classic adult disorder.
- Because early childhood problems ADHD and conduct problems tend to persist long term, it is not clear whether outcomes are attributable to early onset bipolar disorder versus its associated comorbidities.
- Some studies found that bipolar disorder during later adolescence predicted continuity of the disorder at age 24. However, subsyndromal cases had an increase in psychopathology with adverse outcomes, but not an increase in bipolar disorder.
- Both the bipolar disorder and the subsyndromal cases had an increased risk of antisocial and borderline personality symptoms.

SCHIZOPHRENIA - Subtypes: Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual

Diagnostic Criteria

The essential features are a mixture of characteristic symptoms that have been present for a significant portion of time during a one month period. Some symptoms may persist for at least six months.

Symptoms: delusions, hallucinations, disorganized speech and/or behavior, affective flattening, alogia, avolition, social/occupational dysfunction

Specific Features

- Cultural differences may influence the identification of delusions, hallucinations, or behavioral manifestations
- Onset is usually between late teens and mid thirties. An onset prior to adolescence is rare, and may indicate a chronic condition
- Women are more likely to have a later onset, more prominent mood symptoms, and a better prognosis. The sex ratio is approximately even.
- Lifetime prevalence is estimated to be between .5% and 1%



CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- The risk is 10 times higher for first degree biological relatives of those diagnosed with Schizophrenia, than the general population
- Possible etiologies include an excess of dopamine or an imbalance in the dopamine and norepinephrine levels in the brain; an increased volume of the lateral and third ventricles; or environmental stressors that may trigger the disease in a biologically vulnerable person;

Differential Diagnosis

- Rule out psychotic disorders due to general medical condition, substance use, or mood disorders
- Rule out Schizoaffective, Schizophreniform, and Delusional Disorders

Treatment

- Pharmacological treatment with antipsychotic medications
- Substance Abuse Assessment as needed.
- Brief cognitive behavioral therapy –Medication compliance and Social and interpersonal skills training
- Patient /family education about the illness, medication compliance, and the importance of a support system
- Early intervention at the first sign of relapse
- Day treatment centers that emphasize occupational therapy and build a patient's living, social, and vocational skills can be important for maintaining them in the community and to prevent decompensation of symptoms.
- Hospitalize the patient to stabilize them on medication, to provide safety when they become a threat to self and/or others, and when their behavior becomes grossly disturbed and their functioning becomes minimal
- Individual insight oriented psychotherapy is not recommended for this population

Prognosis

- Generally a chronic condition

ADJUSTMENT DISORDERS

Subtypes

With Depressed Mood, With Anxiety, With Mixed Anxiety and Depression, With Disturbance of Conduct, With Mixed Disturbance of Emotion and Conduct, With Mixed Disturbance of Emotions and Conduct, Unspecified)

The essential features are the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor(s).

Specific Features

- Cultural issues should be considered when making a clinical judgment as to whether a patient's response to a stressor is maladaptive; individuals with disadvantaged social conditions may be at increased risk as a result of possibly experiencing a higher degree of life stressors
- The disorder occur in any age group
- Males and females are equally affected
- 5% to 20% of persons in outpatient mental health treatment receives this diagnosis

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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

Differential Diagnosis

- Rule out Personality Disorders, PTSD, Acute Stress Disorder, Bereavement, and/or psychological factors affecting a medical condition

Treatment

- Brief Individual Cognitive Behavioral Therapy is the treatment of choice. Treatment components may include eclectic therapy techniques to meet the patient's changing needs, defining and maintaining a clear and specific focus, as well as stressors, identifying and utilizing positive coping skills to manage current stressors, educating the patient in a model that explains symptoms, and normalizes the patient's reaction to stressors
- Medication may be prescribed in some cases for a brief period of time. Psychiatric evaluation for psychotropic medication is recommended if symptoms are severe and do not improve within 4 to 6 sessions.

Prognosis

- By definition symptoms should alleviate within six months after the stressor(s) end

ANXIETY DISORDERS

There are numerous medical disorders or drugs that may cause symptoms of anxiety. These include many cardiovascular, respiratory, endocrine, or neurological conditions. Drugs such as caffeine, aspirin, anticholinergic medications, cocaine, decongestants, or withdrawal from alcohol, opiates or sedatives can produce anxiety. All of the above must be considered when evaluating a patient with a complaint of anxiety.

PANIC DISORDER (SPECIFY WITH OR WITHOUT AGORAPHOBIA)

The essential features of a panic attack are a sudden intense fear or discomfort, with four or more of the following symptoms developed abruptly and reached a peak within about 10 minutes. The majority of panic attacks occur unexpectedly, though there is a subset of panic attacks that are precipitated by specific situations.

Symptoms of panic attacks: palpitations, pounding heart, sweating, trembling or shaking, shortness of breath or feeling smothered, feelings of choking, chest pain, nausea or gastrointestinal distress, dizziness, lightheadedness, derealization, fear of losing control or dying, paresthesias, chills or feeling flushed.

Criteria for Agoraphobia:

- Anxiety about being in places from which escape might be difficult, or in which help may not be available in the event of a panic attack
- The situations are either avoided, endured with marked distress, or produce anxiety about having a panic attack

Specific features



CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- The lifetime prevalence is 1.6-2.2%, and 30-50% of community samples of those with panic disorder also have agoraphobia.
- The risk in females is about twofold over males.
- The typical age of onset usually occurs in early adulthood, though limited symptoms may occur earlier.
- First degree relatives of persons with Panic Disorder have a 4 to 7 times greater chance of developing a Panic Disorder; twin studies indicate a genetic component.
- There is a high comorbidity with Major Depressive Disorder and Substance Abuse Disorders.
- Levels of avoidance and apprehension are stronger predictors of level of impairment and quality of life than frequency of panic attacks

Differential Diagnosis

- Rule out Anxiety Disorder due to a general medical condition, substance use or other anxiety disorder, i.e. Social Phobia, Obsessive-Compulsive Disorder or PTSD

Treatment

- Effective treatment should lead to the reduction in frequency and intensity of symptoms as well as a reduction in anticipatory anxiety and agoraphobic avoidance. The goal of treatment is return to a premorbid level of functioning.
- Antidepressants are the treatment of choice. SSRIs and SNRIs, in particular secondary to their cost, tolerability and safety profile. TCAs and MAOIs may also be considered.
- Benzodiazepines may also be helpful, particularly in the initiation phase of treatment to control the symptoms of panic, or to target residual symptoms of anxiety. Caution should be taken with long term use of benzodiazepines because of the risk of dependence. Before prescribing a benzodiazepine, a patient should be assessed for a comorbid substance abuse disorder.
- Patients may also benefit from group cognitive behavioral therapy.
- Treatment should be continued for one year or more after an acute response to promote symptom reduction, and decrease the risk of recurrence. Length of treatment should be tailored according to the patient's presentation and history.
- If there is a decision to taper medications, it ideally should be done slowly to allow for monitoring of symptoms and recurrence of panic disorder.

Prognosis

- The usual course of the disorder is chronic with waxing and waning phases.
- Approximately six to ten years post treatment, 30% of the patients are well, 40-50% are improved but symptomatic, and the remaining 20-30% have symptoms that are the same or slightly worse.

AGORAPHOBIA WITHOUT A HISTORY OF PANIC DISORDER

The essential features are similar to those of a Panic Disorder with Agoraphobia, except that the focus of fear is on the occurrence of incapacitating or extremely embarrassing panic like symptoms, or limited attacks rather than a full blown attack. Agoraphobic fears typically involve characteristic clusters of situations that include being outside of the home alone; being in a crowd or standing in line; being on a bridge; and traveling in a bus, train, or automobile.

Specific Features

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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- Cultural factors need to be considered
- Females are more often diagnosed with this disorder
- Epidemiological studies are generally unreliable due to frequent, improper diagnosis

Differential Diagnosis

- Rule out Anxiety Disorder due to a general medical condition, substance use, or other Anxiety Disorder such as social phobia, PTSD, and Obsessive-Compulsive Disorder

Treatment

- Treatment is similar for that of Panic Disorder, but combined medications and behavioral approaches are most effective in preventing relapse
- The patient, as well as their family members, may benefit from group therapy

Prognosis

- Some cases may persist for years and are associated with significant impairment

SOCIAL PHOBIA

The essential feature is a marked and persistent fear of embarrassment in social or performance situations.

Specific Features

- Clinical presentation may vary across cultures
- Lifetime prevalence varies from 3-13%
- Typical onset is in the mid-teens, and onset may abruptly follow a humiliating experience or may be more insidious
- Social Phobia occurs more frequently in women
- There is a higher incidence among first degree relatives of those diagnosed with the disorder

Differential Diagnosis

- Rule out Panic Disorder with Agoraphobia, Agoraphobia, Separation Anxiety disorder, Specific Phobia, Pervasive Developmental Disorder, Schizoid Personality Disorder, and Avoidant Personality Disorder

Treatment

- Psychotropic medications in conjunction with psychotherapy is the most efficacious treatment
- SSRI's and Venlafaxine are the mainstays of treatment. Benzodiazepines and Buspirone may be used as adjunctive treatments.
- In specific performance situations Beta-Blockers are frequently used before exposure to a phobic stimulus.
- Brief Cognitive-behavioral therapy: Exposure treatments, self study activities are widely used.



CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

Prognosis

- The course is frequently continuous and lifelong, however symptoms may lesson with age

SPECIFIC PHOBIA

The essential feature is a marked and persistent fear of clearly discernible, circumscribed objects or situations.

Specific Features

- The content and prevalence of the phobia varies within cultures
- Females are most often diagnosed with this disorder
- Age of onset is often in childhood
- Lifetime prevalence ranges from 10% to 11.3%
- Preliminary evidence suggests that the type of phobia can be aggregated within families

Differential Diagnosis

- Rule out Panic Disorder with Agoraphobia, Social Phobia, PTSD, Obsessive Compulsive Disorder, Separation Anxiety Disorder, and Hypochondriasis

Treatment

- Behavioral approaches such as in-vivo or imaginal exposure are most effective (longer periods of exposure tend to be more effective)
- Use of an anti-anxiety medication at the time of exposure to the anxiety provoking situation

Prognosis

- Generally, phobias that persist into adulthood do not remit without treatment

OBSESSIVE-COMPULSIVE DISORDER (OCD)

The essential features are recurrent obsessions or compulsions that are sufficiently severe to cause marked distress, be time consuming and interfere significantly with a person's normal occupational or social functioning.

Symptoms/Obsessions: recurrent thoughts, impulses or images that are experienced as intrusive, and cause marked distress; the individual attempts to ignore or suppress such thoughts, impulses or images and recognizes the obsession is a product of their mind.

Symptoms/Compulsions: repetitive behaviors which the individual is driven to perform in response to an obsession; the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event/situation.



CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

Specific Features

- The onset is gradual, and appears in adolescence or adulthood; symptoms are similar in children and adults
- It is equally common in males and females
- The lifetime prevalence is 2-3%
- 35% of first degree relatives with the disorder are also afflicted
- The concordance rate is higher for monozygotic twins suggesting a strong genetic component

Differential Diagnosis

- Rule out Anxiety Disorder due to a general medical condition, Substance Use, Body Dysmorphic Disorder, Specific or Social Phobia, Major Depression, Generalized Anxiety Disorder, Hypochondriasis, Delusional Disorder, Schizophrenia, tic Disorder, Obsessive Compulsive Personality Disorder

Treatment

- Insight oriented psychotherapy, appears to have little benefit and is generally not recommended
- SSRIs and Clomipramine (Anafranil) are the medications of choice. Prior to initiating treatment with Clomipramine as with the initiation of any tricyclic medication, and EKG is recommended.
- If treatment with above is unsuccessful, Depakote, Lithium or Tegretol may be added. Venlafaxine and the MAOIs may also be tried as second-line agents.
- A combination of medication and behavioral therapy is the treatment of choice, and has longer lasting effects. Relapse frequently occurs when medications are discontinued.
- Supportive therapy may be helpful as an adjunct to address the patient's depressed mood, sexual dysfunction, and difficult family relationships that usually occur with OCD. Community support groups may also be helpful.

Prognosis

- Persons with OCD have chronic waxing and waning symptoms related to stress

POST-TRAUMATIC STRESS DISORDER (PTSD)

The essential feature is the development of characteristic symptoms following a patient's exposure to an extremely traumatic stressor. The stressor may involve personal experience of an event involving either actual or threatened death or serious injury; witness to an event involving death, injury or threat to another person; or the unexpected or violent death, serious harm or threat of death to a family member or close associate. The symptoms last for more than a month.

Symptom Criteria: The traumatic event is persistently re-experienced, persistent avoidance of stimuli associated with the trauma, a numbing of individual responses, or persistent symptoms of increased arousal

Specific Features

- There are elevated rates of persons diagnosed with PTSD who have emigrated from areas of social unrest and civil conflict
- Children's symptoms may manifest as nightmares about monsters, rescuing others, threats to self or others, repetitive play of the traumatic event, or a sense of a shortened future
- Onset can occur at any age

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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- Symptoms usually present within three months of the trauma, although there can be a delay of months or years
- Lifetime prevalence ranges from 1% -14; studies of at risk individuals has yielded prevalence rates ranging from 3% to 58%

Differential Diagnosis

- Rule out Adjustment Disorder, Acute Stress Disorder, OCD, Schizophrenia/other psychotic disorders, Mood disorders with Psychotic Features, and malingering
- If a patient's symptoms more aptly fit another DSM IV-R disorder, a PTSD diagnosis is not given

Treatment

- Several randomized controlled trails generally support the use of SSRIs and SNRIs over placebo for non-combat related PTSD. The use of SSRIs in combat related PTSD cannot be recommended with the same level of confidence based on recent literature reviews.
- Prazosin appears to be effective in reducing trauma nightmares, and total PTSD symptoms.
- Atypical antipsychotic medications show some efficacy when used as an adjuvant treatment in partial responders. As always patients receiving an antipsychotic medication should be monitored for side effects including weight gain and metabolic changes.
- There is limited evidence of efficacy to recommend the treatment of anticonvulsants in the treatment of PTSD.

Prognosis

- Fifty percent of the patients completely recover within three months, for others symptoms may persist for one year of indefinitely

ACUTE STRESS DISORDER

The essential features are the development of characteristic anxiety, and dissociation. Symptoms occur within one month after exposure to a traumatic stressor, and are similar to PTSD, but last less than a month

Specific features

- Cultural factors influence the pattern of symptomatic responses to traumatic events
- Onset can occur at any age
- Prevalence in a population exposed to traumatic stress depends on the severity and persistence of the trauma, and the degree of exposure

Differential Diagnosis

- Rule out Adjustment Disorder, PTSD, Mental Disorder due to a general medical condition, Substance Use, Brief Psychotic Disorder, Major Depression, or Malingering

Treatment

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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- Please refer to the PTSD section

GENERALIZED ANXIETY DISORDER (INCLUDES OVERANXIOUS DISORDER IN CHILDHOOD)

The essential features are excessive anxiety, worry and apprehensive expectation about particular events. Symptoms occur more days than not, for a period of at least six months. The person finds it difficult to control the worry.

Symptoms: restlessness, easily fatigued, difficulty concentrating, irritability, muscle tension and sleep disturbance

Specific Features

- Cultural variations may determine how anxiety is expressed, and whether the patient's worries are realistically excessive
- Children may present as perfectionists who are concerned with approval, punctuality, or the occurrence of catastrophic events
- Onset generally occurs in childhood, although the onset after the age of 20 is not uncommon
- The ratio of gender prevalence is 2 males: 3 females
- Lifetime prevalence is 5%
- Etiology is unknown

Differential Diagnosis

- Rule out all other Anxiety Disorders, Separation Anxiety Disorder, Adjustment Disorder, Mood Disorders, Psychotic Disorders or nonpathological anxiety; hyperthyroidism, mitral valve prolapse, and pheochromocytoma

Treatment

- Assess for possible comorbid Substance Abuse or medical condition
- Some patients respond to medication, others psychotherapy, and others a combination of the two
- SSRIs, Venlafaxine, benzodiazepines and buspirone are the first line pharmacotherapeutic agents
- Cognitive behavioral approaches such as modifying maladaptive thought patterns and teaching coping mechanisms and relaxation skills are effective
- Referral to community support groups

Prognosis

- A chronic condition that often worsens in times of stress

EATING DISORDERS

Symptoms: Severe disturbance in eating behavior either by a refusal to maintain a minimally normal body weight for age and height -Anorexia Nervosa or by engaging in episodes of binge eating and purging-Bulimia Nervosa.

ANOREXIA NERVOSA

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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

Subtypes

1. Restricting Type: Weight loss is attained by dieting, fasting, or excessive exercise. No binge eating or purging.
2. Binge-Eating/Purging Type: Self induced vomiting, use of laxatives, diuretics and enemas. Some might not binge eat, thus consuming small amounts of food, however they engage in regular purging at least once weekly.

Specific Features

- Anorexia Nervosa usually develops during childhood or early adolescence with failure to make expected weight gains
- Weight loss of less than 85% expected body weight is attained by the reduction of food intake, excessive exercise, purging and the use of diuretics, diet pills and enemas. A distorted body image is also present
- The presence of amenorrhea is evident as well as other menstrual disturbances

Differential Diagnosis

- Rule out comorbid Substance Abuse, Major Depressive Disorder and Obsessive Compulsive Disorder, Other Medical Conditions, Social, Phobia, and Body Dysmorphic Disorder

Specific Culture, Age, and Gender Features

- Anorexia Nervosa is more prevalent in industrialized societies where female attractiveness is linked to being thin
- It is most common in the United States, Canada, Europe, Australia, Japan, New Zealand, and South Africa, with minimal information available about other cultures
- It is rarely present before puberty.
- Studies in adolescents suggest that Anorexia Nervosa is present in 0.5%-1.0%. The mean age is 17 years with bimodal peaks at ages 14 and 18.
- Increased risk of Anorexia Nervosa among first-degree biological relatives with the disorder, with an increased risk of Mood Disorder.

Treatment

- Individual and Group Treatment-
- Cognitive Behavioral Therapy: Challenging distorted thought patterns, restructuring incorrect thoughts and beliefs that maintain the disease. Decrease ambivalence and compulsions
- Behavior modification: Challenge and extinguish/modify compulsive behaviors and rituals associated with food/exercise.
- Support groups in conjunction with therapy.
- Patient should be within 85% to 90% of healthy body weight- Otherwise Residential Treatment or even Inpatient Treatment should be considered depending on body weight and present malnutrition symptoms.
- Consultation with a nutritionist and / or PCP to monitor serial serum and electrolyte levels and prevent hospitalization due to medical condition.
- Family involvement to include psycho-educational / supportive groups in the community.
- Assessment and care for comorbid psychiatric conditions such as: Substance Abuse and Borderline Personality Disorder.



CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- Psychotropic medication Evaluation in some cases
- High risk for suicide

Treatment Intensity

- Initial Assessment should include Substance Abuse history and referral to community support groups and resources.
- Behavior modification should include weekly sessions and a specific behavioral plan after Initial Assessment.
- Communication with PCP / Nutritionist to include in Treatment Plan development and interventions. A daily log should monitor weight monitoring, caloric intake, and exercise.
- Treatment goals should include specific expected weight gain as measured in daily / pounds.

Prognosis

- Fair to Poor, as there is a risk of recurrent episodes
- Medical and physical complications may arise causing death due to malnutrition

BULIMIA NERVOSA

Subtypes

1. Purging Type: The person regularly engages in self-induced vomiting or the misuse of laxatives, diuretics or enemas.
2. Nonpurging Type: The person has used other compensatory behaviors: excessive exercise, and fasting, but no use of self-induced vomiting, use of laxatives, diuretics or enemas.

Specific Features

- Individuals with Bulimia Nervosa normally maintain their body weight within a normal range for their age and height.
- Individuals tend to be overweight prior to engaging in bingeing and purging.
- Low self esteem and episodes of depression accompany the behaviors.
- There is a high concern for body weight and shape, predominantly in the purging type. Irregular menstrual cycles are also common, as well as medical complications such as gastric ruptures, cardiac arrhythmias and fluid and electrolyte imbalances.

Differential Diagnosis

- Anorexia Nervosa, Binge-Eating/Purging Type, Major Depressive Disorder with Atypical Features, and Borderline Personality Disorder

Specific Culture, Age, and Gender Features

- Most common in industrialized countries such as United States, Europe, Canada, Australia, Japan, New Zealand and South Africa, with minimal information about other cultures



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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- Bulimia is usually present on late adolescence or early adult life
- There is a prevalence of Substance Abuse and Mood Disorder history in first-degree biological relatives
- Prevalence: In adolescents and young adult females is between 1% and 3%, and in males is one-tenth occurrence of that in females

Treatment

- Individual and Group Treatment
- Cognitive Behavioral Therapy –Challenge and restructure off incorrect thoughts and beliefs that work to maintain the disease.
- Mastery of social skills and roles and adaptation to interpersonal situations to reduce the negative relationship between negative mood, low self esteem, interpersonal function and eating disorder
- Behavior Modification: Develop the absence of significant reduction of binge and purge cycles.
- Support groups, in conjunction with individual therapy

Prognosis

- Fair to poor, with possible medical complications

SUBSTANCE ABUSE

The most common substances that can be classified as drugs of abuse include:

- Alcohol
- Amphetamines or other Sympathomimetics
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opioids
- PCP
- Sedatives
- Hypnotics
- Anxiolytics.

Features of Substance Abuse

The essential features of substance abuse are maladaptive patterns of substance use leading to a clinically significant impairment within a 12-month period. This can be demonstrated by:

- Recurrent substance abuse leading to failure to fulfill major role obligations at work, school, or home.
- Recurrent substance use in situations where it is physically dangerous.
- Recurrent legal problems related to substance use

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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

- Continued substance use despite recurrent social or interpersonal problems

Features of Substance Dependence

The essential feature of substance dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating continued use despite significant substance-related problems. This needs to be manifested by three of the following in a 12-month period:

- Tolerance
- Withdrawal
- The substance is taken in larger amounts or for longer than was intended
- Persistent desire or unsuccessful efforts to cut down or control use
- Increased amounts of time is spent in activities necessary to obtain the substance or recover from its effects
- Important social or occupational activities are given up or reduced secondary to use
- Substance use is continued despite persistent or recurrent physical or psychological problems caused or exacerbated by the substances

Along with substance dependence is the concern for substance withdrawal once the substance is discontinued.

Withdrawal symptoms are generally substance specific syndromes that occur after heavy and prolonged use. In addition, the withdrawal causes clinically significant distress or impairment to social or occupational functioning.

Alcohol, opiates, sedative hypnotics have potentially medically complicated withdrawal syndromes that require treatment in an inpatient setting. Psychcare does not currently allow for outpatient detoxification from these substances.

Clinical History and Assessment

Substance abuse and dependence often coexists with other psychiatric disorders and a diagnosis is confounded by the comorbid occurrence of both disorders. Therefore, a complete clinical history is essential to properly diagnose the disorder. A substance disorder diagnosis is further complicated by denial or minimization of the substance use. It is recommended that a complete clinical history include:

- A detailed history of past and present substance use, and its effects on the patients functioning. Important details to note would be the last date of use, the amount used, quantity, frequency and duration of use, subjective effects, and other drugs used.
- A general medical and psychiatric history and examination to include history of seizures and blackout periods.
- A history of previous substance abuse treatment and compliance with treatment recommendations, length of sobriety, and level of functioning obtained while sober.
- A complete family and social history
- Blood, urine and or breath toxicology screenings for substances
- Screening for medical conditions commonly associated with substance abuse/dependence.
- Screening and diagnosis of comorbid psychiatric conditions. Care must be taken to ensure that symptoms are not related to substance withdrawal. These symptoms may remit within three or four weeks of abstinence.



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Treatment Interventions

Substance abuse/dependence is a biopsychosocial disease and treatment must be tailored to address all of the issues noted below.

- Substance abuse/dependence treatment includes a number of different modalities, depending on the current needs of the patient.
- Treatment should be in the least restrictive setting, with a primary focus on the patient’s safety.
- The ideal outcome is total abstinence. A patient may move from one level of care to another based on a thorough risk assessment and their ability to benefit from treatment.
- Referrals to 12 step programs and other community resources
- Family involvement when possible
- Psychiatric management to treat comorbid psychiatric conditions that may affect the person’s ability to remain abstinent.
- Communication and coordination of treatment with other medical or behavioral health providers.
- Treatment of comorbid medical conditions
- Substance abuse education related to relapse prevention
- The use of medication to ease withdrawal. This is done in an inpatient setting.
- Referral for follow up outpatient substance abuse treatment post discharge from an inpatient setting.
- The use of medications to decrease cravings, anxiety related to abstinence.

Treatment Setting and Patient Presentation

Level of care criteria, based on the ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition - Revised are as follows:

TREATMENT SETTING	PATIENT PRESENTATION
Inpatient Detoxification	The patient presents with a likelihood of severe withdrawal.
Inpatient Treatment	The patient has a comorbid psychiatric or medical condition that places the member at risk.
Intensive Outpatient Treatment	The patient presents with a marked interference in functioning, but is not in acute withdrawal.
Individual Outpatient Treatment	Individual therapy with a clinician who is trained and experienced in treating substance abuse. The patient is motivated, involved in a 12-step recovery program, and has adequate psychosocial supports. Treatment should focus on abstinence and recovery, providing the patient with tools for dealing with sobriety.



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PRE-ASSESSMENT PROTOCOL FOR ELECTRO-CONVULSIVE THERAPY (ECT)

Behavioral and medical pre-assessment of the appropriateness for ECT is essential for safe and effective treatment.

Inpatient ECT: The members' attending psychiatrist requests inpatient ECT. It is the responsibility of the attending psychiatrist to provide the Medical Director with all pertinent clinical information necessary to determine the appropriateness of ECT. When indicated, the Medical Director will contact the attending psychiatrist for additional clinical information. Once all clinical information is received, the Medical Director will request a second opinion from a network psychiatrist with an expertise in ECT. When the attending psychiatrist is not administering the treatment, the network psychiatrist contracted to perform ECT at the network facility may provide the second opinion.

Outpatient ECT: The members' treating psychiatrist requests outpatient ECT. It is the responsibility of the treating psychiatrist to provide the Medical Director with all pertinent clinical information necessary to determine the appropriateness of ECT. When indicated, the Medical Director will contact the treating psychiatrist for additional clinical information. Once all clinical information is received, the Medical Director will request second opinion from a network psychiatrist with an expertise in administering ECT.

Appropriateness for Treatment

The literature notes the following circumstances, but are not limited to, in which ECT may be recommended by the members' psychiatrist:

- Major Depression
- Mania
- Mixed affective states
- Dysthymia
- Affective Disorders secondary to a medical condition
- Schizophrenia (with prominent affective symptoms)
- A syndrome of Catatonia.
- Instances in which drug therapy has failed, and/or poorly tolerated
- The severity of the psychiatric or medical condition dictates a need for a rapid, definite response (i.e. severe suicidal ideation, or lethal catatonia, and acute mania)
- The risks of ECT are lesser than those of other treatments (i.e. elderly patients or pregnant women)
- ECT should be considered a first line treatment when there is a history of past episodes, which yielded positive results for the member.
- Treatment of delirium from other etiologies such as Neuroleptic Malignant Syndrome, and the motor manifestations Parkinson's Disease

Coordination of a pre-evaluation psychiatric assessment, and medical clearance by the members' PCP or internist is necessary to provide safe and effective treatment.



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A thorough pre-evaluation assessment by a psychiatrist includes, but is not limited to, the following:

- A detailed neuropsychiatric history, with a thorough interview and examination, including past treatment modalities and medications
- Knowledge of the members' dominant hand (for language), to determine electrode placement as necessary
- Substance abuse screening and history, including all past treatment modalities and medications
- Discontinuation of anticonvulsant medication(s) and/or Lithium prior to ECT
- A second opinion with psychiatrist who is knowledgeable in ECT protocols

Medical clearance for ECT is completed by the health plan credentialed PCP or internist. Based on industry standards, it is recommended that medical clearance include the following assessments:

- Identification of medical risk factors with a focus on cardiovascular disease, nervous system disorders, and/or a prior history of procedures that required general anesthesia
- Treatment of an underlying medical illness, which may need to be treated prior to ECT
- A complete physical exam, including neurological clearance
- Laboratory work-up
- EKG
- X-Rays of the cervical / thoracic / lumbar spine.

It is at the discretion of the PCP or internist as to what assessments are performed in conjunction with hospital standards.

ALZHEIMER'S DISEASE

Epidemiology

Alzheimer's disease is the most common cause of dementia in the elderly accounting for 60-75% of cases. The frequency of dementia doubles every 5 years, from 1% of individuals 60-64 years of age; to 35-45% of those > 85 years of age. An estimated 3/5-4.5 million Americans and 25 million worldwide have dementia.

The estimated cost of caring for dementia patients in 2003 was \$156 billion and costs will continue to rise as the population ages.

Risk and protective factors have been identified through epidemiologic and case controlled studies. Lifestyle changes in midlife may have the greatest impact on the eventual development of Alzheimer's disease. It is uncertain if factors that reduce the risk of Alzheimer's disease will also reduce the risk of the progression of MCI (mild cognitive impairment) to Alzheimer's, or the progression of established Alzheimer's disease.

Risk Factors

- Age
- Female gender
- ApoE-4 genotype
- Family history of dementia
- Hypercholesterolemia



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- Hyper-homocysteinemia
- Diabetes
- Head injury
- Psychological stress
- Hypertension
- Smoking

Protective Factors

- Education
- Active cognitive involvement
- Physical activity/exercise
- Diet with high antioxidant content
- Omega-3 fatty acids
- Vitamins E,C
- Alcohol (modest use)
- Statins

Assessment of Cognitive Impairment

The clinical assessment includes clinical, laboratory and imaging studies.

Clinical Assessment:

- History of present illness
- Medical and psychosocial history
- Family history
- Current medications

The above should be corroborated by a caregiver or other knowledgeable informant.

The mental status examination should assess five basic cognitive domains, including attention, memory, language, visual-spatial function and executive function.

The mental status examination is an essential part of the assessment of cognition and typically includes standardized assessments such as the Mini-Mental State Examination (MMSE) or the Montreal Cognitive Assessment (MOCA). The Functional Activity Questionnaire measures instrumental activities of daily living such as using transportation, balancing a checkbook, and preparing a meal. The Neuropsychiatry Inventory –Questionnaire can be completed by a caregiver and provides information regarding twelve common behavioral changes and behavioral syndromes.

Neuropsychological measures may be particularly useful when questions arise in regard to distinguishing normal aging from MCI.

Laboratory and Imaging Studies:

According to the American Academy of Neurology Guideline, routine laboratory assessment of cognitively impaired patients includes basic laboratory studies of:

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- Complete blood count,
- Electrolytes,
- Blood sugar,
- Liver function tests
- Blood urea nitrogen
- Thyroid stimulating hormone and serum B-12 level.

Additional testing may be warranted in specific clinical circumstances. These include:

- Erythrocyte sedimentation rate
- Homosysteine Level
- Testosterone Level
- Apolipoprotein E Genotype,
- Presenilin 1 Mutation Testing
- HIV Viral Titers
- CD4 and T Cell Count

CT and MRI of the brain provide structural imaging to exclude brain tumors, subdural hematomas, and obstructive hydrocephalus. Single Photon Emission CT demonstrates cerebral blood flow; patterns distinctive for Alzheimer's disease, frontotemporal dementia, and vascular dementia.

PET imaging can reveal distinctive metabolic profiles for different dementia syndromes.

Genetic testing:

Genetic testing is not generally a part of the evaluation of patients with dementia, except in very specific circumstances.

Psychiatric Status

Ninety percent of patients with dementia develop neuropsychiatric or behavioral symptoms during the course of the disease. The following symptoms tend to evolve over time, so regular monitoring is important.

- Depression is common, particularly in the early stages of dementia. This includes monitoring for suicidal ideation, anxiety, sleep and appetite disturbances.
- Hallucinations or delusions are more common later in the illness. These may be accompanied by agitation or aggression.
- Changes in cognitive status
- Changes in functional status

An acute worsening of cognition, functioning, behavior or mood, and/or delirium may be due to infection, dehydration, or changes in medication.

Patient Safety

It is important to regularly assess the patient with dementia for cognitive deficits that pose a danger to self or others. These include:

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- Suicidality
- Aggression
- Proper supervision
- Fall prevention
- Nutrition and hygiene issues
- Abuse and neglect

Family education is an integral part of the treatment plan. This includes information about the course of the illness, available educational resources and support, assessment of the caregiver's stress level, supporting a family's decision about institutionalization, and advising the family to address financial and legal issues.

Pharmacological Treatments

Nonpharmacological interventions should always be tried first. If the dementia is secondary to another medical condition, this should always be treated optimally first. For example, if the dementia is secondary to multi-infarcts, blood pressure should be well controlled.

Pharmacodynamics may be altered in elderly patients and those with dementia. The decision to medicate should be carefully considered and polypharmacy avoided whenever possible.

Treatment for Cognitive and Functional Losses:

- The only FDA approved medications for dementia or cognitive impairment are the Cholinesterase Inhibitors (Tacrine, Donepezil, Rivastigmine, and Galantamine), Memantine and the combination of Ergoloid Mesylates
- Several other medications including NSAIDS, Statins, and Estrogen Supplementation have shown a lack of efficacy in placebo-controlled trials

Treatment for Psychosis and Agitation:

- There is evidence for the efficacy of first and second generation antipsychotics although this benefit is often modest. Because of the potential toxicity of these agents, the risks and benefits need to be reassessed on an ongoing basis, and the lowest effective dose should be sought. Their uses should be limited to psychosis or behavioral disturbances.
- Benzodiazepines have a higher likelihood of side effects and a lower likelihood of benefit than antipsychotics, but they are occasionally useful in treating some patients particularly when anxiety is prevalent. Long term use should be avoided, if possible.
- The use of anticonvulsants has very little supporting evidence, but for patients who are sensitive or unresponsive to other agents a trial of Gabapentin or Valproate may be considered.
- Support of the use of Trazodone or Buspar is limited to case studies and small clinical trials.

Treatment of Depression:

Placebo-controlled trials of antidepressants in patients with dementia have mixed results, but clinical consensus supports the use of antidepressants in dementia patients with persistently depressed mood.

- SSRIs may be preferred because they are better tolerated. Venlafaxine and Duloxetine are also options.
- Mirtazepine can produce sedation and weight gain at low doses
- Trazodone can be used when sedation or severe agitation is present



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- Cyclic antidepressants or MAOIs can be used when others are not effective.
- Psychostimulants and dopamine agonists: There is a small amount of evidence that dopaminergic agents, such as psychostimulants, Amantadine, Bromocriptine, and Bupropion (Bupropion has been associated with the risk of seizures) may be helpful in the treatment of severe apathy in patients with dementia. These agents should be used with caution secondary to the side effect profile.
- ECT should only be considered in treating depression that is severe, life threatening or does not respond to other treatments.

Sleep Disturbances:

Treatment of sleep disturbance in dementia is aimed at decreasing the frequency and severity of insomnia, interrupted sleep, and nocturnal confusion. Available data do not support the recommendation of a specific course of action regarding sleep.

AUTISM

INTRODUCTION

Psychcare has developed the guidelines in order to provide treatment recommendations and strategies related to Autism Spectrum Disorders including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder, NOS in keeping with the Steven A. Geller Autism Coverage Act.

The resources used to develop the guideline were evidence-based clinical practice guidelines from recognized sources. This guideline was reviewed and approved by our Clinical Standards Committee. The members of the committee include our network practitioners.

Diagnostic Criteria

Autism is characterized by the following essential features: persistent difficulty in interacting socially, impairment in speech, language, and communication, and repetitive and restricted behavior patterns (insistence on sameness, stereotypic or self stimulatory behavior). There are three Pervasive Developmental Disorders that are specifically mandated for coverage under Steven A. Geller Autism Coverage Act fall under the Autism Spectrum Umbrella and they are marked by corresponding symptoms:

- | | |
|--|---|
| <i>Autistic Disorder:</i> | impairments of social interaction, communication, and imaginative play prior to three years of age. Stereotyped behaviors, interests, and activities. |
| <i>Asperger's Disorder:</i> | characterized by impairments in social interactions and the presence of restricted interests and activities, with no clinical significant general delay in language, and testing in the range of average to above average intelligence. |
| <i>Pervasive Developmental Disorder, NOS:</i> | commonly referred to as atypical autism – a child may receive this diagnosis when he/she does not meet criteria for a specified diagnosis, but there is a severe and pervasive impairment in specified behaviors. |



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Specific Features

- Symptoms and features of autism can present themselves in a wide variety of combinations from mild to severe.
- Qualitative impairment in social interaction, as manifested by at least two of the following: (1) marked impairment in the use of multiple nonverbal behaviors; (2) failure to develop peer relationships appropriate to developmental level; (3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people; or (4) lack of social or emotional reciprocity.
- Qualitative impairments in communication as manifested by at least one of the following: (1) delay in, or total lack of the development of spoken language; (2) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others; (3) stereotyped and repetitive use of language or idiosyncratic language; and/or (4) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.
- Restricted repetitive and stereotyped patterns of behavior, interests, and activities as manifested by at least one of the following: (1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus; (2) apparently inflexible adherence to specific, nonfunctional routines or rituals; (3) stereotyped and repetitive motor mannerisms; or (4) persistent preoccupation with parts of objects.
- Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction; (2) language as used in social communication; or (3) symbolic or imaginative play.
- Failure to develop peer relationships appropriate to developmental level.
- Apparently inflexible adherence to specific, nonfunctional routines or rituals.

Related Challenges Impacting Treatment Planning

- Individual differences may occur in the following areas:
 - Sensory Processing
 - Motor Skills (visual, fine, and gross)
 - Executive functions (organization, planning problem solving)
 - Motivational profiles
 - Learning mastery (Acquisition + Generalization + maintenance)
 - Learning style
 - Co-existing conditions
 - Attention

Best Practice Parameters

- Early Identification and Intervention: Intervention should begin at the earliest possible age
- Intervention Intensity: Effective intervention includes large numbers of functional, developmentally-relevant and high-interest learning opportunities
- Family Involvement: Families should be actively involved in education and treatment
- Professional Training: Treatment programs should be directed and implemented by teams of professionals with extensive training and specialized experience in autism interventions
- Systematic Instruction: Systematic instruction and ongoing objective assessment of progress is essential
- Structured Learning Environment: Treatment settings require highly supportive physical, temporal, and staffing environments



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- Evidence-Based Instruction: Teaching procedures should be highly individualized, carefully planned, research-based, and allow for generalization and maintenance of skills
- Transition Planning: Transitions should be carefully planned and well supported
- Critical Programmatic Areas: Communication, Social Development, Cognitive Development, Sensory Development, Motor Development, Adaptive Functioning, and Reduction of maladaptive behaviors using positive behavior supports

Treatment Intensity

- The mainstay of treatment for Autism involves speech therapy, physical therapy, occupational therapy, and applied behavioral analysis.
- While there are different treatment modalities utilized to treat the behavioral aspects of Autism (Applied Behavioral Analysis, Sensory integration, Music Therapy, Touch Therapy, Dolphin Therapy, Hypnotherapy, Hyperbaric therapy, Hormone therapies, Immunological therapies, Anti-yeast therapies, Vitamin therapies, Chelation therapy, Dietary interventions), the only intervention that does NOT lack empirical support currently is Applied Behavioral Analysis. This is currently the only intervention mandated by Steven A. Geller Autism Coverage Act for the treatment of the behavioral aspects of Autism.
- Applied Behavioral Analysis has its roots in behavior theory. It emphasizes antecedent and consequence-based interventions. Below are three types of interventions:
 - **Discrete Trial Training (DTT):** A discrete trial is a single cycle of behaviorally-based instruction routine. The particular trial may be repeated several times in succession, several times a day, over several days (or longer) until the skill is mastered. The parts of a discrete trial include: The discriminative stimulus (the cue to which the teacher would like the child to respond), the prompting stimulus (the cue from the teacher to help the child respond correctly), the response (the skill or behavior that is the target of the instruction), the reinforcing stimulus (a reward designed to motivate the child to respond and respond correctly), and an optional part called the inter-trial interval (a brief pause between two consecutive trials).
 - **Pivotal Response Training (PRT):** A behavioral treatment intervention based on two pivotal behaviors that affect a wide range of behaviors in children with autism: motivation and responsivity to multiple cues. PRT works to increase motivation by including components such as child choice, turn-taking, reinforcing attempts and interspersing maintenance tasks. PRT has been used to target language skills, play skills and social behaviors in children with autism.
 - **Applied Verbal Behavior (AVB):** A behavioral treatment that addresses the difficulties in the development of communication by emphasizing functional language and tying it to motivational variables. AVB separates the components of language into several verbal operants which enable us to more specifically target language deficits and ensure that a patient is utilizing language in its functional context.

The Role of the Behavioral Analyst

- To provide documentation and information related to the patient and the treatment of the patient's symptoms
- Develop highly individualized, carefully planned, research-based treatment/intervention plan to treat the patient's symptoms in an appropriate setting and intensity



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- Review interventions
- Evaluate effectiveness of interventions based on: (1) a description of the intervention; (2) the anticipated outcome; and (3) risks/side effects/limitations

Prognosis

- Symptoms of autism are reliably measured by 18 months of age
- The American Academy of Pediatrics recommends screening for Autism Spectrum disorder twice before age 2
- The American Academy of Pediatrics recommends treatment when Autism Spectrum Disorder is suspected.
- Outcomes are more favorable for those receiving early intervention.
- Specialized early intervention yields more favorable outcomes than generic interventions



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REFERENCES

A Task Force Report of the American Psychiatric Association. (2001) The Practice of Electroconvulsive Therapy, Recommendations for Treatment, Training, and Privileging, Second Edition. Chapter 11, Pages 125 – 128.

American Association of Child and Adolescent Psychiatry: Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Attention– Deficit/ Hyperactivity Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36:10 Supplement, October 1997. Washington, DC.

American Association of Child and Adolescent Psychiatry: Practice Parameters for the Assessment and Treatment of Children, Adolescents with Attention– Deficit/ Hyperactivity Disorder. 2007. Washington, DC.

American Association of Child and Adolescent Psychiatry: Practice Parameters for the Assessment and Treatment of Children, Adolescents with Bipolar Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46:1, January 2007. Washington, DC.

American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC.

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Text Revision. Washington, DC.

American Psychiatric Association. (2007). Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias, Second Edition, Washington, DC.

American Psychiatric Association. (1993). Practice Guideline for Treatment of Patients with Major Depressive Disorder in Adults. Washington, DC.

American Psychiatric Association. (2000). Practice Guideline for Treatment of Patients with Major Depressive Disorder, Second Edition. Washington, DC.

American Psychiatric Association. (2010). Treating Major Depressive Disorder, A Quick Reference Guide, October 2010. Washington, DC.

American Psychiatric Association. (1995). Practice Guideline for Treatment of Patients with Bipolar Disorder. Washington, DC.

American Psychiatric Association. (2002). Practice Guideline for Treatment of Patients with Bipolar Disorder, Revision. *Official Journal of the American Psychiatric Association. Volume 159, Number 4, April 2002.* Washington, DC.

American Psychiatric Association. (1995). Practice Guideline for Psychiatric evaluation of Adults. Washington, DC.

American Psychiatric Association. (1998). Practice Guideline for Treatment of Patients with Panic Disorders. Washington, DC

American Psychiatric Association. (2006). Guideline Watch: Practice Guideline for Treatment of Patients with Panic Disorders. Washington, DC



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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

American Psychiatric Association. (2009). Practice Guideline for Treatment of Patients with Panic Disorder, 2nd Edition. Washington, DC

American Psychiatric Association. (2009). Guideline Watch (March 2009): Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder. Washington, DC

American Psychiatric Association. (2007). Practice Guideline for Treatment of Patients with Obsessive-Compulsive Disorders. Washington, DC

American Psychiatric Association. (1997). Practice Guideline for Treatment of Patients with Schizophrenia. Washington, DC

American Psychiatric Association. (2006). Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition. Washington, DC

American Psychiatric Association. (2007). Guideline Watch (April 2007): Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition. Washington, DC

American Psychiatric Association. (2004). Practice Guideline for Treatment of Patients with Schizophrenia, Second Edition. Washington, DC

American Psychiatric Association. (1995). Practice Guideline for the Treatment of Patients with Substance Use Disorders – Alcohol, Cocaine, Opioids. Washington, DC

American Society of Addiction Medicine. (2001). ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition - Revised. Chevy Chase, Maryland.

Behavioral Health Network of Vermont. Behavioral Health Network of Vermont Clinical Practices Guide - Version 2 (1995).

Bergin, A. E. & Garfield, S. L. (1994). Handbook of Psychotherapy and Behavior Change. New York: John Wiley & Sons, Inc.

Coffey, E. C., (1998) The pre-ECT evaluation. *Psychiatric Annals* 28, (9) p 506.

Coffey, E.C., (1993) *The Clinical Science of ECT.* American Psychiatric Press. Washington, DC

Conners, C.K., & Jett, J. L. (2001). Attention deficit hyperactivity disorder (in adults and children): The latest assessment and treatment strategies. Kansas City, MO: Dean Psych Press Corp.

Electro Convulsive Therapy, Consumer and Family Information. (2001) *Psychiatric Services* 52, (9) 1145

Gomez, A., Taub, J., & Armstrong, M. (2000) Louis de la Parte Florida Mental Health Institute, University of South Florida. Use of Best Treatment Protocols in Managed Care Environments. Retrieved on February 5th, 2003: www.fmhi.usf.edu/institute/pubs/pdf/ahca/TreatmentProt.pdf

Horizon Behavioral Care. (1997) (Rev 2002) The HBS Clinical Practice Guidelines. Retrieved on February 5th, 2003 from www.horizoncare.net/practitioner.html

Psychcare Clinical Management Guidelines, Reviewed 5/01; Revised 5/02; Reviewed 5/03; Reviewed 9/03; Revised 11/03; Revised 2/04; Revised 9/04; Revised 5/05; Revised 8/05; Revised 11/05; Revised 7/06; Revised 10/06; Revised 6/07; Revised 8/07; Revised 5/08; Revised 3/09; Revised 12/09; Revised 3/10; Reviewed 5/10; Revised 6/10; Revised 12/10; Revised 1/11; Reviewed 3/11; Reviewed Compendium 5/12; MDD Guideline 6/12;



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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

Harbor Behavioral Healthcare. Section Three: Treatment Philosophy and Clinical Guidelines.

HEDIS®, 1999 Technical Specifications, Volume 2. National Committee for Quality Assurance.

HEDIS®, 2006 Technical Specifications. National Committee for Quality Assurance.

HEDIS®, 2010 Technical Specifications, Volume 2. National Committee for Quality Assurance.

Hirschfeld, R.M. (2005). Guideline Watch: Practice Guideline for the Treatment of Patients with Bipolar Disorder, 2nd Edition. American Psychiatric Association.

Jamison KR, 1999. Suicide and manic-depressive illness: An overview and personal account. In Jacobs DG, Ed., *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco, CA: Jossey-Bass, p. 251.

Kaplan, H. I., & Saddock, B. J. (1994). Synopsis of Psychiatry. Williams and Wilkins.

Liliedahl, Richard L. & Hansen, Mulloy G. (1997). Ambulatory, Primary, and Pharmaceutical Care. In Healthcare Management Guidelines. Milliman & Robertson.

Liliedahl, Richard L. & Hansen, Mulloy G. (2002). Ambulatory, Primary, and Pharmaceutical Care. In Healthcare Management Guidelines. Milliman & Robertson.

MCC Managed Behavioral Health Care, Inc. The MCC Preferred Practices Guide, Second Edition, 1992.

Murphy, P., & Schachar, R. (2000). Use of self-ratings in the assessment of symptoms of attention deficit hyperactivity disorder in adults. *American Journal of Psychiatry*, 157 (7), 1156-1159.

National Institute of Mental Health. *Bipolar Disorder Research at the National Institute of Mental Health.* NIH Publication No. 00-4502. Printed 2000.

National Institute of Mental Health. *Attention Deficit/ Hyperactivity Disorder.* Bethesda, MD: National Institute of Mental Health, US Department of Health and Human Services; Revised 2003.

National Alliance for the Mentally Ill. (2004). *Attention-Deficit/Hyperactivity Disorder.* Retrieved October 27, 2004 from http://nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement

National Research Council (2001). *Educating Children with Autism, Committee on Educational Interventions for Children with Autism.* Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

New York State Department of Health (1999). *Clinical Practice Guideline: The Guideline Technical Report. Autism/Pervasive Developmental Disorders, Assessment and Intervention for Young Children (0-3 years).* Albany, NY: New York State Department of Health, Early Intervention Program.

Primary Psychiatry. Part 1 Volume 14, No.2. (February 2008). Cummings, J.L. MD. The Black Book of Alzheimer's Disease. Pages 66-76.

Ridgely, M. S., Giard, J. A., & Shern, D. L., (1999) Major Dimensions of Managed Care Behavioral Health Care Arrangements. Retrieved on 1/31/2003 from www.fmhi.usf.edu/institute/pubs/pdf/abstracts/taxonomy/html

Psychcare Clinical Management Guidelines, Reviewed 5/01; Revised 5/02; Reviewed 5/03; Reviewed 9/03; Revised 11/03; Revised 2/04; Revised 9/04; Revised 5/05; Revised 8/05; Revised 11/05; Revised 7/06; Revised 10/06; Revised 6/07; Revised 8/07; Revised 5/08; Revised 3/09; Revised 12/09; Revised 3/10; Reviewed 5/10; Revised 6/10; Revised 12/10; Revised 1/11; Reviewed 3/11; Reviewed Compendium 5/12; MDD Guideline 6/12;



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CLINICAL MANAGEMENT GUIDELINE COMPENDIUM

Searight, H.R., Burke, J.M., & Rottnek, F. (2000) *American Family Physician, Adult ADHD: Evaluation and Treatment in Family Medicine*. Retrieved October 27, 2004 from <http://www.aafp.org/afp/20001101/2077.html>

Simpson, R. L., de Boer-Ott, S., Griswold, D., Myles, B., Byrd, S., Ganz, J., et. Al. (2005). *Autism Spectrum Disorders: Interventions and Treatments for Children and Youth*. Thousand Oaks, CA: Corwin Press.

Weiner, R.D. (1988) Indications for use of ECT. *American Psychiatric Association Review of Psychiatry*, 7, 458-481.

Wilens, T. & Dodson, W. (2004). A clinical perspective of attention-deficit/hyperactivity disorder into adulthood. *Journal of Clinical Psychiatry*, 65 (10), 1301-1313.