NSMHA Contract Memorandum 2005-012

Date: October 18, 2005

To: Jess Jamieson, President APN and CEO, Compass Health
Charles Roxin, *bridgeways*
Michael Watson, Lake Whatcom RTC
Andy Byrne, Whatcom Counseling and Psychiatric Center
Tom MacIntyre, Catholic Community Services Northwest
Claudia D'Allegri, Sea Mar
Janelle Sgrignoli, Snohomish County Human Services
Linda Carlson, Volunteers of America

From: Deirdre Ridgway, NSMHA Contracts Manager

Subject: Updated Clinical Guidelines

Attached please find our updated clinical guidelines, as approved by NSMHA's Board of Directors on October 13, 2005. It includes new guidelines for Adult Dementia and Youth-Attention Deficit/Hyperactivity Disorder. The guidelines will soon be available on our website.

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

117 North First Street, Suite 8 • Mount Vernon, WA 98273 • 360.416.7013
800.684.3555 • Fax 360.416.7017 • TTY 360.419.9008 • Email nsrsn@nsrsn.org • Web Site http://nsmha.org

North Sound Mental Health Administration

Clinical Guidelines

Effective October 1, 2005

Table of Contents

North Sound Mental Health Administration
Statement of Intent, Mission and Values

The North Sound Mental Health Administration mission statement is as follows: "*We join together to enhance our community's mental health and support recovery for people with mental illness served in the North Sound region, through high quality culturally competent services.*"

The North Sound Mental Health Administration's Clinical Guidelines provide a foundation to assist our mental health system in the delivery of high quality, consistent clinical services. They promote the delivery of consistent clinical care on a regional basis.

These clinical guidelines are **not** to be construed to limit the individualization of treatment, clinician judgment or the ability of the clinician to provide treatment in the best interests of the client. Provision of treatment may be qualified by limitations of payment sources and funding.

The basis for these guidelines is the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) however we recognize that symptoms and clinical presentation do not always meet clear DSM IV-TR diagnostic criteria and response to clinical intervention is not uniform.

Any clinical intervention requires the clinician to adapt a treatment program based on medical necessity and individualized for each client. Guidelines are based on evolving scientific research and experience. Consequently, these guidelines will be reviewed and updated periodically.

All should be considered guidelines only, and we realize that adherence to them does not guarantee a successful outcome, nor should they be construed as including all the proper methods of care or excluding other acceptable methods of care aimed at the same results.

Please note that these guidelines are qualified by the limitations of payment sources and funding as designated through current contracts, state WAC and RCW standards and Federal requirements.

These clinical guidelines have been developed for the predominant diagnosis categories served in our region in collaboration with the Associated Provider Network, Compass Health, Sea Mar, Lake Whatcom RTC, Whatcom Counseling and Psychiatric Clinic, bridgeways, Snohomish County ITA, Volunteers of America and the Tulalip Tribe, our contracted providers.

CORE VALUES AND PRINCIPLES – KEY ELEMENTS OF CONSUMER CARE

A. Eligibility / Access
- Eligible Consumers shall have timely access to medically necessary Mental Health Services and supports.
- NSMHA requires a no decline policy that assures the provision of medically necessary mental health services to eligible consumers.
- There shall be a single entry point by which services are most easily accessed. Such entry point shall be provided on a 24 hour, 365-day basis throughout the region (including regional crisis line).
- All parts of the mental health system will assist consumers in obtaining access to appropriate services.
- Consumer access to specific mental health support or treatment services shall not be dependent on consumer willingness to participate in other (concurrent) treatment options. *Exception: Shelter Plus Care*

B. Consumer Services / Consumer Rights
- Consumer services shall, at all times, be provided with dignity, respect, courtesy, and fairness.
- Consumer participation, voice, and satisfaction with services shall be a valued goal.
- Consumer's individual and cultural differences shall be honored through culturally competent service provision.
- Continuity of care shall be provided with seamless access.
- Consumer confidentiality shall be respected and preserved.
- Consumers shall be provided with maximum alternatives and choice in matters of their care.
- There shall be an integrated inpatient/outpatient system.
- Homeless consumers shall be provided with mental health services.
- The NSMHA supports the Mental Health Division Consumer Rights at the provider level
- Active provider outreach and engagement for enrolled or unserved consumers are required.
- Mental Health crisis workers shall have access to current crisis plans and individual treatment plans at all times. The NSMHA supports a meaningful information system for all mental health professionals that provides ready access to information regarding the specific consumer's crisis plans and individualized treatment plans.
- There shall be comprehensive complaint and grievance service made available (and tracked) at all levels of the system.

C. Strength Based Services
- Consumers' skills, capabilities, strengths, and assets will be recognized and utilized in the individual service plan. Services provided in partnership between consumer, provider and other systems.
- Families, communities, and natural supports will be valued and utilized in serving the needs of consumers.
- It is in the best interest for consumers to live as independently as possible in communities and settings of their choice. Consumers' mental health improves when they participate in and increasingly assume responsibility for their own care.

- A range of residential services and housing supports shall be provided, emphasizing least restrictive, stable living options that are age, culturally, and linguistically appropriate. "Housing" is defined in WAC 388.
- Consumers shall be assisted with engaging in meaningful daily activities. This could include volunteerism and active participation in their community and proactive assistance in educational and employment services.

D. Mental health systems and services improve when consumers participate in planning and quality assurance at all levels.
   - People with mental illness are best served by people who care about them.

E. The NSMHA and its providers are committed to safety of:
   - Public
   - Consumer
   - Staff

F. Collaboration
   - NSMHA and its contractors will work in collaboration with other systems to meet the needs of the whole person.
   - Services shall proactively follow mental health consumers, regardless of setting (wherever they are) in the mental health or physical health system.
   - Mentally ill consumers in the justice system shall have access to mental health services.

G. Education
   - The importance of community education programs about mental health issues is a core value.
   - NSMHA and its providers will educate the public about the scope of available services, service locations, crisis response services, client rights and responsibilities.
   - The NSMHA and its providers shall actively promote public education regarding mental health and stigma reduction.

H. Consumers, family members, NSMHA and its contractors shall advocate for consumer rights, funding for services, and quality
   - Both NSMHA and its Member Counties provide technical assistance to all parties in the Region.

All NSMHA providers will develop and implement policies and procedures that support these guidelines. The provider's Medical Director must approve the provider policies and procedures. When the guidelines are not felt to be desirable for a particular client, the rationale for not following the guidelines will be documented in the client's medical record.

All services are provided in accordance with the current NSMHA Clinical Eligibility and Care Standards Manual which establish access to care, continued stay and discharge criteria.

Adult-Bipolar Disorders (DSM IV-TR codes 296.xx, 296.89, 301.13, 296.80)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Bipolar disorder is characterized by disturbances in mood polarity with associated changes in cognition, affect, concentration, psychomotor behaviors, neuro-vegetative symptoms, self-esteem, interest and judgment.** **2. Bipolar disorder is characterized by one or more Manic or Mixed Episodes and often includes on or more Major Depressive episodes. Cyclothymia is characterized by fewer less severe periods of depressive and manic symptoms over at least a 2 year period.** **3. Disorder is equally common in both sexes.** **4. Onset is usually during adolescence or early adulthood. A first manic episode after forty indicates a possible medical or substance-related etiology.** **5. Higher prevalence of the disorder for people who have first degree biological relatives with Bipolar Disorder.** **6. Screen for other conditions that are co-morbid or may be confused with Bipolar disorder (e. g. substance use, medical conditions like Multiple Sclerosis, hypothyroidism, other mood disorders and psychotic disorders.** **7. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm.** **3. Case management services may be helpful for coordination and family support and advocacy.** **4. Individual and/or group psychotherapy can be provided to promote mood stabilization and build on mood management skills, provide skill building and support.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment.** **7. Co-occurring disorder treatment as indicated.** **8. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **9. Because of the chronic nature of the disorder, treatment may be long term. Relapse prevention should be included in treatment planning.** **10. Residential Treatment/Housing/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing.** **11. Inpatient services for acute stabilization as necessary.**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

Adult- Depressive Disorders (DSM IV-TR codes 296.2x-296.3x)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Major Depression: Characterized by disturbances in affect, interest, neuro-vegetative symptoms, concentration, psychomotor behavior and self-esteem** **2. Average age of onset is mid-twenties** **3. Disorder is more common in women** **4. Number of past episodes is predictive of likelihood of subsequent episodes (e.g. 50-60% chance of second episode after a first episode, 70% chance of third episode after a second and 90% chance of fourth episode after a third)** **5. Higher prevalence of the disorder for people with first degree biological relatives with Major Depression** **6. Screen for other conditions that may be co-morbid or may be confused with Major Depressive Disorder (e.g. substance abuse, organic conditions, dementia with older adults, other mood disorder and schizoaffective or other psychotic disorders** **7. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm.** **3. Case management services may be helpful for coordination and family support and advocacy.** **4. Individual and/or group psychotherapy can be provided.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment.** **7. Co-occurring disorder treatment as indicated.** **8. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **9. Residential Treatment/Housing Support/Respite/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing.** **10. Inpatient services for acute stabilization as necessary**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **American Academy of Family Physicians** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

Adult-Schizophrenia and other Psychotic Disorders (DSM IV-TR codes 295.xx, 295.4x)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Schizophrenia is not characterized by a single feature but by many disturbances in the following areas: content and form of thought, perception, affect, sense of self, volition, relationships to the external world, psychomotor behaviors.** **2. Typically there is no disturbance in the level of consciousness.** **3. Onset is usually during adolescence or early adulthood, however it may also begin in middle or late adult life.** **4. Disorder is equally common in both sexes.** **5. Higher prevalence of the disorder for people who have first degree biological relatives with Schizophrenia.** **6. Screen for other conditions that are co-morbid or may be confused with Schizophrenia (e.g. Delirium, dementia, substance use, pervasive developmental disorder and other psychotic disorders.)** **7. Clients need to be periodically assessed for substance abuse.** **8. Assess risk to self and others at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	1. The treatment plan includes a strategy to prevent psychotic episodes. The strategy includes assisting the client and support persons in recognizing early signs and symptoms of an episode, adhering to the treatment plan (including taking prescribed medication) and accessing timely assistance. The strategy is updated as needed. 2. The treatment plan includes at a minimum assessment of the need for medication. 3. Case management services may be helpful for coordination and family support and advocacy. 4. The client will be monitored for side effects and/or medication non-compliance. Should these problems occur the treatment plan will address them. 5. For persons at risk of tardive dyskinesia, there is ongoing assessment for involuntary movements. 6. Clients hesitant to stay engaged in mental health services may need specialized outreach sensitive to their needs and preferences. 7. Individual intervention: Case management interventions of varying degrees of intensity based upon medical necessity to build skills and symptom management. Therapy with clients may include assisting the client to address issues of loss, previous treatment experiences, relationship issues, parenting skills, self-image and co-occurring conditions. 8. Group Intervention: Combinations of skill building, support and educational groups to promote skill building and symptom management. 9. Employment/Vocational Services: Varied employment strategies including pre-vocational activities to assist clients wishing to pursue employment 10. Residential Treatment/Housing Support/Respite/Crisis beds: For those requiring 24 hour care or access to appropriate community-based housing resources. 11. Co-occurring Disorder Treatment: Integrated treatment into a standard chemical dependency program or standard chemical dependency treatment plus separate program for schizophrenia. 12. Education: For client and significant others or support persons regarding schizophrenia, symptoms, treatment and prognosis. Referral to NAMI or similar programs or groups may assist clients, families and significant others to obtain specific training programs and support. 13. Crisis Planning: Individualized crisis plan focusing on early symptoms of decompensation, safety and management strategies. 14. Inpatient Services for acute stabilization as needed.
Optimal Outcome of Treatment	**As a result of treatment, clients learn to manage their illness, live independently in their environment of choice and engage in activities of choice which are integrated in the community with minimal need for support or treatment. Ongoing satisfaction with quality of life is important to the recovery process.**
References	**DSM IV-TR Wyoming Public Mental health System Guidelines** **American Psychiatric Association** **King County Mental Health Plan** **Associated Provider Network** **The Expert Consensus Guideline Series: Treatment of Schizophrenia, The Journal of Clinical Psychiatry, 1996** **Surviving Schizophrenia: A Family Manual by E. Fuller Torrey**

Adult-Anxiety Disorders (DSM IV-TR 300.00, 300.01, 300.02, 300.3, 300.21, 300.22, 300.23, 300.29, 308.3 309.81,)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Clients with Anxiety Disorders often self-medicate. Clinicians should assess for use or abuse of over-the-counter, prescription, or street drugs and alcohol.** **2. Clients with anxiety symptoms should also be assessed for depression.** **3. Many anxiety disorders run in families. For example, first-degree biological relatives of individuals with Panic Disorder are up to 8 times more likely to develop Panic Disorder.** **4. There is considerable cultural variation in the expression of anxiety.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Many clients, due to the discomfort of the anxiety symptoms become avoidant of anxiety-inducing situations, including mental health treatment. A priority of treatment is to establish a collaborative relationship which emphasizes rapport building and hope.** **3. Treatment plan includes interventions consistent with the level of risk for self-harm.** **4. Case management services may be helpful for coordination and family support and advocacy.** **5. Individual and/or group psychotherapy can be provided to promote mood stabilization and build on anxiety management skills, and provide support.** **6. Cognitive-behavioral approaches should be considered.** **7. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **8. Co-occurring disorder treatment as indicated** **9. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **10. Inpatient services for acute stabilization as necessary.**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

	Adult Dementia (DSM IV codes – 290.1x – 290.4x, 294.x) PAGE ONE
Diagnostic Features	**Consistent with DSM IV –TR criteria.** **Dementia is a complex and multi-dimensional neuro-biological disorder with many symptoms common to other conditions such as depression, anxiety, psychosis, etc. The essential feature of dementia is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia, apraxia, agnosia, or a disturbance in executive functioning. (More complex presentations can include memory impairment plus fluctuations in cognition, recurrent visual hallucinations, agitation, motor rigidity or restlessness and fluctuations in motor function.) The disturbances must be sufficiently severe to cause impairment in functioning and represent a decline from a previously higher level of functioning. Some types of dementia include Alzheimer's, Vascular, Dementia due to Parkinson's, Dementia due to Lewy Body Disease.**
Assessment Components and Considerations	**A. The age at onset of dementia depends on the etiology, but is usually late in life, with the highest prevalence above age 85. Dementia is uncommon in children but can occur as the result of general medical conditions such as head trauma, brain tumors, etc.** **B. Because of the difficulty of obtaining direct pathological evidence of the presence of Alzheimer's disease, the diagnosis can be made only when other etiologies for the dementia have been ruled out.** **C. Screen for other conditions that are co-morbid or may be confused with dementia, such as Major Depressive Disorder, Schizophrenia, and delirium.** **D. The course of dementia varies based on etiology. Alzheimer's type tends to be slowly progressive, and may include personality changes or increased irritability in the early stages. Vascular dementia usually has an abrupt onset, with step-like changes, although it can present with an insidious onset and gradual decline, similar to Alzheimer's.** **E. Dementia can result from causes other than Alzheimer's or vascular disease. Other causes of dementia coded in the DSM-IV include HIV Disease, Head Trauma, Parkinson's Disease, Huntington's Disease, Pick's Disease, Creutzfeldt-Jakob Disease, and Other General Medical Conditions. Differential diagnosis requires a corresponding medical diagnosis, from which the dementia is judged to originate.** **F. Substance-induced Persisting Dementia carries the same set of cognitive deficits but there is evidence from history, physical examination, or laboratory findings that the deficits are etiologically related to the persisting effects of substance use. In such cases pre-existing developmental or organic deficits should be ruled out. Dementia-related symptoms in individuals with known substance use/abuse must be assessed differentially to distinguish transient symptomatology from residual dementia which may be persistent.** **G. In some cases, dementia may result from multiple etiologies.**

	Dementia (DSM IV codes – 290.1x – 290.4x, 294.x) PAGE TWO
Treatment Guidelines	Although a diagnosis of dementia does not by default indicate that mental health services are necessary or appropriate, a number of symptoms associated with dementia may be present which require intervention. These symptoms may include sleep disturbances, psychosis, anger and aggression, depression, and anxiety, among others. A. Medical Referral: Confirm with the individual's primary physician that a screening for medical issues has been completed to rule out alternative causes of confusion, behavior changes and memory loss. Screening may include B-12 level, thyroid function panel including TSH, serum electrolytes, urinalysis for UTI, CBC with differential to check for other signs of infectious or metabolic disease, and CT scan or MRI, among others. If screening has not occurred, request that the individual's primary physician do so. B. Individual Intervention: Except in the earliest stages of the disease, individual therapy is rarely indicated, as the dementia tends to rob the individual of insight into their own condition, as well as the ability to process new information and modify their own behavior. Reminiscence therapy and validation therapy have been shown to be effective approaches. C. Behavior-oriented approaches: Although there are limited data from formal assessments of these treatments, there is widespread agreement that behavioral approaches can be effective in lessening or abolishing problem behaviors. D. Family/Caregiver Consultation: The individual's natural supports, if any, are a significant part of treatment. Educate the family and caregivers regarding dementia, symptoms, treatment and prognosis. Help them connect to community resources. Provide information about behavioral and environmental interventions designed to support the individual with dementia. Educate family/caregivers to the risks to themselves for mood disorders, i.e. "caregiver burnout," and the need to maintain their own health for the stability and longevity of both themselves and the individual with dementia. Help family/caregivers locate support services for themselves as appropriate. E. Group Intervention: Support groups are appropriate for both the client and the family/caregivers, although it is preferable that these groups be separate to allow a free expression of concerns, especially by family/caregivers. F. Psychiatric Assessment: As appropriate to determine indication for medication or for medical stabilization. G. Employment/Vocational Services: Vocational services are rarely indicated for these clients. For individuals still working, information about planning for retirement may be appropriate. H. Residential Treatment/Housing/Crisis Beds: Assess appropriateness of current housing for safety and supervision needs. If individual lives alone, assess environment for hazards, i.e. decaying food, pet feces, fall risk, firearms, kitchen and home heating safety, etc. If individual lives with family or caregivers, educate them to potential hazards and how these hazards might be mitigated. Assist client and family/caregivers with planning for future housing needs in anticipation of disease progression. I. Co-Occurring Disorder Treatment: Chemical dependency treatment is rarely indicated for the same reasons that individual therapy is not. Management of a chemical dependency is best accomplished through the use of environmental interventions, i.e. limiting access to the substance and providing significant amounts of supervision. J. Crisis Planning: Individualized crisis plan focusing on early symptoms of decompensation, safety and management strategies. K. Inpatient Services: For acute stabilization as necessary.
Optimal Outcome of Treatment	**The client will remain as functionally independent as the disease progression allows, and will experience a minimal amount of emotional and behavioral disturbance related to the disorder.**
References	**Associated Provider Network** **Diagnostic and Statistical Manual of Mental Disorders, fourth edition.** **Treatment of Agitation in Older Persons with Dementia; The Expert Consensus Guideline Series; Alexopoulos et al; April 1998** **Dictionary of Psychology; Chaplin (1985)** **American Psychiatric Association Dementia Practice Guideline**

Youth-Depressive Disorders	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Higher prevalence of the disorder for people with first degree biological relatives with Major Depression.** **2. Screen for other conditions that may be co-morbid or may be confused with Depressive Disorders (e.g. substance abuse, organic conditions , other mood disorder or other psychotic disorders.** **3. Family/caregivers should be involved in the assessment process whenever possible. Family systems should be assessed to determine needs that can be met that may be contributing to the mood disorder.** **4. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm. Interventions may need to involve others beyond the youth and family, such as school personnel.** **3. Case management services may be helpful for coordination and family support and advocacy.** **4. Individual, family and/or group psychotherapy can be provided.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Co-occurring disorder treatment as indicated.** **7. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **8. Inpatient services for acute stabilization as necessary**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **American Academy of Family Physicians** **Associated Provider Network** **Wyoming Public Mental Health Guidelines**

Youth-Bipolar Disorders (296.xx-301.13)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. The presentation of Bipolar Disorder in youth often differs from the presentation in adults. Youth with mania frequently present with symptoms that are considered atypical. Changes in mood, mental excitement and psychomotor agitation are often erratic. Irritability, belligerence, and mixed states are more common than euphoria. Reckless behaviors typical of Bipolar Disorder in adults may present as behavioral problems, school failure, fighting, dangerous play, and overly sexualized behaviors.** **2. Discriminating between manic symptoms and normal childhood behavior may be difficult. Therefore, consideration of current and past history regarding symptom presentation, treatment response, and psychosocial stressors is important to gain a historical perspective on the youth's behavior.** **3. A family history of Bipolar Disorder should alert the clinician to consider that diagnosis.** **4. Differentiating between Bipolar Disorder and ADHD is frequently difficult. ADHD usually has an onset before age 7 and is a consistent characteristic of the youth's behavior pattern. Bipolar Disorder is usually episodic.** **5. Early onset** **6. Screen for other conditions that may be co-morbid or may be confused with Bipolar Disorder (e.g. substance abuse, organic conditions, other mood disorder and schizoaffective or other psychotic disorders.)** **7. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Youth with Bipolar Disorder are at increased risk for suicide.** **3. Treatment plan includes interventions consistent with the level of risk for self-harm.** **4. Individual, family and/or group psychotherapy can be provided.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Case management services may be helpful for coordination and family support and advocacy.** **7. Co-occurring disorder treatment as indicated.** **8. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **9. Because of the chronic nature of the disorder, treatment may be long term. Relapse prevention should be included in treatment planning.** **10. Inpatient services for acute stabilization as necessary**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **American Academy of Family Physicians** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

YOUTH-Attention Deficit Hyperactivity Disorder (DSM IV code = 314.xx) PAGE ONE	
Diagnostic Features	**Consistent with DSM IV –TR criteria.** **ADHD is a complex and multi-dimensional neuro-biological mental health disorder with many symptoms common to other conditions such as depression, anxiety, post-traumatic stress disorder, etc. As such, there is no one physical or psychological test for ADHD. The diagnosis is further complicated by the fact that the primary symptoms of inattention, impulsivity, and /or hyperactivity are not always apparent in all situations. Therefore, the evaluation and diagnosis is best when it involves multiple informants or data representing a variety of setting and situations.** **The following are subtypes of the Attention-Deficit/Hyperactivity Disorder diagnosis:** **A. Combined Type: Essential feature is 6 plus symptoms of inattention and 6 plus symptoms of hyperactivity-impulsivity.** **B. Inattentive type: Essential feature is 6 plus symptoms of inattention but fewer than 6 symptoms of hyperactivity-impulsivity.** **C. Hyperactive-Impulsive Type: Essential feature is 6 plus symptoms of hyperactivity-impulsivity but fewer than 6 symptoms of inattention.**
Assessment Components and Considerations	**1. Structured diagnostic interview with client or, in the case of children, include parents/caretakers to obtain symptoms, age of onset and stability of symptoms.** **2. Developmental, family and other relevant histories (academic, medical, psychiatric, substance abuse).** **3. Data regarding school or occupational performance as appropriate or requested to verify presence of symptoms in these settings.** **4. Diagnostic interview with the client (mental status evaluation, client description of the problems, etc.). Note: Many clients may not display problematic behavior in a clinic office setting, one to one with a stranger/adult.** **5. Psychometric assessment may assist in the differential diagnosis using standard rating scales. Two types are recommended: a "broadband" mental health instrument such as the Behavior Assessment Scale for Children (BASC) or the Achenbach Children's Behavior Checklist (CBCL), and a second instrument that is ADHD specific such as the Conners or the ADHD Rating Scale IV.** **6. Screen for other conditions that are co-morbid or may be confused with ADHD (e.g. substance abuse, learning disability, adjustment disorder, organic conditions, oppositional/conduct disorder, mood disorder, neurological problem, mental retardation, pervasive development disorder, abuse, etc.).** **7. Requests for previous records such as tests, previous treatment from other professionals who have worked with the client will be helpful (e.g. therapists, teacher, school counselors, primary physician).** **8. Referral for a physical examination if none has been conducted in the past year should be considered.**

YOUTH	Attention Deficit Hyperactivity Disorder (DSM IV code = 314.xx) PAGE TWO
Diagnostic Criteria	1. Persistent pattern of inattention, hyperactivity, and/or impulsivity which is more frequent and severe than is typically observed in an individual with a comparable level of development and intellectual ability. 2. Some symptoms causing impairment were present before seven (7) years of age. 3. Symptoms are present in two (2) or more settings (e.g., at school and at home). 4. Clear evidence of clinically significant impairment in social or academic functioning. 5. Symptoms do not occur exclusively during a course of a psychotic disorder (e.g., schizophrenia) and are not better accounted for by another disorder (e.g., mood disorder, anxiety, dissociative disorder, or personality disorder).
Treatment Guidelines	1 Treatment plan determined by severity of symptoms and includes interventions consistent with the level of risk for self-harm. 12. Multi-modal approaches have been shown to have best support by the 2005 Washington Report of the Children's Evidence Based Practices Expert Panel. Team approaches are also recommended. 13. Individual interventions: Based on medical necessity to build skills and promote stabilization. Utilizing behavior management techniques may be beneficial toward desired outcome through changing the child/youth's environment to help improve behavior. Include parent/caregivers/schools in treatment regarding children/youth whenever possible. 14. Group Interventions: Skill building group and/or parent education as appropriate 15. Psychiatric Assessment: As appropriate to determine indication for medication or for medication stabilization. For most children, stimulant medications are a safe and effective way to relieve ADHD symptoms. 16. Employment/Vocational/Academic Services: Varied employment and academic strategies including behavioral consultation/support, pre-vocational and supported employment to assist clients wishing to pursue employment or academic objectives. 17. Co-Occurring Disorder Treatment: Integrated treatment into a standard chemical dependency treatment program, or standard chemical dependency treatment plus separate treatment services for ADHD. 18. Educate the client, parents and significant others as appropriate regarding ADHD symptoms, treatment and prognosis as well as specific training on how to deal with behavior issues in a positive way. 19. Crisis Planning: Individualized crisis plan as necessary focusing on early symptoms of decompensation, safety and management 20. Residential Treatment/Housing/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing. 21. Inpatient services for acute stabilization as necessary.
Other Resources, Information	A. Coordination of treatment efforts with the school and a referral as needed for further psycho-educational testing and/or Section 504 special education services and/or accommodations are recommended for consideration B. Referral to local CHAD organizations are a potential for parents whose children have ADHD. CHAD offers information, resources and support and are located in chapters around the state.
Optimal Outcome of Treatment	The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.
References	DSM IV-TR Associated Provider Network 2005 Washington State Report of the Children's Evidence Based Practices Expert Panel American Academy of Pediatrics ADHD Practice Guideline.