

**APPENDIX B:**  
**CLINICAL PRACTICE GUIDELINES.**

# CLINICAL PRACTICE GUIDELINE: DEPRESSION

HIP guidelines do not substitute for the clinical judgment of the health care practitioner and are intended only to assist the practitioner by organizing relevant information on the management of preventive care and certain disease states. Individual patient treatment may vary from this guideline based on the health care practitioner's clinical judgment.

## Diagnosis

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- Before making a diagnosis of Major Depressive Disorder, organic factors or other known causes of mood disorders should be ruled out. These include general medical disorders (thyroid dysfunction, diabetes), substance abuse, medication side effects, other non-mood psychiatric disorders and grief reactions.
  
- To make this diagnosis, there must be either depressed mood or the loss of interest or pleasure in nearly all activities, which must be present for at least two weeks. The individual must also experience at least four additional symptoms from the following list over the same time frame:
  - Significant weight loss/gain.
  - Insomnia/hypersomnia.
  - Psychomotor agitation/retardation.
  - Fatigue.
  - Feelings of worthlessness.
  - Impaired concentration.
  - Recurrent thoughts of death or suicide.
  
- The symptoms typically cause clinically significant distress and/or impairment in social, occupational or other important areas of functioning.
  
- If a patient is psychotic, manic (elevated mood, increased energy, racing thoughts), suicidal, or exhibits comorbid substance abuse he or she should be referred for psychiatric specialty care (call the HIP Mental Health Center in your area or the Mental Health Service Line for a referral to a network provider 1-888-447-2526).

## Patient Education

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- Education concerning Major Depressive Disorder, its treatment and prognosis should be provided to all patients. Patients should be informed that Major Depression is a true medical illness, with effective treatment options. When treatment is followed accordingly, patients will experience a state of well-being and symptom relief.

- The successful treatment of Major Depression requires compliance with the full course of treatment. Many patients may be poorly motivated, unduly pessimistic over their chances of recovery with treatment, suffering from deficits in memory, or taking poorer care of themselves. In addition, side effects of medication may lead to noncompliance.
- A discussion with patients pertaining to expected treatment length (six to eight months) and side effects of medication should be routinely conducted. Patients are often more compliant with their treatment protocols when they are provided with detailed information.

## Treatment Options

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Treatment modalities may include pharmacotherapy, psychotherapy or the combination of the two.

- *Pharmacotherapy/Antidepressant Medications:*

- Medication can be used as an initial treatment modality for patients with mild, moderate or severe depression.
- Prior to prescribing medication, it is important to review with your patients that initial treatment effects may take up to four weeks. Patients should also be advised of the most common medication side effects (which typically occur within the first two weeks).
- The monitoring of response over time is quite important. It is suggested that patients be seen a minimum of three times during the initial three months of treatment. The first follow-up visit should be within two weeks of beginning medication. It is then advised that the patient be seen once a month for the following two months.
- If you find that the patient is not compliant with the recommended follow-up visits or their treatment protocol, please contact the case management program at **1-800-447-0769**.
- If a patient does not respond to the initial medication within four weeks, or is intolerant of side effects, a reappraisal of the treatment regimen should take place with a possible referral to a psychiatrist.
- Medication should be continued for four to six months after full remission of symptoms. Maintenance therapy should be considered for recurrent episodes.

- *Psychotherapy:*

- Psychotherapy alone may be considered as an initial treatment modality for patients with mild to moderate Major Depressive Disorder. If this option is chosen, patients should be referred for mental health services. Services are available at the HIP Mental Health Centers, or by calling the Mental Health Service Line for a referral to a network provider (**1-888-447-2526**).

- *Antidepressant Medications and Psychotherapy:*

- The combination of medication and psychotherapy may be a useful initial treatment choice for patients with moderate to severe Major Depressive Disorder. In addition, patients with a poor response to or poor compliance with a single modality may benefit from combined treatments.

# CLINICAL PRACTICE GUIDELINE:

## ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADD AND ADHD)

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### Diagnosis

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- Before making the diagnosis of ADD/ADHD, the diagnoses of learning disorder, conduct disorder and developmental disorder should be considered as alternative diagnoses and/or as frequently occurring comorbid diagnoses.
- To make the diagnosis of ADD/ADHD, there must be a persistent pattern of inattention and/or hyperactivity/impulsivity that is more severe and frequent than is typically observed in individuals at a comparable level of development, which has been present since before age seven and which shows clear evidence of interference with developmentally appropriate social, academic or occupational functioning.
- This disorder is usually first evident in childhood and adolescence. However, some individuals may not present for clinical attention until adulthood.
- The symptoms must not occur exclusively during the course of another Axis I psychiatric disorder (schizophrenia, pervasive developmental disorder) and must not be better accounted for by another psychiatric disorder (mood disorder, anxiety disorder or personality disorder). Some impairment from the symptoms must be present in two or more settings (e.g., at school/work and at home).
- For children, the overall approach to diagnosis includes a comprehensive interview with the child's adult caregivers; a mental status examination; a medical evaluation for general health and neurological status; ADD/ADHD focused parent and teacher rating scales (Conners, Brown scales); and school reports.

## Criteria

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- Either (1) or (2) must be present:

(1) Six or more of the following symptoms of inattention have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

### *Inattention*

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
- Often has difficulty sustaining attention in tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork, chores or duties.
- Often has difficulty organizing tasks and activities.
- Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
- Often loses things necessary for tasks or activities.
- Is often easily distracted by extraneous stimuli.
- Is often forgetful in daily activities.

(2) Six more of the following symptoms of hyperactivity-impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with development level.

### *Hyperactivity*

- Often fidgets with hands or feet or squirms in seat.
- Often leaves seat in classroom or in other situations in which remaining seated is expected.
- Often runs about or climbs excessively in situations in which it is inappropriate.
- Often has difficulty playing or engaging in leisure activities quietly.
- Is often “on the go” or often acts as if “driven by a motor.”
- Often talks excessively.

### *Impulsivity*

- Often bursts out answers before questions have been completed.
- Often has difficulty awaiting turn.
- Often interrupts or intrudes on others.

## Patient Education

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- Education concerning ADD/ADHD, its treatment and prognosis should be provided to all patients and their parents. A medical illness model should be provided with an expectation that when treatment is followed accordingly, patients will experience a state of well-being and symptom relief.
- Education should include the fact that this is a physiological disorder, the specific behaviors targeted for improvement, the expected length of treatment (likely long term), and the positive and negative (sleep interruption, appetite changes, gastrointestinal, agitation) effects of medication. The cooperation of school, daycare and agencies is crucial to the success of treatment.

## Treatment Options

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- While psychosocial interventions (i.e., educational remediation, structure/routine and cognitive-behavioral therapy) should be considered in the management of ADD/ADHD, stimulant medication therapy is the most effective current treatment for ADD/ADHD. Medications include Ritalin, Dexedrine and the longer acting Concerta. These medications decrease one's level of hyperactivity and improve one's ability to focus, work and learn. In addition, these medications tend to improve physical coordination and control impulsive/destructive behaviors.
- When medication is used in treatment, the Institute for Clinical Systems Improvement recommends that every patient treated for ADD/ADHD be seen for a minimum of two follow-up visits per year. It is also important to check the appropriate ADD/ADHD diagnosis on the encounter forms whenever ADD/ADHD services are provided.
- It is important to explain that ADHD is a complex disorder that requires close attention and monitoring. If stimulant use does not prove to be helpful, the patient should be referred to a psychiatrist for a more specialized treatment regimen. Psychiatrists are available at the HIP mental health centers or by calling the Mental Health Service Line for a referral to a network provider (1-888-447-2526).
- Those diagnosed with ADD/ADHD may benefit from a combined treatment approach of pharmacotherapy and psychotherapy. In addition, social skills training and emotional counseling have been beneficial for children and young adults impacted by ADD/ADHD. Parents of diagnosed children may find educational classes, skill training classes and support groups to be particularly useful in helping them to manage their children. These services are available at HIP Mental Health Centers or by calling the Mental Health Service line for a referral to a network provider (1-888-447-2526).

## References

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American Academy of Pediatrics. (May 2000). Diagnosis and Evaluation of the Child with Attention Deficit/Hyperactivity Disorder (AC0002). *Pediatrics*. 105 (5), p. 1158-70.

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

# CLINICAL PRACTICE GUIDELINE: ALCOHOL AND OTHER DRUG TREATMENT

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## Diagnosis

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- AOD disorders are diagnosed as either dependence or abuse. Both involve a maladaptive pattern of substance use leading to clinically significant impairment or distress.
  
- According to DSM-IV criteria<sup>1</sup>, diagnosis of *substance dependence* is indicated when three or more of the following occur at any time in the same 12-month period:
  1. Tolerance.
  2. Withdrawal.
  3. Substance is often taken in greater amounts or over a longer period than was intended.
  4. Persistent desire or unsuccessful efforts to cut down or control use.
  5. A great deal of time is spent in activities necessary to obtain substance.
  6. Important social, occupational or recreational activities are given up or reduced because of substance use.
  7. The substance use is continued despite knowledge of having a persistent problem due to the substance.
  
- A diagnosis of *substance abuse* is indicated when at least one of the following occurs at any time within the same 12-month period:
  1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home.
  2. Recurrent substance use in situations in which it is physically hazardous.
  3. Recurrent substance-related legal problems.
  4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

- Given the prevalence of alcohol and other drug abuse, it is recommended that just like questions about diet, exercise and smoking, questions about alcohol use should be included among routine behavioral and lifestyle questions asked of all persons who seek care in a medical setting.<sup>2,3</sup> In addition, the following conditions are considered “red flags” that may suggest alcohol or other drug abuse:<sup>4</sup>
  - Liver disease.
  - Cerebrovascular disease (e.g., hemorrhagic stroke).
  - Traumatic injury (20-25 percent of patients meet alcohol abuse criteria<sup>5</sup>).
  - Dementia.
  - Hypertension.
  - Gastrointestinal system problems (e.g., gastritis, ulcers of stomach or duodenum).
  - Chronic obstructive pulmonary disease (COPD) (smoking is associated with alcohol use).
  - Insomnia.
  - Depressive or anxiety disorders.
  - Trauma/abuse.
  - Family history of substance abuse.
  - Marked change in school or job performance.
- Alcohol and drug abuse can also negatively impact most medical conditions including, but not limited to pregnancy and diabetes.<sup>4</sup>

## Screening

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- There are several brief assessment tools for substance abuse screening. One commonly used screening device for alcohol misuse is the **CAGE** questionnaire.<sup>6</sup> CAGE is a mnemonic device that can be used to remember the questions.
  1. Have you ever felt you ought to **C**ut down on your drinking?
  2. Have people **A**nnoyed you by criticizing your drinking?
  3. Have you ever felt **G**uilty about your drinking?
  4. Have you ever had a drink first thing in the morning as an “**E**ye opener”?

Scoring: “Yes” to 2 questions: strong indication for alcoholism.  
 “Yes” to 3 questions: confirms alcoholism.

- **CAGE – AID** is an adaptation of **CAGE** used to screen for drug abuse:
  1. Have you ever felt you ought to **C**ut down on your drug use?
  2. Have people **A**nnoyed you by criticizing your drug use?
  3. Have you ever felt **G**uilty about your drug use?
  4. Have you ever used drugs first thing in the morning to steady your nerves or to get rid of a hangover (“**E**ye-opener”)?

Scoring: A “yes” answer to any of these questions is likely to indicate drug abuse and should spur further investigation.

## Treatment Options

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- If the brief assessment reveals mild to moderate substance-related problems or at-risk use is discovered (e.g., one positive response to the CAGE, exceeding established limits of alcohol use, five or more lifetime episodes of marijuana use, or questionable use of prescription medication) a brief intervention on the part of the physician is recommended.<sup>2</sup>
- Critical Components of Brief Intervention<sup>2</sup>
  1. Provide feedback about the screening results, impairment, and risks while clarifying the findings.
  2. Inform patients about safe consumption limits and offer advice about change.
  3. Assess patient’s readiness for change.
  4. Negotiate goals and strategies for change.
- If the brief assessment reveals a possible need for a referral to specialized treatment, HIP has care managers available to conduct further assessments and to connect patients with an appropriate level of care. Some of the available treatment options include outpatient counseling (typically one or two times/week), intensive outpatient counseling (typically five to seven days/week), detoxification (outpatient or inpatient), pharmacotherapy (e.g., medication to manage withdrawal or discourage use, antagonist/agonist substitution therapy, and medication to treat comorbid psychiatric conditions), residential, and inpatient hospitalization. Care managers are available by calling **1-888-447-2526**.
- When referring a member to specialized treatment, it is very important to discuss the chronic nature of substance abuse and the need for ongoing treatment. This is being reinforced by the HEDIS measure<sup>7</sup> “Engagement in AOD Treatment.” This HEDIS measure recommends that adults diagnosed with AOD disorders receive at least two additional AOD services within 30 days of initiating AOD treatment.

## References

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1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, APA, 1994.
2. CSAT (Center for Substance Abuse Treatment) “A Guide to Substance Abuse Services for Primary Care Physicians,” BKD234, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP Series 24).
3. Institute of Medicine. Broadening the Base of Treatment for Alcohol Problems. Washington, DC: National Academy Press, 1990.
4. Substance Abuse and Mental Health Services Administration. (2002). Evidence Based Care Models for Recognizing and Treating Alcohol Problems in Primary Care: Supplemental Sections. Rockville, MD.
5. CSAT (Center for Substance Abuse Treatment), “A Guide to Substance Abuse Services for Primary Care Physicians,” BKD234, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP Series 16).
6. Ewing JA. Detecting alcoholism. The CAGE questionnaire. *JAMA* 1984; 252:1905-7.
7. National Committee for Quality Assurance. Draft Document for HEDIS 2004 Public Comment. Copyright 2003.