# Washington County

## Mental Health Practice Guidelines
## 2013

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## Mental Health Practice Guidelines
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## About these Practice Guidelines:

These practice guidelines were developed to assist Washington County network providers in identifying approaches to working with clients who have been diagnosed with a mental health disorder. Each section identifies both the Oregon Department of Human Services Addictions and Mental Health Division's approved Evidence Based Practices and best practice alternatives for a variety of diagnoses. Neither the list of diagnoses nor the practice interventions are considered complete; they will be continually developed over time. Interventions are listed in no particular order, they are simply grouped into Evidence Based Practices and best practice alternatives.

Practices are briefly defined at the end of this document. Providers should ensure that they have received adequate training to implement the approach as designed. Similarly, providers are expected to continually strive for the highest level of fidelity possible for any of the listed Evidence Based Practices that they utilize.

In no case should these guidelines take the place of sound clinical judgment. Safety must always be prioritized and clinicians are expected to use their judgment when choosing a practice approach. Specific attention to assessing suicide risk and safety planning is noted for some disorders however this practice should be done with all clients, regardless of their presentation. These guidelines describe a variety of practices that are associated with commonly occurring diagnoses, however they are not treatment guidelines in that they do not prescribe the specific course of the intervention. It is up to the individual clinician to work with the client to define the course of treatment within the practice intervention.

Practice guidelines are independent of service authorization for reimbursement. Regardless of the intervention selected, it is up to the individual practitioner to obtain the necessary authorization for reimbursement.

All services provided to clients should incorporate Washington County's Values and Principles:

- **Client Centered:** Services honor client choice and treatment plans are developed in collaboration with the client. Focus is on the client taking personal responsibility for their treatment with the clinician sharing knowledge and resources in a supportive manner.

- **Individualized:** The services offered to each client will be individualized to meet his or her needs, rather than expecting that the client fit into an existing service package.

- **Strengths-Based/Recovery Oriented:** Clients and clinicians will adopt a belief that clients can recover from a mental illness by maximizing their personal strengths. Services will focus on identifying each client's strengths and resources, and building upon these to meet the goals that the client and their family have identified.

- **Holistic:** A client's mental health treatment is seen as being only a single component of their wellbeing and emphasis is placed on identifying other existing needs that present in conjunction with their mental illness.

- **Family/Support Inclusive:** There is recognition of the supportive role family and other significant individuals play in a client's life and efforts are made to include these individuals into service planning whenever possible.

- **Evidence Based:** The majority of services provided are recognized evidence-based practices that are empirically validated. These services are evaluated against fidelity scales when available. Practices for which evidence of effectiveness does not exist are eliminated and providers continually evaluate efficacy, quality assurance and consumer satisfaction.

- **Accessible:** Services are readily accessible to client in that they are geographically located throughout Washington County, are provided in a "no wrong door" manner in that clients may access services through multiple avenues, and access is available in a timely manner.

- **Culturally Competent:** Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

- **Least Restrictive/Community Based:** Services take place in settings that are the most appropriate and natural for the client and are the least restrictive and intrusive available to meet the needs of the client.

- **Collaborative:** Services are not provided in isolation of other human service providers but rather in collaboration to assure the client's needs are met in the most effective manner possible. Other providers may include a client's primary care physician, social services providers, employment specialists, substance use treatment providers, criminal justice, and any other human service provider that is involved in the client's care.

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# Adjustment Disorders in Adults

## Description:

Adjustment disorders are responses to an identifiable stressor or stressors that result in clinically significant emotional and/or behavioral symptoms. Symptoms may be in one or more of the subtypes of depressed mood, anxiety, and disturbance of conduct. Adjustment disorders begin within 3 months of the onset of a stressor and last no more than 6 months after the stressor has terminated (DSM 2000). Studies indicate that Adjustment Disorder may be present in 10-30% of the outpatient population and 2-8% of the general population (DSM 2000).

## Associated Evidence Based Practices:

Several evidence based practices may be utilized to treat anxiety disorders; including:

- Solution Focused Brief Therapy
- Medication Management
- Cognitive Behavioral Therapy (Trauma Focused)

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Impairment in functioning at school, work or within interpersonal relationships is common.

Symptoms may present as somatic complaints.

Brief treatment is generally indicated in adjustment disorder presentations.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

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# Adjustment Disorders in Children and Adolescents

## Description:

Adjustment disorders are responses to an identifiable stressor or stressors that result in clinically significant emotional and/or behavioral symptoms. Symptoms may be in one or more of the subtypes of depressed mood, anxiety, and disturbance of conduct. Studies indicate that Adjustment Disorder may be present in 10-30% of the outpatient population and 2-8% of the general population (DSM 2000).

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat adjustment disorders in children and adolescents; includin:

- Cognitive Behavioral Therapy (Trauma Focused)
- Solution Focused Brief Therapy
- Brief Strategic Family Therapy
- Medication Management

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Family Therapy
- Case Management
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Specific attention should be paid to assessing suicide risk and conducting safety planning.

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# Anxiety Disorders in Adults

## Description:

Lifetime prevalence of Generalized Anxiety Disorder is 5%, with Panic Disorder less common at a lifetime prevalence of 2%. Anxiety Disorders affect about 40 million American adults age 18 years and older in a given year (Kessler, Chiu, Demler, & Walters, 2005) causing them to be filled with fearfulness and uncertainty. Unlike the relatively mild, brief anxiety caused by a stressful event (such as speaking in public or a first date), anxiety disorders last at least 6 months and can get worse if they are not treated. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. There are several different types of anxiety disorders including, but not limited to:

- Generalized Anxiety Disorder
- Panic Disorder with or without Agoraphobia
- Phobias
- Obsessive-Compulsive Disorder and Posttraumatic Stress Disorder (discussed in more detail in other sections)

## Associated Evidence Based Practices:

There are two evidence based practices that may be utilized to treat anxiety disorders:

- Solution Focused Brief Therapy
- Medication Management

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Cognitive Behavioral Therapy
- Outcome Ratings Scale
- Desensitization/Exposure Therapy
- Seeking Safety

## Other Considerations:

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There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Clients who present with severe agoraphobia may need to be seen in their residence until there is adequate symptom management so that they are able to attend appointments in an agency setting.

Research suggests that cognitive behavioral approaches are more efficacious than other psychotherapeutic approaches (psychodynamic therapy, supportive psychotherapy). Additionally, short-term interventions have been shown to be as effective as long-term approaches (Bloom, Yeager, & Roberts, 2004) and should be utilized whenever possible.

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# Anxiety Disorders in Children and Adolescents

## Description:

Lifetime prevalence of Generalized Anxiety Disorder is 5%, with Panic Disorder less common at a lifetime prevalence of 2%. Separation Anxiety Disorder is relatively common, affecting about 4% of children. Unlike the relatively mild, brief anxiety caused by a stressful event (such as speaking in public or the first day of school), anxiety disorders last at least 6 months and can get worse if they are not treated. Panic disorder with or without Agoraphobia typically has an onset of late adolescence up to mid-thirties. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. There are several different types of anxiety disorders including, but not limited to:

- Generalized Anxiety Disorder
- Separation Anxiety Disorder
- Panic Disorder with or without Agoraphobia
- Phobias

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat anxiety disorders; including:

- Cognitive Behavioral Therapy for Childhood Anxiety Disorder
- Solution Focused Brief Therapy
- Medication Management

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Family Therapy
- Case Management
- Outcome Ratings Scale
- Desensitization/Exposure Therapy
- Seeking Safety

## Other Considerations:

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There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Clients who present with severe agoraphobia may need to be seen in their residence until there is adequate symptom management so that they are able to attend appointments in an agency setting. When seen in children there is often accompanying school refusal, therefore it is important to work closely with education providers during the course of treatment.

Research suggests that cognitive behavioral approaches are more efficacious than other psychotherapeutic approaches (psychodynamic therapy, supportive psychotherapy). Additionally, short-term interventions have been shown to be as effective as long-term approaches (Bloom, Yeager, & Roberts, 2004) and should be utilized whenever.

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# Attention Deficit/Hyperactivity Disorder (ADHD), in Adults

## Description:

ADHD is a persistent pattern of inattention and/ or hyperactivity-impulsivity that is more frequent and more severe than peers of a comparable level of development. While often thought of as a childhood disorder, it frequently persists into adulthood. Studies estimate that between 30 and 70% of children diagnosed with ADHD will continue to exhibit symptoms into adulthood (Silver, 2000).

## Associated Evidence Based Practices:

There are two evidence based practices associated with treatment of adult ADHD:

- Medication Management
- Solution Focused Brief Therapy

## Best Practice Alternatives:

- Psychoeducation
- Cognitive Behavioral Therapy
- Life Coaching

## Other Considerations:

There is a high co-morbidity with anxiety and affective disorders. These, along with any physical health conditions, should be assessed thoroughly.

Clients may initially not recognize the underlying disorder and present seeking help for depression or anxiety rather than ADHD (NIMH, 1996).

Individuals may benefit by being connected to a non-clinical professional "coach" who can assist the client in leaning skills for managing scheduling and organizing.

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# Attention Deficit/Hyperactivity Disorder (ADHD), in Children and Adolescents

## Description:

ADHD is a persistent pattern of inattention and/ or hyperactivity-impulsivity that is more frequent and more severe than peers of a comparable level of development. While it can be diagnosed after age seven, some symptoms must have been present prior to that age and the impairments must be present in more than one setting (i.e. home and school). The prevalence of ADHD is estimated to be 3-7% of school-age children (DSM 2000).

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat attention deficit hyperactivity disorder, including:

- Incredible Years (Parent Education)
- Parent-Child Interaction Therapy
- Functional Family Therapy
- Medication Management
- Collaborative Problem Solving
- Wraparound

## Best Practice Alternatives:

- Social Skills Training
- Cognitive Behavioral Therapy
- Family Therapy
- Case Management

## Other Considerations:

ADHD has a 54-84% co-morbidity rate with Oppositional Defiant Disorder, and many of these youth go on to develop Conduct Disorder (AACAP 2007). Therefore it is important to complete a comprehensive assessment and provider treatment for co-morbid conditions as indicated.

In addition, there is a high co-morbidity between ADHD and substance abuse, which is highest for adolescents with both ADHD and Conduct Disorder. Clinicians should be regularly assessing for

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substance use and when indicated, providing treatment for any co-occurring substance use disorder with integrated dual diagnosis treatment whenever possible.

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# Behavior Disorders in Children and Adolescents

## Description:

The two most common behavior disorders in children and adolescents are Conduct Disorder and Oppositional Defiant Disorder (ODD). Oppositional Defiant Disorder is usually manifested by age eight, whereas Conduct Disorder is typically a later onset, between middle childhood and middle adolescence. ODD is often a precursor to Childhood-Onset Type Conduct Disorder. ODD is characterized as a recurrent pattern of negativistic, hostile or defiant behavior, as well as angry and vindictive behavior. Conduct Disorder is defined as a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated. There is some overlap in symptoms of both disorders; however Conduct Disorder includes aggressive and violent behavior and severe examples where rights of others are violated (DSM 2000).

## Associated Evidence Based Practices:

There are a number of evidence based practices that may be utilized to treat behavior disorders, including:

- Brief Strategic Family Therapy
- Multi-systemic Therapy
- Parent-Child Interaction Therapy
- Functional Family Therapy
- Wraparound
- Incredible Years (Parent Education)
- Multi-Dimensional Treatment Foster Care
- Collaborative Problem Solving

## Best Practice Alternative:

- Systemic Family Therapy
- Parent Education

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Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Research indicates that dramatic short-term interventions are generally not successful and that Inoculation type interventions such as boot camp or shock incarceration are ineffective and potentially injurious (AACAP 2007). There is also evidence to support contra-indication for interventions in a group setting with other youth with ODD or Conduct Disorder type behaviors (Bazelon).

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# Bipolar Disorders in Adults (Mild to Moderate)

## Description:

Bipolar disorder is a serious brain disorder that causes extreme shifts in mood, energy, and functioning. Bipolar disorder is characterized by episodes of mania and depression that can last from days to months, and sometimes cycles within hours in children. Generally, those who suffer from bipolar disorder have symptoms of both mania and depression (sometimes at the same time). Bipolar disorder is a chronic and generally life-long condition with recurring episodes that often begin in adolescence or early adulthood. Mild to moderate presentations may include Bipolar I, Bipolar II and Cyclothymia.

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat bipolar disorders, including:

- Wellness (Illness) Management and Recovery
- Supported Employment
- Medication Management
- Supported Education
- Supported Housing
- Solution-Focused Brief Therapy
- Family Psychoeducation
- Strengths Model of Case Management

## Best Practice Alternatives:

- Individual Psychotherapy
- Family Therapy
- Outcome Ratings Scale
- Cognitive Behavioral Therapy

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

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Emphasis should be placed on assisting the client in identifying early signs and symptoms of manic and depressive episodes to ensure that treatment can be adjusted as early as possible (APA, 2002).

The client's functional status should be assessed and used to determine if the client would be better served in a rehabilitation program or outpatient services.

Emphasis should be paid to assessing suicide risk and conducting safety planning

Some clients may be reluctant to give up the experience of mania or hypomania due to the associated increased euphoria, energy and heightened self esteem. Clients may benefit from ongoing psychoeducation to reinforce long-term management of the disorder.

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# Bipolar Disorders in Adults (Moderate to Severe)

## Description:

Bipolar disorder is a serious brain disorder that causes extreme shifts in mood, energy, and functioning. Bipolar disorder is characterized by episodes of mania and depression that can last from days to months, and sometimes cycles within hours in children. Generally, those who suffer from bipolar disorder have symptoms of both mania and depression (sometimes at the same time). Bipolar disorder is a chronic and generally life-long condition with recurring episodes that often begin in adolescence or early adulthood. In severe Bipolar I Disorder psychosis may be present.

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat bipolar disorders, including:

- Wellness (Illness) Management and Recovery
- Strengths Model of Case Management
- Supported Employment
- Consumer-Run Drop-In Centers
- Assertive Community Treatment
- Family Psychoeducation
- Medication Management
- Supported Education
- Supported Housing

## Best Practice Alternatives:

- Case Management
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Specific attention should be paid to assessing suicide risk and conducting safety planning.

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When clients present with rapid cycling episodes, they should receive a thorough medical evaluation to assess for any underlying medical conditions that may be contributing to the cycling such as hypothyroidism (APA, 2002).

Some clients may be reluctant to give up the experience of mania or hypomania due to the associated increased euphoria, energy and heightened self esteem. Clients may benefit from ongoing psychoeducation to reinforce long-term management of the disorder.

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# Bipolar Disorders in Children and Adolescents (Mild to Moderate)

## Description:

Bipolar disorder is a serious brain disorder that causes extreme shifts in mood, energy, and functioning. Bipolar disorder is characterized by episodes of mania and depression that can last from days to months, and sometimes cycles within hours in children. Generally, those who suffer from bipolar disorder have symptoms of both mania and depression (sometimes at the same time). Bipolar disorder is a chronic and generally life-long condition with recurring episodes that often begin in adolescence or early adulthood, and now more commonly even in children. The disease affects males and females equally, although onset before age ten is predominately in males.

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat bipolar disorders, including:

- Medication Management
- Functional Family Therapy
- Family Psychoeducation
- Wraparound

## Best Practice Alternatives:

- Individual Psychotherapy
- Cognitive Behavioral Therapy
- Family Therapy
- Case Management
- Collaborative Problem Solving
- Outcome Ratings Scale
- Medication Management

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

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In addition there is a high rate of co-morbidity with ADHD, which should be carefully assessed and treated when indicated.

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# Bipolar Disorders in Children and Adolescents (Moderate to Severe)

## Description:

Bipolar disorder is a serious brain disorder that causes extreme shifts in mood, energy, and functioning. Bipolar disorder is characterized by episodes of mania and depression that can last from days to months, and sometimes shift within hours in children. Generally, those who suffer from bipolar disorder have symptoms of both mania and depression (sometimes at the same time). Mania in adolescents is likely to include psychotic features, school truancy, antisocial behavior, school failure or substance use. Bipolar disorder is a chronic and generally life-long condition with recurring episodes that often begin in adolescence or early adulthood, and now more commonly even in children. The disease affects males and females equally, although onset before age ten is predominately in males.

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat bipolar disorders, including:

- Functional Family Therapy
- Wraparound
- Family Psychoeducation
- Medication Management

## Best Practice Alternatives:

- Individual Psychotherapy
- Cognitive Behavioral Therapy
- Family Therapy
- Case Management
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Specific attention should be paid to assessing suicide risk and conducting safety planning.

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In the event that no safe or effective community-based treatment is available it may be indicated to consider a short term period of stabilization and treatment in a psychiatric residential treatment facility.

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# Borderline Personality Disorder in Adults

## Description:

Borderline Personality Disorder is a disorder that is characterized by affective dysregulation, impulse-behavioral dyscontrol and cognitive-perceptual difficulties. Individuals with Borderline Personality Disorder often engage in self-destructive behaviors and treatment must include a focus on responding to crises while developing a therapeutic alliance (APA, 2001). Many individuals who have been diagnosed with Borderline Personality Disorder have histories of traumatic abuse. Clinicians should empathetically validate the experience while focusing on the client taking responsibility for controlling and preventing current self-destructive patterns.

## Associated Evidence Based Practices:

Two approved evidence based practices may be utilized to treat borderline personality disorders:

- Dialectical Behavioral Therapy
- Medication Management

## Best Practice Alternatives:

- Cognitive Behavioral Therapy
- Motivational Interviewing
- Strengths Model of Case Management
- Family Psychoeducation

## Other Considerations:

Suicide threats, gestures and attempts are common with individuals diagnosed with Borderline Personality Disorder. Approximately 8-10% of these individuals commit suicide, therefore emphasis should be placed on managing risk (DSM, 2000).

There is often a high co-morbidity with substance use disorders, depressive disorders, eating disorders, PTSD, and anxiety disorders (APA, 2001). Treatment for other co-occurring mental health disorders should generally occur simultaneously. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

When treatment is provided by more than one individual, emphasis must be placed on close collaboration among all treatment team members to maintain consistency and reduce splitting.

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Regression is common throughout the course of treatment; care should be taken to not dramatically change the course of treatment unless the regression persists. Hospitalization, when utilized, should be focused on resolution of the immediate crisis with rapid return to the community.

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# Borderline Personality Disorder in Adolescents

## Description:

Borderline Personality Disorder is a disorder that is characterized by affective dysregulation, impulse-behavioral dyscontrol and cognitive-perceptual difficulties. Individuals with Borderline Personality Disorder often engage in self-destructive behaviors and treatment must include a focus on responding to crises while developing a therapeutic alliance (APA, 2001). Many individuals who have been diagnosed with Borderline Personality Disorder have histories of traumatic abuse. Clinicians should empathetically validate the experience while focusing on the client taking responsibility for controlling and preventing current self-destructive patterns. Prevalence of this disorder is predominately in females, about 75% of the 2% prevalence in the general population (DSM, 2000).

## Associated Evidence Based Practices:

Several evidence based practices may be utilized to treat borderline personality disorders, including:

- Dialectical Behavioral Therapy
- Medication Management
- Family Psychoeducation

## Best Practice Alternatives:

- Family Therapy
- Wraparound
- Outcome Ratings Scale
- Cognitive Behavioral Therapy

## Other Considerations:

Because the personality of adolescents is still developing, the diagnosis of Borderline Personality Disorder should be made with care in this age group (APA, 2001).

Suicide threats, gestures and attempts are common with individuals diagnosed with Borderline Personality Disorder. Approximately 8-10% of these individuals commit suicide; therefore emphasis should be place on managing risk (DSM, 2000).

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There is often a high co-morbidity with substance use disorders, depressive disorders, eating disorders, PTSD, and anxiety disorders (APA, 2001). Treatment for other co-occurring mental health disorders should generally occur simultaneously. When indicated, the client should receive integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment. Hospitalization, when utilized, should be focused on resolution of the immediate crisis with rapid return to the community.

When treatment and case management are provided by more than one individual, as is common with adolescents involved in multiple systems, emphasis must be placed on close collaboration among all treatment team members to maintain consistency and reduce splitting. Regression is common throughout the course of treatment; care should be taken to not dramatically change the course of treatment unless the regression persists.

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Washington County Mental Health

Practice guidelines

November, 2013

# Co-Occurring Mental Health and Substance Abuse Treatment in Adults

## Description:

Individuals who have been diagnosed with both a mental disorder and a substance use disorder are considered to be dually diagnosed. There is a much higher prevalence of substance use among individuals diagnosed with a mental illness than the general population. In 2005, adults who experienced a major depressive episode were more than twice as likely to use illicit substances (SAMHSA, 2005).

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat co-occurring mental health and substance use disorders. including:

- Co-occurring Disorders: Integrated Dual Diagnosis Disorders
- Supported Employment
- Assertive Community Treatment
- Seeking Safety
- Family Psychoeducation
- Medication Management
- Supported Education
- Motivational Interviewing
- Drug Court

## Best Practice Alternatives:

- Mental health treatment with concurrent substance abuse treatment including:
  - Matrix Model
  - 12-Step
  - Smart Recovery
- Family Therapy

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Other Considerations:

Whenever possible, both mental health services and substance abuse treatment should occur within a single provider and preferably by a single, dually credentialed clinician. When this is not available, services within a single provider by separate but collaborating mental health and substance abuse clinicians is recommended.

If concurrent mental health and substance abuse treatment occurs utilizing separate provider networks, effort should be made to have regular and close collaboration between providers.

All mental health clinicians should have orientation and training to screen for substance use disorders. This should be an integrated component of any behavioral health assessment.

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Washington County Mental Health

Practice guidelines

November, 2013

# Co-Occurring Substance Abuse and Mental Health Treatment in Adolescents

## Description:

Individuals who have been diagnosed with both a mental disorder and a substance use disorder are considered to be dually diagnosed. There is a much higher prevalence of substance use among individuals diagnosed with a mental illness than the general population. In a 2005 study, 38% of adolescents with a Major Depressive Episode in the past year had used illicit substances. In the same study, almost 20% met criteria for substance abuse or dependence (SAMHSA 2006).

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat co-occurring mental health and substance use disorders, including:

- Co-Occurring Disorders: Integrated Dual Diagnosis Disorders
- Brief Strategic Family Therapy
- Multi-systemic Therapy
- Functional Family Therapy
- Family Psychoeducation
- Medication Management
- Motivational Interviewing
- Wraparound

## Best Practice Alternatives:

- Mental health treatment with concurrent substance abuse treatment including:
  - Matrix Model
  - 12-Step
  - Smart Recovery
- Cognitive Behavioral Therapy

## Other Considerations:

Whenever possible, both mental health services and substance abuse treatment should occur within a single provider and preferably by a single, dually credentialed clinician. When this is not available, services within a single provider by separate but collaborating mental health and substance abuse

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clinicians is recommended. Family therapy approaches have the most empirical support as an efficacious intervention with older children and adolescents who are dually diagnosed.

If concurrent mental health and substance abuse treatment occurs utilizing separate provider networks, effort should be made to have regular and close collaboration between providers.

Substance use and abuse are known risk factors for adolescent suicide (Sadock 2004). Specific attention should be paid to assessing suicide risk and conducting safety planning.

All mental health clinicians should have orientation and training to screen for substance use disorders. This should be an integrated component of any behavioral health assessment.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Washington County Mental Health

Practice guidelines

November, 2013

# Depressive Disorders in Adults (Mild to Moderate)

## Description:

Depressive episodes are periods of at least two weeks during which there is either a depressed mood or the loss of interest or pleasure in nearly all activities (DSM, 2004). Depressive disorders are one of the most common mental disorders to affect adults. Mild to moderate depressive disorders include Dysthymic Disorder, Major Depression and Depression NOS. In 2005, 7.3 percent of the adult population reported a depressive episode and 14.2 percent reported at least one depressive episode over the course of their life (SAMHSA. 2006). Frequently other mental disorders such as substance abuse, anxiety disorders, eating disorders, compulsive disorders and Borderline Personality Disorder will co-occur with major depression (DSM, 2000).

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat depressive disorders, including:

- Solution Focused Brief Therapy
- Supported Employment
- Wellness (Illness) Management and Recovery
- Medication Management
- Supported Education
- Family Psychoeducation

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Case Management
- Family Therapy
- Outcome Ratings Scale
- Cognitive Behavioral Therapy

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Specific attention should be paid to assessing suicide risk and conducting safety planning. After an initial treatment period, ongoing prescribing can often be managed by the individual's primary care physician.

Clients with mild to moderate depression may respond to either therapy or medication management or a combination of treatments.

Family therapy has been associated with better outcomes than medication alone and should be considered when feasible (Asen, 2002).

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Washington County Mental Health

Practice guidelines

November, 2013

# Depressive Disorders in Adults (Moderate to Severe)

## Description:

A major depressive episode is defined as a period of at least two weeks during which there is either a depressed mood or the loss of interest or pleasure in nearly all activities (DSM, 2004). Depressive disorders are one of the most common mental disorders to affect adults. In 2005, 7.3 percent of the adult population reported a depressive episode and 14.2 percent reported at least one depressive episode over the course of their life (SAMHSA. 2006). Moderate to severe episodes can impact a person's ability to maintain housing, employment and interpersonal relationships. There is a high association with suicide with up to 15% of individuals diagnosed with severe depression dying by suicide (DSM, 2000). Frequently other mental disorders such as substance abuse, anxiety disorders, eating disorders, compulsive disorders and Borderline Personality Disorder will co-occur with major depression (DSM, 2000).

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat depressive disorders. These are:

- Supported Employment
- Supported Housing
- Supported Education
- Consumer-Run Drop-In Centers
- Wellness Management and Recovery
- Assertive Community Treatment
- Strengths Model of Case Management
- Medication Management
- Family Psychoeducation
- Motivational Interviewing

## Best Practice Alternatives:

- Outcome Ratings Scale
- Cognitive Behavioral Therapy
- Electroconvulsive Therapy (severe only)

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Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Specific attention should be paid to assessing suicide risk and conducting safety planning. Major Depressive Disorder with psychosis tend to have a higher risk of suicide and recurrent episodes (APA, 2000).

The client's functional status should be assessed and used to determine if the client would be better served in a rehabilitation program or outpatient services.

Electroconvulsive Therapy is considered only for very severe presentations of depression and after the symptoms have been shown to not respond sufficiently to other forms of treatment.

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Washington County Mental Health

Practice guidelines

November, 2013

# Depressive Disorders in Children and Adolescents (Mild to Moderate)

## Description:

The prevalence of Major Depressive Disorder is estimated to be 2% in children and 4-8% in adolescents. A Major Depressive Episode is characterized by at least two weeks of a pervasive mood change manifested by either depressed or irritable mood, and/or loss of interest and pleasure. In early childhood, symptoms may be irritability and frustrations evidenced by temper tantrums and other behavioral problems. Dysthymic Disorder is characterized by a persistent, long-term change in mood that is less intense but more chronic than Major Depressive Disorder, and is often co-morbid with Major Depressive Disorder.

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat depressive disorders, including:

- Cognitive Behavioral Therapy for Depression in Adolescents
- Cognitive Behavioral Therapy (Trauma Focused)
- Family Psychoeducation
- Solution Focused Brief Therapy
- Medication Management
- Brief Strategic Family Therapy
- Collaborative Problem Solving
- Motivational Interviewing

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Family Therapy
- Wraparound
- Case Management
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders and therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

After an initial treatment period, ongoing prescribing can often be managed by the individual's primary care physician.

Specific attention should be paid to assessing suicide risk and conducting safety planning.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Washington County Mental Health

Practice guidelines

November, 2013

# Depressive Disorders in Children and Adolescents (Moderate to Severe)

## Description:

The prevalence of Major Depressive Disorder is estimated to be 2% in children and 4-8% in adolescents. A Major Depressive Episode is characterized by at least two weeks of a pervasive mood change manifested by either depressed or irritable mood, and/or loss of interest and pleasure. In early childhood, symptoms may be irritability and frustrations evidenced by temper tantrums and other behavioral problems. Dysthymic Disorder is characterized by a persistent, long-term change in mood that is less intense but more chronic than Major Depressive Disorder, and is often co-morbid with Major Depressive Disorder.

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat depressive disorders, including:

- Cognitive Behavioral Therapy for Depression in Adolescents
- Cognitive Behavioral Therapy (Trauma Focused)
- Family Psychoeducation
- Solution Focused Brief Therapy
- Medication Management
- Collaborative Problem Solving
- Wraparound
- Motivational Interviewing

## Best Practice Alternatives:

- Individual Psychotherapy
- Family Therapy
- Case Management
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Specific attention should be paid to assessing suicide risk and conducting safety planning.

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Treatment of depressed youth should always take place in the least restrictive treatment setting that is safe and effective. In extreme cases where this is not possible in the community, short term stabilization and treatment in Psychiatric Residential Treatment Services facility may be indicated.

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*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Washington County Mental Health

Practice guidelines

November, 2013

# Eating Disorders in Adults

## Description:

The two most common types of eating disorders are Anorexia Nervosa and Bulimia Nervosa. Anorexia Nervosa typically begins in mid to late adolescence, though there have been cases documented in children as young as seven. This disorder is generally characterized by refusal to maintain a minimally normal body weight, intense fear of gaining weight and a significantly disturbed body image (DSM 2000). Bulimia Nervosa is characterized by episodic binge eating followed by purging behaviors such as self-induced vomiting, misuse of laxatives, fasting or excessive exercise (DSM 2000). Eating disorder are less common in males than females, with a ratio of about 1:9 (APA 2006).

## Associated Evidence Based Practices:

There is only one approved evidence based practice for eating disorder in adults:

- Medication Management

## Best Practice Alternatives:

- Cognitive Behavioral Therapy
- Family Psychoeducation
- Outpatient Individual or Group Therapy
- Dialectical Behavioral Therapy (with emphasis on eating disorders)
- Family Therapy
- Partial Hospitalization
- Residential Treatment
- Inpatient Treatment
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Depression commonly co-occurs with eating disorders. This should be carefully assessed and treated as indicated.

All treatment for individuals with eating disorders should be done in close collaboration with physical health care providers.

Psychotropic medications generally should not be the primary or sole intervention..

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Washington County Mental Health

Practice guidelines

November, 2013

# Eating Disorders in Children and Adolescents

## Description:

Anorexia Nervosa typically begins in mid to late adolescence, though there have been cases documented in children as young as seven. In younger children and adolescents, obsessional behavior and depression are common, as well as physical symptoms such as nausea, abdominal pain and the inability to swallow (APA 2006). This disorder is generally characterized by refusal to maintain a minimally normal body weight, intense fear of gaining weight and a significantly disturbed body image (DSM 2000). Bulimia Nervosa is characterized by episodic binge eating followed by purging behaviors such as self-induced vomiting, misuse of laxatives, fasting or excessive exercise (DSM 2000). Eating disorder are less common in males than females, with a ratio of about 1:9 (APA 2006).

## Associated Evidence Based Practices:

There is only one approved evidence based practice for eating disorder in children and adolescents:

- Medication Management

## Best Practice Alternatives:

- Cognitive Behavioral Therapy
- Family Psychoeducation
- Outpatient Individual and Family Psychotherapy
- Systemic Family Therapy
- Group Psychotherapy
- Dialectical Behavioral Therapy (with an emphasis on eating disorders)
- Partial Hospitalization
- Residential Treatment
- Inpatient Treatment
- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

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Depression and Anxiety commonly co-occur with eating disorders. This should be carefully assessed and treated as indicated.

All treatment for individuals with eating disorder should be done in close collaboration with physical health care providers.

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Washington County Mental Health

Practice guidelines

November, 2013

# Obsessive-Compulsive Disorder in Adults

## Description:

Obsessive-Compulsive Disorder is manifested as recurrent obsessions or compulsions that are severe enough to be time consuming or cause marked distress or significant impairment. Obsessions are defined as persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress (DSM 2000). Compulsions are defined as repetitive behaviors (hand washing, ordering, checking) or mental acts (counting, repeating words silently), the goal of which is to prevent or reduce anxiety or distress, as opposed to for pleasure or gratification (DSM 2000).

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat obsessive compulsive disorders, including:

- Supported Employment
- Medication Management
- Supported Education
- Strengths Model of Case Management

## Best Practice Alternatives:

- Outcome Ratings Scale
- Family Psychoeducation
- Cognitive Behavioral Therapy
- Exposure and Response Prevention Therapy

## Other Considerations:

When other psychiatric disorders are present, these should be treated concurrently. There is often a high comorbidity with depression and generalized anxiety disorders which may impact the clients ability to respond to cognitive behavioral therapy (Abramowitz & Schwartz, 2004).

Incorporating exposure and response prevention into cognitive behavioral therapy may be helpful for treating compulsions. For more severe clients, a combination of cognitive behavioral therapy and medication may be indicated (March, Frances, Carpenter, & Kahn, 1997)

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Excessive use of alcohol, sedatives and anxiolytics should be assessed and treated if indicated (DSM, 2000).

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Washington County Mental Health

Practice guidelines

November, 2013

# Obsessive-Compulsive Disorder in Children and Adolescents

## Description

Obsessive-Compulsive Disorder is manifested as recurrent obsessions or compulsions that are severe enough to be time consuming or cause marked distress or significant impairment. Obsessions are defined as persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress (DSM 2000). Compulsions are defined as repetitive behaviors (hand washing, ordering, checking) or mental acts (counting, repeating words silently), the goal of which is to prevent or reduce anxiety or distress, as opposed to for pleasure or gratification (DSM 2000). Obsessive-Compulsive Disorder is found more often in males than females when diagnosed in children.

## Associated Evidence Based Practices:

Several evidence based practices may be utilized to treat obsessive compulsive disorders, including:

- Cognitive Behavioral Therapy for Child Anxiety Disorder
- Medication Management
- Family Psychoeducation

## Best Practice Alternatives:

- Individual and Family Psychotherapy
- Collaborative Problem Solving
- Case Management
- Outcome Ratings Scale

## Other Considerations:

There is a high co-morbidity rate of Tourette's disorder or other tic disorder, which should therefore be assessed and treatment provided as clinically indicated.

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*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

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Washington County Mental Health

Practice guidelines

November, 2013

# Pervasive Developmental Disorders in Children and Adolescents

## Description:

Pervasive Developmental Disorders are characterized by patterns of delay and deviance in the development of social, communicative, and cognitive skills which arise in the first years of life. The more common of these diagnoses include Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorder, NOS.

## Associated Evidence Based Practices:

Evidenced Based Practices used to treat pervasive developmental disorders are:

- Medication Management
- Collaborative Problem Solving
- Family Psychoeducation
- Wraparound

## Best Practice Alternatives:

- Social Skills Training
- Family Therapy
- Family Coaching/ Parent training
- Case Management

## Other Considerations:

Generally individual psychotherapy is not indicated; however it may be appropriate for some higher functioning or older children and adolescents diagnosed with Asperger's Disorder and another co-morbid condition (AACAP 1999).

Interventions for children and adolescents with Pervasive Developmental Disorders should also be sought through the Developmental Disabilities Program and every effort should be made to collaborate with that program and integrate case planning for clients and families.

In addition, treatment planning for youth with Pervasive Developmental Disorder should always involve the education provider, as these youth almost always require specialized education services which should integrate with the mental health treatment plan.

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*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Washington County Mental Health

Practice guidelines

November, 2013

# Post Traumatic Stress Disorder in Adults

## Description:

Posttraumatic Stress Disorder is developed in response to exposure to an extreme traumatic stressor either directly or indirectly, or to being threatened with exposure to such a stressor. Traumatic events experienced directly may include, but are not limited to, sexual or physical abuse, military combat, being kidnapped or taken hostage, torture, natural or manmade disasters or automobile accidents. Traumatic events experienced indirectly may include witnessing violent assaults or murder, witnessing death due to war or disaster, or unexpectedly seeing a dead body or body parts (DSM 2000). Symptoms are grouped into three categories: re-experiencing of the trauma, avoidance of stimuli associated with the trauma and increased arousal.

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat post traumatic stress disorders, including:

- Seeking Safety
- Eye Movement Desensitization and Reprocessing (EMDR)
- Solution Focused Brief Therapy
- Cognitive Behavioral Therapy (Trauma Focused)
- Medication Management

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Outcome Ratings Scale
- Prolonged Exposure Therapy for Posttraumatic Stress
- Family Psychoeducation

## Other Considerations:

There is often a high co-morbidity with depressive disorders, anxiety disorders and substance use disorders, therefore these should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Research supports exposure therapy, cognitive therapy and anxiety management techniques as effective treatments for PTSD (Vonk, Bornick & Graap, 2004).

Psychotherapy is often recommended as first line intervention. Medication prescribing in conjunction with psychotherapy may be indicated in more severe presentations (Foa, Davidson, & Frances, 1999). Exposure therapy may be indicated for symptoms of intrusive thoughts, flashbacks and trauma related fears, panic and avoidance (Foa, Davidson, & Frances, 1999).

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Washington County Mental Health

Practice guidelines

November, 2013

# Post Traumatic Stress Disorder in Children and Adolescents

## Description:

Posttraumatic Stress Disorder is developed in response to exposure to an extreme traumatic stressor either directly or indirectly, or to being threatened with exposure to such a stressor. Traumatic events experienced directly may include, but are not limited to, sexual or physical abuse, military combat, being kidnapped or taken hostage, torture, natural or manmade disasters or automobile accidents. Traumatic events experienced indirectly may include witnessing violent assaults or murder, witnessing death due to war or disaster, or unexpectedly seeing a dead body or body parts (DSM 2000). Symptoms are grouped into three categories: re-experiencing of the trauma, avoidance of stimuli associated with the trauma and increased arousal.

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat post traumatic stress disorders, including:

- Cognitive Behavioral Therapy (Trauma Focused)
- Solution Focused Brief Therapy
- Medication Management
- Collaborative Problem Solving
- Parent Child Interaction Therapy
- Wraparound
- Incredible Years

## Best Practice Alternatives:

- Short-term Individual Psychotherapy
- Trauma Focused Family Therapy
- Eye Movement Desensitization and Reprocessing (EMDR)
- Outcome Ratings Scale
- Seeking Safety

## Other Considerations:

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There is often a high co-morbidity with substance use disorders therefore this should be carefully assessed. When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

Children and families who have recently emigrated from areas of severe unrest may have elevated rates of Posttraumatic Stress Disorder. When working with this population clinicians should do thorough assessments of trauma history.

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*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Washington County Mental Health

Practice guidelines

November, 2013

# Psychotic Disorders in Adults

## Description:

Psychotic disorders may present with a variety of symptoms including delusions, hallucinations**,** disorganized speech and disorganized behavior. Onset of Schizophrenia is typically in the 20's however the disorder may present earlier or later. There are a number of diagnoses that have psychosis as a primary presenting symptom including: Schizophrenia, Schizoaffective disorder, Delusional Disorder and Psychosis, NOS.

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat psychotic disorders, including:

- Medication Management
- Family Psychoeducation
- Assertive Community Treatment
- Wellness (Illness) Management and Recovery
- Strengths Model of Case Management
- Supported Employment
- Consumer-Run Drop-In Centers
- Cognitive Behavioral Therapy for Schizophrenia and other Psychotic Disorders
- Supported Housing
- Supported Education

## Best Practice Alternatives:

- Outcome Ratings Scale

## Other Considerations:

There is often a high co-morbidity with substance use disorders with nearly on-half of clients diagnosed with schizophrenia having a co-existing substance use disorder (APA, 2004). When indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Methamphetamine use can often result in symptoms that are similar to non-substance induced psychotic disorders. Extended evaluation may be required to differentiate the etiology of the psychosis.

Family members and other natural supports should be included in treatment planning and service provision whenever possible.

Emphasis should be placed on addressing suicide risk as this is the leading cause of premature death among individuals diagnosed with schizophrenia (APA, 2004).

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Washington County Mental Health

Practice guidelines

November, 2013

# Psychotic Disorders in Children and Adolescents

## Description:

Psychotic disorders may present with a variety of symptoms including delusions, hallucinations, disorganized speech, disorganized behavior and negative symptoms such as flat affect or paucity of speech. There are a number of diagnoses that have psychosis as a primary presenting symptom, including: Schizophrenia, Schizoaffective Disorder, Delusional Disorder and Psychosis, NOS. Onset of Schizophrenia prior to age thirteen is rare, and is more likely in males than females. The peak age of onset is between ages fifteen and thirty. This disorder is challenging to diagnose in children and early adolescents as there can be overlap between symptoms of this disorder and symptoms of psychotic mood disorders. Delusional Disorder is much less common, with prevalence in the general population at about .03%.

## Associated Evidence Based Practices:

A number of evidence based practices may be utilized to treat psychotic disorders, including:

- Medication Management
- Family Psychoeducation
- Wraparound
- EASA (EAST)
- Cognitive Behavioral Therapy for Schizophrenia and other Psychotic Disorders
- Supported Education

## Best Practice Alternatives:

- Case Management
- Family Support Groups
- Psychiatric Day Treatment
- Social Skills Training
- Outcome Ratings Scale

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Other Considerations:

Suicide is the leading cause of premature death for individuals with Schizophrenia. It is important to assess for the presence of suicidal potential and command hallucinations and conduct safety planning as indicated (APA 2004).

There is often a high co-morbidity with substance use disorders (up to 50% with adolescents) (AACAP 2000). Therefore this should be carefully assessed and, when indicated, the client should received integrated dual diagnosis treatment or, at a minimum, concurrent substance abuse evaluation and treatment.

In the event that no safe or effective community-based treatment is available it may be indicated to consider a short term period of stabilization and treatment in a psychiatric residential treatment facility.

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Washington County Mental Health

Practice guidelines

November, 2013

# Reactive Attachment Disorder of Infancy or Early Childhood in Children

## Description:

Reactive Attachment Disorder is essentially the early onset of abnormal social relatedness across contexts that is distinguishable from pervasive developmental disorders and is the result of grossly pathological care (AACAP 2005). Children who present with Reactive Attachment Disorder have a history of being raised in environments characterized by extreme neglect. Symptoms include hypervigilance, excessive inhibition, indiscriminate sociability and disorganized attachment behaviors (DSM 2000).

## Associated Evidence Based Practices:

Several approved evidence based practices may be utilized to treat reactive attachment disorder, including:

- Multi-systemic therapy
- Parent-Child Interaction Therapy
- Wraparound
- Brief Strategic Family Therapy
- Incredible Years
- Medication Management

## Best Practice Alternatives:

- Parent Education/ Family Coaching

## Other Considerations:

*This practice guideline is intended to provide information about treatment options and does not replace sound clinical judgment nor does it authorize treatment. The list of above practices is not exhaustive and additional treatment interventions may be added at any time. All treatment decisions should be made in conjunction with the client and/or the client's family.*

Studies show that treatment is more effective when it involves the caregiver and focuses on the interactions between the child and caregiver, as opposed to individually focused therapy (AACAP 2005).

Unless safety is not able to be maintained in a community-based setting, inpatient treatment is generally contra-indicated for Reactive Attachment Disorder, as the goal of treatment is to foster attachment between the child and primary caregiver (APA 2002).

Interventions that involve non-contingent physical restraint or coercion, such as therapeutic holding, rebirthing therapy, compression holding, or reworking of trauma are contra-indicated due to lack of empirical evidence and high safety risks (AACAP 2005, APA 2002).

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# Definitions:

Evidence Based Practices:

- **Assertive Community Treatment:** A multi-disciplinary clinical team approach of providing 24-hour, intensive community services in the individual's natural setting that help individuals with serious mental illness live in the community. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Brief Strategic Family Therapy:** Brief Strategic Family Therapy (BSFT) is a short-term, problem-focused therapeutic intervention, targeting children and adolescents 6 to 17 years old, that improves youth behavior by eliminating or reducing drug use and its associated behavior problems and that changes the family members' behaviors that are linked to both risk and protective factors related to substance abuse. *http://modelprograms.samhsa.gov/pdfs/model/Bsft.pdf*

- **Cognitive Behavioral Therapy:** A combination of cognitive and behavioral therapies, this approach helps people change negative thought patterns, beliefs, and behaviors so they can manage symptoms and enjoy more productive, less stressful lives. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Consumer-Run Drop-In Centers:** Mental health treatment or support services that are provided by current or former mental health consumers. Includes social clubs, peer-support groups, and other peer-organized or consumer-run activities. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Dialectical Behavioral Therapy (DBT)**: A psychosocial treatment developed by Marsha M. Linehan specifically to treat individuals with borderline personality disorder. While DBT was designed for individuals with borderline personality disorder, it is used for patients with other diagnoses as well. The treatment itself is based largely in behaviorist theory with some cognitive therapy elements as well. *http://en.wikipedia.org/wiki/Dialectical_behavioral_therapy*

- **Electroconvulsive Therapy:** Also known as ECT, this technique uses low voltage electrical stimulation of the brain to treat some forms of major depression, acute mania, and some forms of schizophrenia. This technique is considered only when other therapies have failed, when a person is seriously medically ill and/or unable to take medication, or when a person is very likely to commit suicide. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Eye Movement Desensitization and Reprocessing (EMDR)**: A psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. After successful treatment with EMDR, affective distress is relieved, negative beliefs are reformulated, and physiological arousal is reduced. During EMDR the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist directed lateral eye movements are the most

commonly used external stimulus but a variety of other stimuli including hand-tapping and audio stimulation are often used. *http://www.emdr.com*

- **Family Psychoeducation:** A method of working in partnership with families to impart current information about the illness and to help them develop coping skills for handling problems posed by mental illness in one member of the family. The goal is that practitioner, consumer, and family work together to support recovery. It respects and incorporates their individual, family, and cultural realities and perspectives. Psychoeducation can be used in a single family or multi-family group format, depending on the consumers and family's wishes, as well as empirical indications. *http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/InfMHPL.asp*

- **Functional Family Therapy:** Functional Family Therapy (FFT) is an empirically-grounded, family-based intervention program for acting-out youth. A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity so often characteristic of these families. *http://www.strengtheningfamilies.org/html/model_programs_1997/mfp_pg2.html*

- **Incredible Years:** The Incredible Years Training Series provides three comprehensive, multifaceted, and developmentally based curricula for parents, teachers, and children. The program is designed to promote emotional and social competence and to prevent, reduce, and treat aggressive, defiant, oppositional, and impulsive behaviors in young children 2 to 8 years old. *http://modelprograms.samhsa.gov/pdfs/model/IncYears.pdf*

- **Integrated Dual Diagnosis Treatment:** Combining mental health and substance abuse treatments within the same system of care. Clinicians use a variety of techniques to address both the mental health and substance abuse including assessment, stage-wise treatment and motivational interviewing.

- **Medication Management (MedMAP):** Evidence-based medicine that is a mixture of clinical research, expert consensus, and practitioner expertise. MedMAP uses evidence-based medicine to guide medication decisions. MedMAP is designed to involve consumers, family members and supporters, practitioners, program leaders, and the public mental health authority in a united effort to practice medication prescribing in the interest of recovery of the consumer. MedMAP provides guidelines and algorithms that were developed using research and evidence to help the agencies, practitioners and consumers achieve the best possible recovery outcomes. *http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/workbook/appendixd.asp*

- **Multi-dimensional Treatment Foster Care:** MTFC is an alternative to placement in group/residential care settings or to incarceration or psychiatric hospitalization where youth are placed singly in well-trained and supported community foster homes. MTFC includes multi-level interventions in family, community, and school settings. *http://www.oslccp.org/MTFC%20Overview.htm*

- **Multi-systemic Therapy:** MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to

his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies. *http://www.mstservices.com/text/treatment.html*

- **Parent-Child Interaction Therapy:** Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. In PCIT, parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior. *http://pcit.phhp.ufl.edu/*

- **Seeking Safety:** Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians. The treatment was designed for flexible use. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD. *http://www.seekingsafety.org/3-03-06/aboutSS.html*

- **Solution-Focused Brief Therapy** (SFBT)**:** A type of talking therapy that focuses on what clients want to achieve through therapy rather than on the problem(s) that made them seek help. The approach does not focus on the past, but instead, focuses on the present and future. It is often referred to as simply 'solution focused therapy' or 'brief therapy.' *http://en.wikipedia.org/wiki/Solution_focused_brief_therapy*

- **Strengths Based Case Management:** The strengths perspective emphasizes building on people's strengths and capacities rather than focusing exclusively on their deficits, disabilities, or problems. The strengths model refers to how these are applied in practice. As an orientation to practice, emphasis is placed on uncovering, reaffirming, and enhancing the abilities, interests, knowledge, resources, aspirations and hopes of individuals, families, groups, and communities. The strengths model has been employed in helping done with adults with severe and persistent mental illness, people struggling with alcohol and drug abuse, seriously emotionally disturbed children and their families, older citizens, children and adults in the justice system, and communities and neighborhoods. *http://www.socwel.ku.edu/publications/strengths/index.shtml*

- **Supported Employment:** Supportive services that include assisting individuals in finding work; assessing individuals' skills, attitudes, behaviors, and interest relevant to work; providing vocational rehabilitation and/or other training; and providing work opportunities. Includes transitional and supported employment services. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Supported Education:** A treatment approach that emphasizes education and career goals by assisting individuals with preparation, personal coaching and support around education. The goal is successful education so that the individual can attain fulfilling and appropriate work that provides a living wage.
  *http://www.supportededucation.com/supported.html*

- **Trauma Focused Cognitive Behavioral Therapy:** TF-CBT was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies that focus on enhancement of interpersonal trust and empowerment. The program can be provided to children 3 to 18 years of age and their parents by trained mental health professionals in individual, family, and group sessions in outpatient settings. It targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems.
  *http://modelprograms.samhsa.gov/pdfs/model/TFCBT.pdf*

- **Wellness Management and Recovery (aka Illness Management and Recovery):** The Wellness Management and Recovery Program consists of a series of weekly sessions in which mental health practitioners help people who have experienced psychiatric symptoms develop personal strategies for coping with mental illness and moving forward in their lives. The program can be provided in individual or group formats and generally lasts between 3 to 6 months. *http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/IMRpractinfo.asp*

- **Wraparound: A** definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes. The first component is a family-centered decision-making process that identifies those services and supports that will help meet the family's needs. The second component is the actual array of services and supports that are implemented. Operating together, these two components provide the primary active ingredients of the wraparound intervention. *http://www.rtc.pdx.edu/nwi/WAOverview.pdf*

## Non-EBP Practices (Best Practice Alternatives):

- **Case Management:** A service that helps people arrange for appropriate services and supports. A case manager coordinates mental health, social work, educational, health, vocational, transportation, advocacy, respite care, and recreational services as needed. The case manager makes sure that the changing needs of the child and family are met.
  *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Collaborative Problem Solving:** The CPS proposes that challenging behavior should be understood and handled in the same manner as other recognized learning disabilities. In other words, difficult children and adolescents lack important cognitive skills essential to handling frustration and mastering situations requiring flexibility and adaptability. The CPS model helps adults teach these skills and teaches caregivers and children to work toward mutually satisfactory solutions to the problems causing conflict.
  *http://www.ccps.info*

- **Concurrent Substance Abuse Treatment:** Treatment for both substance abuse and a mental health disorder at the same time by two different providers. Treatment follows a parallel course however the interventions may be different.

- **Desensitization/Exposure Therapy:** A type of behavioral therapy used to help effectively overcome phobias and other anxiety disorders by gradually exposing patients to the source of anxiety until it can be tolerated. At each step in the progression, the patient is desensitized to the phobia through the use of coping techniques. *http://en.wikipedia.org/wiki/Systematic_desensitization*

- **Group Therapy:** This form of therapy involves groups of usually 4 to 12 people who have similar problems and who meet regularly with a therapist. The therapist uses the emotional interactions of the group's members to help them get relief from distress and possibly modify their behavior. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Hospitalization:** Highly intensive hospital-based interventions utilized in situations where the individual cannot safely receive treatment in a community setting. The facility may or may not be locked and the client may be receiving treatment on either a voluntary or involuntary basis.

- **Individual Therapy:** Therapy tailored for a patient/client that is administered one-on-one. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Inpatient Eating Disorder Treatment:** Eating Disorder treatment provided in a hospital setting 24 hours a day. Inpatient hospitalization provides: (1) short-term treatment in cases where the individual is in crisis and possibly a danger to his/herself or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting. *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Intensive Case Management:** Intensive community services for individuals with severe and persistent mental illness that are designed to improve planning for their service needs. Services include outreach, evaluation, and support.*:* *http://mentalhealth.samhsa.gov/resources/dictionary.aspx#S*

- **Life Coaching:** A practice of assisting clients to determine and achieve personal goals. A coach will use a variety of methods, tailored to the client, to move through the process of setting and reaching goals. Life Coaches may or may not be therapists. *http://en.wikipedia.org/wiki/Life_Coaching*

- **Outcome Rating Scales:** An approach that uses scales administered at the end of therapy sessions to evaluate the effectiveness of the intervention. Client feedback is used to modify the therapeutic intervention as indicated.

- **Outpatient Treatment:** An umbrella term used to describe a variety of treatment that occurs in the community, often in an agency setting. Interventions may include group or individual therapy, case management services, eating disorder treatment, medication management and any number of other treatment options.

- **Partial Hospitalization:** A short-term, intensive intervention that occurs in a hospital setting. Typically the individual receiving treatment will spend half to a whole day at a hospital several days a week. While at the hospital, the client will receive a variety of group and individual interventions including therapy, medication management and skill building training. In partial hospitalization programs the individual returns home at night.

- **Residential Treatment**: A treatment intervention where the client resides at the treatment center with other individuals who are also receiving treatment. The facility may or may not be locked and the client may be receiving treatment on either a voluntary or involuntary basis.

- **Short-Term Therapy** Refers to any individual therapeutic approach that emphasizes time-limited, targeted treatment interventions. A variety of techniques may be utilized including, but not limited to: cognitive behavioral therapy, solution-focused therapy, EMDR, bibliotherapy, etc.

- **Transference-Based Psychotherapy** An intervention that focuses on the conflicts and themes that arise in the relationship between the client and the therapist with the assumption that this will analyze and clarify the nature of problems in the client's relationships outside of therapy. The focus of treatment is integrating positive and negative views of self and others.