Clinical Care Guide

City of Philadelphia Behavioral Health System

Serving Philadelphia's uninsured, underinsured and Medicaid-eligible residents

All correspondence regarding these materials should be directed to:

J. Bryce McLaulin, M. D.
Acting Chief Medical Officer
Community Behavioral Health
801 Market Street, 7th Floor
Philadelphia, Pennsylvania 19107

PHILADELPHIA BEHAVIORAL HEALTH SYSTEM

Philadelphia Office of Mental Health
1101 Market St.
7th Floor
Philadelphia, PA 19107
(215) 685-5400

Coordinating Office for Drug and Alcohol Abuse Programs
1101 Market St.
8th Floor
Philadelphia, PA 19107
215-685-5444

Community Behavioral Health
801 Market St.
7th Floor
Philadelphia, PA 19107
(215) 413-3100

Visit us online at: www.phila-bhs.org

CITY OF PHILADELPHIA
John F. Street
Mayor

PHILADELPHIA BEHAVIORAL HEALTH SYSTEM

Michael J. Covone
Deputy Commissioner
Office of Mental Health (OMH)

Marvin Levine
Director
Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP)

Nancy Lucas
Chief Executive Officer
Community Behavioral Health (CBH)

Table of Contents

Introduction iii

Substance Abuse and Dependence

Medical Necessity Criteria for Substance Abuse and Dependence 1.1

Substance Abuse and Dependence Diagnosis and Treatment 1.3

Alcohol 1.6

Sedatives, Hypnotics and Anxiolytics 1.10

Cocaine 1.13

Inhalants 1.17

Marijuana (Cannabis) 1.19

Opiates 1.21

Substance Induced Mood Disorder 1.25

Substance Induced Psychotic Disorder 1.28

Psychiatric Care

Acute Inpatient Treatment 2.1

Subacute Inpatient Treatment 2.5

Partial Hospitalization 2.12

Psychiatric Outpatient Care 2.16

Psychiatric Evaluation

Psychiatric Evaluation 3.1

Suicide Assessment 3.10

Psychiatric Diagnoses

Psychiatric Diagnoses 4.1

Schizophrenia 4.2

Schizoaffective Disorder 4.7

Brief Psychotic Disorder 4.10

Mood Disorders: Major Depression 4.12

Bipolar Affective Disorders 4.18

Anxiety Disorders: Post-Traumatic Stress Disorder 4.23

Anxiety Disorders: Acute Stress Disorder 4.26

Eating Disorders: Anorexia Nervosa 4.29

Disorders of Impulse Control: Intermittent Explosive Disorder 4.33
Personality Disorders: Antisocial Personality Disorder 4.36
Borderline Personality Disorder.....4.38

Child/Adolescent Psychiatric Care

Psychiatric Inpatient Hospitalization 5.1
Residential Treatment.....5.4
Partial Hospital Treatment 5.7
Psychiatric Outpatient Treatment 5.10
Appendix T.....5.12

Specific Diagnoses of Childhood and Adolescence

Attention Deficit/Hyperactivity Disorder (ADHD).....6.1
Oppositional Defiant Disorder 6.4
Conduct Disorder.....6.6
Pervasive Developmental Disorders 6.9
Special considerations for certain disorders when diagnosed in Children and Adolescents 6.15

Glossary/Bibliography

Clinical Pearls 7.1
Bibliography 7.2
Glossary.....7.3

Index

Index.....8.1

Introduction

The primary purpose of this Care Guide is to assist the staff of CBH in developing appropriate clinical information for decision-making. The Guide also informs providers of expected data to support admission, continued stay and discharge. The Guide sets the standard of documentation for internal record keeping in CBH. Sources of information for the Guide include the Medical Necessity Criteria contained in Appendix T of the original Health Choices Request for Proposals, the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, the Principles of Addiction Medicine, and the philosophy and policies articulated by of the administration of Community Behavioral Health and the Behavioral Health System.

The Guide is designed to facilitate access to care by the members of CBH, not as a means to limit or obstruct access. To determine the best avenue of care for a member, extensive information about the status of a member must be developed and recorded. This information then guides the selection of the best available treatment for the member. These guidelines are to assist the service managers in developing information that will help them authorize appropriate care for members. Being guidelines, they are to be used in a flexible and adaptive manner. They are not hard and fast rules. Certain clinical situations will require special consideration in determining the best treatment. These guidelines should only be used to help the member access the treatment situation that best addresses the member's needs. They are not designed as a means to deny authorization for services.

The clinical care of the patient and decisions about that care are the responsibilities of the attending physician and the facility where the patient is receiving treatment. These guidelines are designed to assist service managers in understanding the care that is described to them. These guidelines are not to be used to prescribe care to providers.

Appropriate management of the members of CBH requires a careful balance of compassion and understanding with the wise stewardship of resources. CBH has a duty to maintain the public trust by making appropriate, high quality care available to its members and by managing its financial resources wisely to ensure the future of the organization and its mission.

Medical Necessity Criteria for Substance Abuse and Dependence

Initial Authorization

Admission/No admission Criteria (Yes to any will require admission)

1. Is the patient unable to cease substance use outside of a secure, inpatient environment?
2. Is the patient in danger of serious withdrawal symptoms?
3. Does the patient have a physical disorder that will complicate the treatment of patient?
4. Is the patient a danger to self or others?
5. Is the patient incapable of meeting basic needs?

Continued Stay

Inpatient treatment (Yes to questions 1, 2, 3 requires inpatient care)

1. Does the patient's condition require 24-hour care in a structured therapeutic environment?
2. Does the patient have a significant psychiatric disorder that is complicating substance abuse treatment?
3. Does the patient have a physical illness(es) that requires continued inpatient care?
4. Has a treatment plan been developed that addresses the problems described in the initial authorization for treatment? Describe plan.
5. Has discharge planning been an integral part of the treatment process?

Discharge Criteria

Yes to all required for discharge

1. Have the indications for admission been stabilized sufficiently to be managed at a lower level of care?
2. Is the patient sufficiently stable to no longer require 24-hour nursing care?

3. Has a discharge plan been developed that addresses the individual needs of the patient?

   A. Does the patient have access to all medications needed to maintain stability in an outpatient setting?

   B. Have community-based support systems been identified and the patient informed of these programs?

   C. Has outpatient care been scheduled for the patient?

   D. Has any necessary care for physical illness been scheduled?

   E. Has appropriate housing been arranged?

Discharge from Rehabilitation Services

Yes to 1-5 for a therapeutic discharge:

1. Has the patient developed the skills needed to address relapse triggers in a positive manner?
2. Has the patient accepted the diagnosis of addiction and recognized its severity?
3. Is the patient able to maintain therapeutic gains in a less structured treatment setting?
4. Is the patient prepared to cope with a return to a home environment?
5. Has the patient sufficiently improved cognitively, emotionally and physically to be able to benefit from therapy at a lower level of care?

Sufficient for discharge: Yes to 6, 7, 8, or 9

6. Has the patient's progress plateaued and is continued care at this level unlikely to achieve a significant change in the patient's status in a reasonable length of time?
7. Is the patient being retained in a rehab setting solely for the purpose of awaiting housing placement?
8. Is the patient failing to comply with the expected requirements of the residential treatment setting?
9. Has the patient had a UDS indicating use of drugs or alcohol during the stay at the rehabilitation setting?

Substance Abuse and Dependence Diagnosis and Treatment

DSM-IV Diagnostic Criteria for Substance Abuse

Have any of the following occurred within a 12-month period?

1. Has recurrent substance use resulted in a failure to fulfill major role obligations at work, school, or home?
2. Has the patient used substances in which it is physically dangerous? (for example, driving while intoxicated)
3. Has the patient had any recurrent legal problem due to the substance use?
4. Has the patient continued to use substances despite having persistent social or interpersonal problems caused by the substance use?

DSM-IV Diagnostic Criteria for Substance Dependence

Have three or more of the following occurred at any time in the same 12-month period?

1. Is the patient tolerant to the substance? (Tolerance is defined as needing increasing amounts of the substance to achieve intoxication or a diminished effect with continued use of the same amount of substance)
2. Is the patient in withdrawal? (Signs and symptoms that are characteristic of the withdrawal from specific substances are present, or the substance must be taken to relieve withdrawal.)
3. Has the substance been taken in larger amounts or over longer periods of time than was intended?
4. Has there been a persistent desire or unsuccessful effort to cut down or control the use of the substance?
5. Is a great deal of time being spent in obtaining the substance or recovering from its use?
6. Have important social, occupational or recreational activities been given up or reduced because of substance abuse?

7. Has the use of the substance continued despite knowledge of having recurrent or persistent physical or psychological problems that are caused or made worse by the substance abuse?

   - **Specify:**
     With Physiological Dependence: Evidence of withdrawal or tolerance (Meets criteria 1 or 2 or both.)

Treatment Goals: Acute Phase of Treatment

1. Identify the drug(s) the patient has been taking
2. Identify risk of severe withdrawal symptoms
3. Identify the appropriate setting of the initial treatment of the patient

Treatment Plan

Specific considerations

1. In addition to establishing that the patient has substance abuse or dependence, the details of the patient's substance history must be elicited:

   - Names of all substances
   - Amounts of the substances ingested
   - Length of time the substances have been used.
   - Previous treatment:
     - Type of treatment
       - Detoxification
       - Rehabilitation
       - Outpatient treatment
       - Intensive outpatient
       - Methadone maintenance
     - Success of previous treatment
       - Use during treatment

- Length of time from cessation of treatment to next use
- What part of treatment was most helpful in maintaining sobriety
- Role of 12-step programs in recovery
- Medications used to assist in maintaining sobriety
- Family history of substance abuse/dependence

Psychiatric diagnoses

1. List any diagnosis(es) made concerning the patient
2. How long had the patient been sober when the diagnosis was made?
3. Treatment(s) for the psychiatric diagnosis:
   - Medication
   - Psychotherapy
   - Compliance
   - Date of last psychiatric treatment
   - Family history of psychiatric disorders

Alcohol

DSM-IV Diagnostic Criteria for Alcohol Withdrawal

Use same criteria for withdrawal from sedatives or benzodiazepines (Valium, Xanax)

A. Has there been a recent cessation of (or reduction of) alcohol use that has been heavy and prolonged?

B. Have two or more of the following developed within several hours to a few days after Criterion A?

1. Autonomic hyperactivity (sweating, rapid pulse)
2. Increased hand tremor
3. Insomnia
4. Nausea or vomiting
5. Transient visual, tactile, or auditory hallucinations or illusions
6. Psychomotor agitation
7. Anxiety
8. Grand mal seizures

Treatment Plan

Initial

Ninety percent of all patients experience only mild to moderate alcohol withdrawal symptoms.

- Severe alcohol withdrawal is a medical emergency and must be promptly treated.
- Detoxification
- Prevention of onset of withdrawal symptoms is key to treatment:
  - To retain patients in treatment
  - To prevent medical complications

SYMPTOMS OF ALCOHOL WITHDRAWAL

Time of Appearance	Symptoms: Mild to Moderate Alcohol Withdrawal	Symptoms: Severe Alcohol Withdrawal
Start: First 6-8 hours	Nausea, vomiting, tremor, insomnia, decreased appetite pulse increase	Same as mild to moderate, plus visual and auditory hallucinations Seizures
Next 1-2 days	Sweating, anxiety, irritability, blood pressure increase, headache, agitation, sensitivity to light and sound, concentration and orientation problems	Seizures, delirium tremens, increased agitation, disorientation, tremulousness, large increases in blood pressure, pulse and respiratory rate, increased body temperature, persistent visual and auditory hallucinations, disorientation
Up to six days		Seizures

TREATMENT REGIMENS FOR ALCOHOL WITHDRAWAL

Clonidine Withdrawal

Day	Time	Procedure and Dose
1	9:00 pm	0.2 mg clonidine orally Two transdermal clonidine #2 patches, one on each arm
3	Morning	Patch on one arm removed
4	Morning	Patch on other arm removed Patient closely observed
5	Morning	Patient observation concluded

MEDICAL MANAGEMENT OF ALCOHOL DETOXIFICATION

Symptom Triggered Medication Regimens	Structured Medication Regimens
1 Monitor the patient every 4-8 hours using CIWA-Ar scale until score is below 8-10 for 24 hours.	**1** One of the following medications is given at a set time interval: • Chlordiazepoxide [Librium] 50mg every 6 hours for 4 doses then 25 mg every 6 hours for 8 doses • Diazepam [Valium] 10 every 6 hours for 4 doses, then 5 mg every 6 hours for 8 doses • Lorazepam [Ativan] 2 mg every 6 hours for 4 doses, then 1 mg every 6 hours for 8 doses
2 Administer one of the following medications every hour when the CIWA-Ar is >8-10 • Chlordiazepoxide [Librium] 50-100 mg • Diazepam [Valium] 10-20 mg • Oxazepam [Serax] 30-60 mg • Lorazepam [Ativan] 2-4 mg	**2** Agitation. If increasing agitation and /or hallucinations are a problem: • Haloperidol [Haldol] 2-5 mg IM alone or in combination with Lorazepam [Ativan] 2-4 mg
3 Repeat CIWA-Ar one hour after every dose to assess the need for more medication to control symptoms of withdrawal	

SPECIAL NOTES

1. Benzodiazepines are well absorbed when taken orally and are, in general, not well absorbed when injected - with the exception of Lorazepam [Ativan].
2. Alcohol and benzodiazepines can be a dangerous mix. Early in the detoxification process, the patient must be carefully monitored if alcohol can be detected in the patient

NOTE: Usually, detoxification is a treatment that leads to another level of care such as rehabilitation. Used in isolation, the patient will almost always return to abusing substances soon after the discharge from the detoxification process.

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged
- Appropriate living circumstances are arranged
- Community supports are identified for patient
- Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care
- Access to medications is arranged
- Case management, if indicated, is arranged.

Sedatives, Hypnotics and Anxiolytics

GENERIC AND BRAND NAMES OF SEDATIVES, HYPNOTICS AND ANXIOLYTICS

Benzodiazepines	Barbiturates	Others
Alprazolam [Xanax]	Amobarbital [Amytal]	Choral Hydrate [Nortec, Somnos]
Chlordiazepoxide [Librium]	Butabarbital [Barbased, Butisol]	Ethchlorvynol [Placidyl]
Clonazepam [Klonopin]	Butalbital [in Fiorinal]	Ethinamate [Valmid]
Clorazepate [Tranxene]	Pentobarbital [Nembutal]	Glutethimide [Doriden]
Diazepam [Valium]	Phenobarbital [Luminal]	Meprobamate [Equanil, Miltown]
Estazolam [ProSom]	Secobarbital [Seconal]	Methaqualone [Quaalude]
Flurazepam [Dalmane]		Methyprylon [Noludar]
Halazepam [Paxipam]		
Lorazepam [Ativan]		
Oxazepam [Serax]		
Prazepam [Centrax]		
Quazepam [Doral]		
Temazepam [Restoril]		
Triazolam [Halcion]		

SEDATIVE-HYPNOTIC DOSE CONVERSION FOR WITHDRAWAL SUBSTITUTION

10 milligrams of Diazepam [Valium] is equal to:

Benzodiazepines		Barbiturates		Other	
Clorazepate (Tranxene)	15 mg	Amobarbital [Amytal]	100 mg	Ethchlorvynol [Placidyl]	300 mg
Clonazepam [Klonopin]	1-2 mg	Butalbital [in Fiorinal]	100 mg	Glutethimide [Doriden]	250 mg
Alprazolam [Xanax]	0.5 mg	Pentobarbital [Nembutal]	50-100 mg	Methyprylon [Noludar]	200 mg
Estazolam [ProSom]	2 mg	Phenobarbital [Luminal]	30 mg	Methaqualone [Quaalude]	300 mg
Chlordiazepoxide [Librium]	25 mg	Secobarbital [Seconal]	100 mg	Meprobamate [Equanil, Miltown]	400 mg
Flurazepam [Dalmane]	15 mg			Carsoprodol [Soma]	700 mg
Lorazepam [Ativan]	2 mg			Choral Hydrate [Nortec, Somnos]	500 mg
Oxazepam [Serax]	10 mg				
Quazepam [Doral]	15 mg				
Temazepam [Restoril]	15 mg				
Triazolam [Halcion]	0.25mg				

Withdrawal from Sedatives, Hypnotics and Anxiolytics

Basic Principles

1. The intensity of the withdrawal symptomatology and the length of time of withdrawal is influenced by the:
   - Amount of the dosing
     - Higher doses taken over time produce more intense withdrawal.
   - The duration of the drug action
     - Medications with a longer duration of action may produce a longer time of withdrawal.
2. After the initial phase of withdrawal, there may be a prolonged period of withdrawal symptomatology that may last a year or longer.
3. The acute detoxification from this group of drugs may take weeks to accomplish.
4. This withdrawal can be quite difficult, with significant patient discomfort despite appropriate medical management.
5. Usually phenobarbital is used to accomplish the detoxification.

SEDATIVE-HYPNOTIC WITHDRAWAL SYMPTOMS

Mild	Moderate	Severe
Anxiety	Panic	Decreased body temperature
Insomnia	Decreased Concentration	Vital sign instability
Dizziness	Tremor	Muscle fasciculations
Headache	Sweating	Seizures
Loss of appetite	Palpitations	Delirium
Increased perception of sound	Perceptual Distortions	Psychosis
Irritability	Muscle Aches	
Agitation	GI upset	
	Insomnia	
	Elevated vital signs	
	Depression	

Cocaine

DSM-IV Diagnostic Criteria for Cocaine Intoxication

A. Is there a history of a recent use of cocaine?

B. Have clinically significant behavioral or psychological changes developed during the use of cocaine?

C. Have two or more developed during or shortly after the use of cocaine?

1. Increased or decreased heart rate
2. Dilated pupils
3. Elevated or lowered blood pressure
4. Sweating or chills
5. Nausea or vomiting
6. Evidence of weight loss
7. Psychomotor agitation or retardation
8. Muscular weakness, decreased respiration, chest pain, or irregular heart rate
9. Confusion, convulsions, abnormal movements, or coma

Treatment Plan

Specific considerations for the management of cocaine intoxication

NOTE: Cocaine is a psychostimulant, often resulting in agitated, disorganized behavior. Medical complications can result from cocaine abuse.

BEHAVIORAL EFFECTS OF ACUTE COCAINE INTOXICA TION

Behavior	Degree of presence
Generally “abnormal” in appearance	Mild
Disorientation	Not present
Memory dysfunction	Mild
Inappropriate and degree of affect	Moderate
Altered mood: depressed	Usually mild, sometimes severe
Altered mood: Elated, euphoric	Very common, highly characteristic
Confused, disorganized	Moderate
Hallucinations	Common
Delusions	Usually none, rarely severe
Bizarre Behavior	Moderate
Poor Judgement	Common
Homicidal or danger to others	May be severe
Suicidal or danger to self	May be severe

MEDICAL EFFECTS OF COCAINE INTOXICATION

Organ System	Medical Effects
Head and Neck	Dilated pupils Sudden headache Grinding of teeth
Pulmonary	Increased rate and depth of respiration Difficulty breathing Pulmonary edema Respiratory failure
Cardiovascular	Increased pulse, 30-50% above normal Increased blood pressure, 15-20% above normal Pale skin due to vasoconstriction Possible circulatory failure Myocardial ischemia Arrhythmia Myocardial infarction, cardiogenic shock
Neurological	Tremor Twitching of small muscles of face, hands and feet Cold sweats Pre-convulsive movements (muscle jerks) Seizures Coma Cerebral edema Stroke
Gastrointestinal	Nausea and vomiting
Renal	Renal failure Urinary incontinence
Body Temperature	Increased body temperature from mild elevations to severe hyperthermia
Other	Skeletal muscle breakdown Hepatic insufficiency

SYMPTOMS AND TREATMENT OF COCAINE WITHDRAWAL

Phase	Time Course	Symptoms	Treatment
Crash			
	Starts right after binge	Stimulant craving	Assess neurological and physical status Obtain urine drug screen.
Initial crash		Intense dysphoria-depression, anxiety, agitation	Obtain history of other drug and past psychiatric history.
Middle crash	Starts 1-4 hours after binge	Craving replaced by a desire for sleep, despite having insomnia	Observe closely, take suicide precautions, if necessary.
Late Crash	Last 3-4 days	Hypersomnia, increased appetite	Allow patient 3-4 days in a quiet environment to recover and to eat and to sleep as much as is needed.
Withdrawal			
Honeymoon phase	Lasts 12 hours to 4 days	Normalization of sleep Fairly normal mood (with only mild dysphoria) Reduced craving	Evaluate for other drug use and past history of psychopathology Pharmacotherapy for stimulant withdrawal has not yet been established
Dysphoria, craving	Lasts 6-18 weeks	Withdrawal symptoms emerge: depression, lethargy, anhedonia	Initiate outpatient treatment program: groups, individual psychotherapy, education, urine monitoring, steps to avoid drug taking situations
Extinction			
	Lasts months to years	Gradual return of mood, interest in environment, and ability to experience pleasure. Gradual extinction of periodic craving episodes.	Relapse prevention techniques and participation in long-term and self-help groups.

Inhalants

DSM-IV Diagnostic Criteria for Inhalant Intoxication

A. Is there a history of recent intentional use of exposure to volatile inhalants (aerosol propellants, gasoline, glue, etc.)?

B. Have clinically significant maladaptive behavioral and/or psychological changes developed during or shortly after exposure to the inhalant?

C. Have two or more of the following developed during or shortly after the use of inhalants?

1. Dizziness
2. Nystagmus (abnormal eye movements)
3. Incoordination
4. Slurred speech
5. Unsteady gait
6. Lethargy
7. Abnormal reflexes (decreased)
8. Psychomotor retardation
9. Tremor
10. Generalized muscle weakness
11. Blurred or double vision
12. Decreased level of consciousness
13. Euphoria

Treatment Plan

Specific Considerations

- Inhalants are most commonly used by children and adolescents.
- Inhalants are readily available in the patient's environment.
- Inhalants are inexpensive and easy to obtain.
- Certain inhalants [hydrocarbons] can cause severe permanent neurological damage.

CHEMICALS FOUND IN INHALANTS

Product	Chemicals
Adhesives	
Airplane glue	Toluene, ethyl acetate
Rubber Cement	Hexane, toluene, methyl chloride, methyl ethyl ketone, methyl butyl ketone
PVC Cement	Trichloroethylene
Aerosols	
Paint Sprays	Butane, propane, fluorocarbons, toluene, hydrocarbons
Hair Sprays	Butane, propane, fluorocarbons
Deodorants, air fresheners.	Butane, propane, fluorocarbons
Analgesic spray	Fluorocarbons
Asthma spray	Fluorocarbons
Anesthetics	
Gases	Nitrous oxide
Liquid	Halothane, enflurance
Locals	Ethyl chloride
Cleaning Agents	
Dry cleaning fluid	Tetrachloroethylene, trichloroethane
Spot removers	Tetrachloroethylene, trichloroethane, trichloroethylene
Degreasers	Tetrachloroethylene, trichloroethane, trichloroethylene
Solvents	
Nail polish remover	Acetone
Paint remover	Toluene, methylene chloride, methanol
Paint thinners	Toluene, methylene chloride, methanol
Correction fluid thinner	Trichloroethylene, trichloroethane
Fuel gas	Butane
Lighter fluid	Butane, isopropane
Fire extinguisher propellant	Bromochlorodifluoromethane
Food Products	
Whipped cream	Nitrous oxide
Other	
“Rush”. “poppers”	Amyl nitrite, butyl nitrite, isopropyl nitrite, butyl nitrite

Marijuana (Cannabis)

DSM-IV Diagnostic Criteria for Cannabis Intoxication

1. Has the individual used cannabis recently?
2. Have clinically significant maladaptive behavioral or psychological changes developed during or shortly after cannabis use? Examples include:
   - Impaired motor coordination
   - Anxiety
   - Sensation of slowed time
   - Impaired judgement
   - Social withdrawal
3. Have two or more of the following signs developed within two hours of cannabis use?
   - Conjunctival injection (red eyes)
   - Increased appetite
   - Dry mouth
   - Tachycardia (increased heart rate)

DSM-IV Diagnostic Criteria for Cannabis Dependence

1. Use criteria for Substance Dependence (see above)

Treatment

Specific Considerations

- Marijuana is a gateway drug, its use frequently leading to other drug use.
- Marijuana is an addicting substance with a physiological withdrawal syndrome with the following symptoms:
  - Insomnia
  - Nausea
  - Anorexia
  - Agitation
  - Irritability
  - Depression
  - Tremor
- The withdrawal syndrome from marijuana looks very much like the withdrawal from opiate dependence.
- The withdrawal from marijuana does not require detoxification or special medical management.
- Marijuana use is frequently a part of the picture with the individual who is abusing many substances.
- Tolerance to marijuana develops quickly and continues for a long time after the last dose.
- Marinol is a medical form of marijuana used to stimulate appetite in individuals with certain physical illnesses such as AIDS and cancer. Taking this medication will make the urine drug screen positive for marijuana.
- Passive inhalation (such as being in a car or a room where marijuana is being smoked, but the individual not smoking marijuana) will not produce positive urine drug screens for marijuana.

Opiates

DSM-IV Diagnostic Criteria for Opioid Intoxication

A. Is there a history of a recent use of an opiate?

B. Have clinically significant maladaptive behavioral and/or psychological changes developed during or shortly after exposure to the opioid?

C. Is there evidence of constricted pupils and one or more of the following:

1. drowsiness or coma
2. slurred speech
3. impairment in attention or memory

DSM-IV Diagnostic Criteria for Opioid Withdrawal

A. Is either of the following present?

1. Reduction or cessation of opiate use after use that is prolonged and heavy
2. Administration of an opiate antagonist after a period of opiate use.

B. Are there three or more of the following present?

1. Dysphoric mood
2. Nausea or vomiting
3. Muscle aches
4. Tearing or runny nose
5. Pupils are dilated, goose flesh, sweating
6. Diarrhea
7. Yawning
8. Fever
9. Insomnia

Treatment Plan

Specific Considerations

- Heroin is the most commonly abused opiate, although any opiate can be abused, including prescription opiates.
- Currently, the heroin in the Philadelphia area is very pure.
- Heroin is becoming a common drug of abuse among adolescents.
- The treatment of the opiate addict should be considered to be a long-term process.
- The treatment of opiate addicts involves a number of approaches, including agonist treatment (methadone).
- Death from accidental overdose is not uncommon.
- Withdrawal symptoms from opiates are very unpleasant, but not life threatening.
- Concurrent addiction to other substances (alcohol and benzodiazepines) is quite common.
- Heroin addicts require a dose of heroin (a fix) approximately every 4-6 hours to prevent withdrawal.

The physical signs of opiate withdrawal are easy to observe.

CLINICAL MANIFESTATIONS OF OPIOID WITHDRAWAL

Vital Signs	Increased heart rate Elevated blood pressure Fever
Central Nervous System	Restlessness Irritability Insomnia Craving Yawning
Eyes	Dilation of pupils Tears
Nose	Runny nose
Skin	Goose flesh
Gastrointestinal	Nausea Vomiting Diarrhea

Detoxification Schedules

Methadone

1. Detoxification with methadone, usually starting at 30-40 mgs and remaining there for 3-4 days, then decreasing by 10 mg until the last 10mg then down by 5 mg—a fairly fast detoxification.
   - Day 1 - 30mg in a single dose
   - Day 2 - 20 mg
   - Day 3 - 10mg
   - Day 4 - 5 mg
   - Stop
2. Start with 30-40 mg; stay there for 3-4 days then decrease by 15% per day.

Clonidine

0.2 mg every 4 hours for 3 days, then taper the dose by 0.2 mg every day or every other day until dose is zero.

Opiate Maintenance Treatment

Currently, methadone and levo-alpha-acetylmethadol (LAAM) are the only opioid agonist medications approved for maintenance of opiate addicts. New medications are expected to be approved in the near future.

Goals of Methadone Maintenance Treatment (MMT) or LAAM

- Prevention or reduction of withdrawal symptoms
- Prevention of relapse
- Prevention of drug craving
- Restoration to (or toward) normal of any physiological disruption of any physiological function disrupted by chronic drug abuse
- Patients are neither intoxicated nor in withdrawal over a 24-hour period

Process of entry into a Methadone Maintenance Program

- Individuals may self-present to Methadone Maintenance Programs.
- Individuals may be referred to Methadone Maintenance Programs.
- Methadone Maintenance is a long-term treatment (2 years or more)
- Methadone Maintenance may not be started on an inpatient basis, except at facilities having a special state license to do so.
- There are no emergency admissions to MMT programs.

Substance-Induced Mood Disorder

DSM-IV Diagnostic Criteria for Substance-Induced Mood

A. Is there a prominent and persistent disturbance in mood that dominates the clinical picture? Either or both of the following must be present:

1. Depressed mood or markedly diminished in all or almost all pleasurable activities
2. Elevated, expansive or irritable mood.

B. Is there evidence of either of the following?

1. The symptoms in Criterion A developed during or within a month of Substance Intoxication or withdrawal.
2. The use of medication is causally related to the disturbance

C. Is the disorder better accounted for by the diagnosis of another Mood Disorder?

D. Did the disturbance occur during a delirium? **(must be no)**

E. Did the symptoms cause significant distress or impairment in important areas of life function?

Treatment Goals: Acute Phase of Treatment

- Identify the substance used or abused by the patient. (This may a substance with a known potential for abuse and addiction, or a medication, such as a blood pressure medication).
- Identify risk of severe withdrawal symptoms.
- Identify time of last use of substance.
- Diagnosis cannot be made if signs and symptoms of intoxication are present.

Specific Considerations

1. Mood disorders are the most common of all the substance induced disorders
2. A thorough history from friends, family and other health professionals may be required to establish the diagnosis.

3. Establishing the relationship between the use of psychoactive substances and the symptoms of mood disorder is a crucial step.
4. Exploring the mood during periods of sustained abstinence from all depressive drugs is critical for the diagnosis.
5. Chronic use of alcohol, sedatives and opiates can cause depressed mood.
6. Withdrawal from stimulants and sedatives can also cause depressed mood.

Specific Substances

- **Alcohol:** alcohol induced depression should remit over the first 2-3 weeks of abstinence.
- **Cocaine:**
  - Usually the depression induced by cocaine is short lived, a day or two.
  - The depression caused by cocaine withdrawal may be more serious and last considerably longer.
- **Benzodiazepines:** the depression induced by benzodiazepines can be serious and severe.

Suicidality

- Individuals with substance induced disorder may be seriously suicidal.
- Relapse into substance use may place the patient at special risk because:
  - Intoxication causes disinhibition.
  - While intoxicated, the consequences of actions are not taken into account.

Diagnosis

For the individual with a valid diagnosis of a substance abuse disorder and a substance-induced mood disorder, the initial treatment setting must be able to address:

- Withdrawal
- Detoxification
- Engagement in recovery process
- Education about addictions
- Medications used (and avoided) in the treatment of Substance-Induced Mood Disorder
- Issues of patient safety
- Psychiatric emergencies

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Substance-Induced Psychotic Disorder

DSM-IV Criteria for Substance-Induced Psychotic Disorder

A Are there prominent hallucinations or delusions? (Do not include hallucinations if the person has insight that the hallucinations are substance-induced.)

B Is there evidence from the history, physical examination, or laboratory findings or either (1) or (2)?

1. The symptoms in Criterion A developed during or within a month of substance intoxication or withdrawal.
2. Medication use is related to the disturbance.

C Is the disturbance better accounted for by a psychotic disorder that is not substance induced?

Evidence that the psychotic disorder is not substance induced includes:

- The symptoms precede the onset of the substance use.
- The symptoms persist for a substantial period of time (about a month) after acute withdrawal or intoxication.
- The symptoms are in excess of what would be normally expected from the type or amount of the substance.

Treatment Planning

Specific Considerations

- The accurate diagnosis of this condition may be difficult depending on the particular circumstances of the patient's situation.
- This disorder is time limited.
- Antipsychotics may be required but usually only on a short-term basis.
- The patient's behavior may be significantly disturbed and the safety of the patient and others must be carefully considered.

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Family education, if indicated, is conducted before discharge.
- Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Acute Inpatient Treatment

Acute treatment represents a level of care designed to meet the needs of patients who have psychopathology resulting in emotional and behavioral manifestations that require an inpatient setting, and represent an imminent threat to themselves or others. The level of clinical intervention that distinguishes acute inpatient treatment is 24 hours per day/seven days per week psychiatric nursing supervision and ongoing assessment. Twenty-four hour monitoring by a multidisciplinary team of behavioral health professionals is required for the patients to remain safe, to be effectively treated and to progress to a less restrictive level of care. The primary consideration for the selection of acute care is the type and acuity of symptoms in the patient's clinical presentation. The safety of patients is of paramount importance; a thorough evaluation of suicidal ideation, homicidal ideation and ability to care for self must be conducted. Patients whose symptoms place them at acute risk of harm to self or others must be admitted to the acute setting. Patients in the acute setting may lack adequate impulse control, the ability to cooperate with the staff of the inpatient unit, the ability to communicate effectively with the inpatient staff, and to accomplish activities of daily living without significant support. Diagnosis, per se, should not be the primary consideration in the selection of this level of care.

Typical care in the acute setting involves:

- daily psychiatric nursing evaluations
- direct services by a Board Certified psychiatrist seven days a week
- medication management in a highly structured therapeutic setting
- psychotherapeutic interventions as indicated.

The therapeutic setting is capable of managing patients who require substantial support to deal with their symptoms and situation. The staff in the acute setting must be of sufficient number and skill to manage violence that results from the patient's psychopathology. Psychiatric and medical physician services are available 24 hours per day, seven days a week for emergencies.

Consults appropriate to the patient's condition are conducted and non-acute medical problems are managed. Patients and their families receive psychoeducation relevant to their particular situation.

Indicators for discharge from an acute setting

Patients are discharged from the acute setting when their symptoms have decreased to a level that no longer requires 24-hour a day monitoring and support. Indicators for discharge include improved impulse control, medication compliance, positive response to medications, effective communication and accomplishment of activities of daily living with minimal support. Significant symptoms may remain at the conclusion of a stay in the acute setting, but can be effectively treated and managed in a less restrictive level of care. Suicidal and homicidal ideation and intent must be carefully evaluated prior to release from the acute setting and, if present, must have diminished to a level that can be safely managed at a lower level of care. Thorough documentation of the risk to self or others must be included in the medical record. Linkages to the next level of care, specifically psychiatric management, psychotherapy, and family support must be firmly in place prior to discharge. Arrangements for having support and/or vocational counseling or rehabilitation should be in place, as well. Patients and their families are centrally involved in the therapeutic process, treatment planning and discharge planning.

Indications for admission to acute inpatient treatment for children and adolescents

The clinical indications for acute inpatient admission and treatment of children and adolescents are the same as adults. However, the typical clinical presentations requiring acute inpatient care are determined by the youngsters' developmental levels. Acute inpatient treatment is designed to address their clinical problems and their emotional, intellectual, social, and educational needs as children and adolescents. The need for acute inpatient treatment for children and adolescents includes:

- imminent threat to themselves or others due to psychopathology
- marked emotional distress that is otherwise intolerable to the child
- marked lack of self-care otherwise appropriate for the child's age and developmental level
- the onset of disturbed behavior or emotional states that has not been already fully assessed
- serious medical conditions that are complicated by severe behavioral disturbance, or
- lack of treatment response for severe psychopathology in less restrictive settings.

The child's threat to self or others may be unique to her/his age, such as the repeated running away of a young adolescent who subsequently lives on the streets, homeless without adult supervision or protection for days or weeks on end. The core clinical needs of a child or adolescent who requires acute inpatient care are the same as adults, including: 24 hours a day/seven days a week psychiatric nursing care, and an intensive multidisciplinary treatment team headed by an attending child and adolescent psychiatrist, daily child psychiatric intervention, and 24 hours per day/seven days per week availability of psychiatric and medical physician services for emergencies. The child or adolescent acute inpatient clinical service should provide a highly structured therapeutic setting with psychotherapeutic and psychotropic medication interventions. The setting should be capable of managing children and adolescents who require substantial therapeutic support to deal with their emotional and behavioral disturbances, including the need to manage agitation and violence that results from the youngster's psychopathology.

Because of the importance of the family and parents in every child's life, the involvement of parents and close family members in the ongoing assessment, stabilization, treatment planning, treatment and aftercare planning is centrally important to acute inpatient care for these young patients. Aftercare planning for a child or adolescent receiving acute inpatient treatment should be actively pursued by the inpatient treatment team from the time of admission. The inpatient team needs to coordinate aftercare planning through the use of timely interagency planning meetings with the child's parents/guardians, but also with other agencies involved with the child, especially the child's school and aftercare treatment provider. Other agency representatives assigned to assist a given child who has been treated with psychiatric hospitalization should be included in the interagency aftercare planning meetings when appropriate, such as DHS workers, child advocate attorneys and caseworkers, SCOH workers, probation officers and targeted case managers.

Indicators for discharge from acute inpatient care

Indicators for discharge from acute inpatient care for patients of all ages include:

- improved impulse control
- lessening and control of any symptom-related dangerousness to patient's self or others
- willingness to take medications as prescribed
- positive response to treatment

- more appropriate social interactions for the patient's given developmental level and
- the ability to manage personal care appropriate to the patient's developmental and adaptive capabilities.

Significant symptoms may remain at the conclusion of a stay in the acute setting, but can be effectively treated and managed in a less restrictive level of care. Suicidal and homicidal ideation and intent, and other high-risk behaviors, such as fire setting, must be carefully evaluated prior to release from the acute inpatient setting and, if present, must have diminished to a level that can be safely managed at a lower level of care. Thorough documentation of the risk to self or others must be included in the medical record. Linkages to the next level of care, specifically psychiatric management, psychotherapy, treatment programming, and family support must be firmly in place prior to discharge. Arrangements for having support and/or vocational counseling or rehabilitation for adult patients should be in place at the time of discharge. Child and adolescent patients should have comprehensive planning and recommendations completed for appropriate educational services after discharge, including the possible need for special education services.

Subacute Inpatient Treatment

Subacute treatment represents a level of care designed to meet the needs of patients who have psychopathology resulting in emotional and behavioral manifestations that require an inpatient setting, but do not represent an imminent threat to themselves or others. Twenty-four hour monitoring by a multidisciplinary team of behavioral health professionals is required for the patients to remain safe, to be effectively treated, and to progress to a less restrictive level of care. The primary consideration for the selection of subacute care is the type and acuity of symptoms. The safety of the patients is of paramount importance. A thorough evaluation of suicidal ideation, homicidal ideation and ability to care for self must be conducted. Patients whose symptoms place them at acute risk of harm to self or others must not be admitted to the subacute setting. Patients in the subacute setting should have adequate impulse control, as well as the ability to cooperate with the staff of the inpatient unit, to communicate effectively with the inpatient staff and to accomplish activities of daily living with minimal support. Diagnosis, per se, should not be the primary consideration in the selection of this level of care.

Typical care in the subacute setting involves: daily psychiatric nursing evaluations, direct services by a Board Certified psychiatrist at least three times weekly, and medication management in a structured, therapeutic setting, psychotherapeutic and social interventions. For children and adolescents, maintenance of academic studies and focus on social skills building are essential. The therapeutic setting is capable of managing patients who require substantial support to deal with their symptoms and situation. Psychiatric and medical physician services are available 24 hours per day, seven days a week for emergencies.

Patients and their families are centrally involved in the therapeutic process, treatment planning and discharge planning. Consults appropriate to the patient's condition are conducted and non-acute medical problems are managed. The patients and their families receive psychoeducation relevant to their particular situation. Patients are discharged from the subacute setting when their symptoms have decreased to a level that no longer requires twenty four-hour a day monitoring and support. Indicators for discharge include good impulse control, medication compliance, effective communication and the accomplishment of activities of daily living consistent with the developmental capabilities of the patient. Significant symptoms may remain at the conclusion of a stay in the subacute setting, but these symptoms can be effectively treated and managed in a less restrictive level of care.

Medical Necessity Criteria for Acute and Subacute Inpatient Hospitalization

Acute Inpatient Admission Criteria

I. Has the patient had an evaluation by a psychiatrist that establishes a psychiatric diagnosis or a provisional psychiatric diagnosis?
(Answer must be yes for admission)

A. Is this diagnosis solely due to substance abuse, mental retardation, or a cognitive disorder? **(Answer must be no for admission)**

II. **The answers to all the following questions are yes.**

A. Does the patient require 24-hour availability of services for diagnosis, monitoring, and assessment?

B. Does the patient require the availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan?

C. Does the patient require the involvement of a psychiatrist in the development and management of the treatment plan?

D. Does the patient require 24-hour availability of psychiatric nursing to implement the treatment plan and monitor the patient's condition and response to treatment?

E. Does the patient require 24-hour clinical management and supervision?

III. **The answer to one or more of these questions is yes.**

A. Does the patient represent a significant risk of harm to self, others, or to the destruction of property?

B. Does the patient have a psychiatric medical condition and physical illness that may compound one another and may result in a medical crisis or medical instability?

C. Is the patient so impaired by the psychiatric condition that the patient's judgement, self-care, social and/or occupational functioning are severely threatened?

D. Does the patient require psychiatric care that would be medically unsafe if administered at a lower level of care?

E. Have the patient's symptoms increased to a degree of severity that this level of care is required to prevent deterioration to a level that may result in danger to self, others or property?

Subacute Inpatient Admission Criteria

Does the patient have a behavioral disturbance that requires an inpatient setting?

Does the patient meet the following criteria? **(All must be answered yes.)**

- The patient is not an immediate threat to self or others.
- The patient has adequate impulse control.
- The patient is able to cooperate with the ward staff.
- The patient can accomplish activities of daily living [ADLs] with minimal or no assistance.
- The patient can communicate effectively with staff.
- The patient requires a 24-hour per day nursing supervision to maintain safety.

FOR CHILDREN AND ADOLESCENTS

- An appropriately executed 201 voluntary commitment, or a court ordered 303 involuntary commitment is in place.
- A comprehensive typewritten psychiatric evaluation has been completed within 10 days of admission. A new evaluation is unnecessary, because the clinical needs of the patient have not changed and aftercare recommendations have not been revised.
- Physical health conditions must be stabilized and in a routine maintenance phase of management.

Narrative Requirements for Acute and Subacute Admission

Focus on current symptoms

- Describe current behavior
- Describe current Mental Status
- Focus on suicidal ideation (SI), homicidal ideation (HI), psychotic, neurovegetative, affective and other symptoms of sufficient severity that the patient is unable to meet basic needs.

Medications

- Names, doses and frequency of dosing, compliance
- Side effects

Other

- Living situation
- Medical problems
- Substance abuse
- Initial diagnosis
- Initial treatment plan

Past History of risk indicators

- Significant suicide attempt
- Successful homicide or serious injury to others
- Forensic history and status
- For children and adolescents, history of physical/sexual abuse

Continued Stay Criteria for Acute and Subacute Treatment

Must meet criteria in I and II.

I. **The answer to one or more of the following is yes.**

A. Does the patient have a persistence of symptoms that meet admission criteria?

B. Have new symptoms developed that meet admission criteria?

C. Has the patient had an adverse reaction to medication; procedures or therapies that require continued hospitalization?

D. Will the withdrawal of inpatient services likely result in decompensation that can not be managed at a lower level of in care?

II. **The answers to all of the following are yes.**

A. Has a physical exam been completed within 24 hours of admission?

B. Has a psychiatrist conducted a psychiatric examination within 24 hours of admission?

C. Is the patient participating in treatment and discharge planning?

D. Does the treatment plan reflect appropriate care for the patient's needs?

Narrative Requirements for Acute and Subacute Continued Stay

Focus on treatment and resolution of symptoms

- Mental Status Changes
- Medications:
  - Names
  - Doses
  - Frequency of doses
  - Response to medications
  - Side effects
  - Compliance

Discharge Criteria for Acute Inpatient Treatment

I. **All of the following must be answered yes for discharge:**

A. Have the patient's symptoms been reduced to a level that the patient's treatment can be managed at a lower level of care?

B. Have any psychiatric medical conditions diminished in severity such that they can be managed at a lower level of care?

C. Can the improvements in the mental and physical status be maintained at a lower level of care?

D. Does the patient no longer represent a danger to self, others or property?

E. Has an effective discharge plan been developed?

OR

If the reason for admission was a diagnostic evaluation and/or a medical treatment, has this been completed?

OR

Has the patient left against medical advice and does not meet criteria for involuntary commitment?

OR

Has the patient been transferred to another facility for continued care?

Discharge Criteria for Specific to Subacute Inpatient Treatment

All of the following must be answered yes.

- Have the patient's symptoms resolved to a sufficient degree that 24-hour/day monitoring is not required?
- Is the patient compliant with medication?
- Are ADLs accomplished with problems?
- Does the patient have good impulse control?
- Is the patient communicating effectively with staff?

FOR CHILDREN AND ADOLESCENTS

- Are ADLs appropriate to the patient's developmental capabilities maintained by the patient?
- Does the patient have improved impulse control to allow for clinical management at a lower level of care?
- Is the patient effectively communicating with staff appropriate to the patient's developmental capabilities?

Narrative Requirements for Subacute Discharge

- Discharge Criteria in RFP are met [see above Psychiatric Inpatient Services]

Partial Hospitalization

Partial hospitalization is a treatment program that combines elements of the inpatient and outpatient setting in a structured, therapeutically intensive treatment program that coordinates clinical services to achieve a stable therapeutic milieu. Partial hospitalization offers an alternative to hospitalization for individuals who represent no imminent danger to themselves or others.

The treatment program in partial hospital settings must have a specified structure and be offered within a specific time framework. Clear guidelines for admission, evaluation, effectiveness of treatment and discharge are necessary for a partial hospitalization program. Signs and symptoms of behavioral disorders are carefully and continuously monitored in this setting to document progress or regression. Prompt and effective intervention with the individual who is exhibiting increased symptomatology is a hallmark of a partial hospitalization program and often averts hospitalization. Crisis intervention may also be a focus of treatment.

Partial hospitalization programs exist for all age groups and a variety of diagnostic categories. Addictive disorders may be treated in partial programs and specialized programs for patients with co-morbid psychiatric disorders and addictive disorders.

Admission to a partial program often follows an inpatient stay. The individual exiting the hospital may have significant residual symptomatology and disability and require the intensive treatment of a partial hospital program to remain stable and/or progress in the resolution of symptoms. Other individuals may be admitted from lower levels of care as an alternative to admission to the hospital. Once the individual has made sufficient progress, discharge from the partial hospital setting to a lower level of care may be possible.

Medical Necessity Criteria for Partial Hospitalization

Admission Criteria

I. The answer to one of the following must be yes

A. Does the patient have an established history of a psychiatric disorder with current symptoms that require this level of care?

B. If the patient lacks a history of a psychiatric disorder, has a psychiatrist, or a licensed clinical psychologist confirmed a psychiatric diagnosis that requires this level of care?

C. Has the patient had an evaluation by a psychiatrist, or a licensed clinical psychologist at another mental health facility who is recommending direct referral to this level of care?

D. Does the patient need a diagnostic evaluation that cannot be performed at a lesser level of care?

II. One of the following must be answered yes for admission to partial hospital:

A. Does the patient have the ability to participate in the partial hospitalization level of care? Specific considerations include:

- Does the patient require intensive biopsychosocial interventions?
- Can the patient be safely maintained at home or in a structured residence?
- Does the severity of the patient's condition prohibit maintenance at a lower level of care?

OR

B. Has the patient had an adverse reaction to medication, procedures, or therapies that requires frequent monitoring that cannot be managed at a lower level of care?

III. All of the answers to the following must be yes:

A. Is the patient receiving active treatment within the framework of a multidisciplinary individualized treatment plan?

B. Is a psychiatrist involved in the development and management of the treatment plan and program?

C. Is the treatment plan for discharge modified in keeping with the changing clinical picture of the patient?

D. Is the patient an active participant in discharge planning?

E. When appropriate, are members of the patient's family and community supports involved with treatment and discharge planning?

Narrative Information Required

SYMPTOMS

Describe the nature and severity of the patient's symptoms in detail.

MEDICATIONS

Names
Doses
Frequency of Doses
Blood levels if applicable
Response
Side effects
Compliance

TREATMENT PLAN

Plans developed for discharge and/or lower level of care.

Discharge Criteria

I. All of the following must be answered yes:

A. Have the symptoms, functional impairments and/or medical problems that warranted admission diminished in severity sufficiently that the patient can be managed at a lower level of care?

B. Will treating the patient at a lower level of care sustain and support the improvement attained at the partial hospital level of care?

C. Has an effective discharge plan been developed and have the treatment providers at a lower level of care agreed to provide care for the patient?

OR

II. One of the following must be answered yes.

A. If the sole reason for admission was to perform a diagnostic evaluation, has it been completed?

B. Has the patient withdrawn from treatment against advice and does not meet criteria for involuntary treatment?

C. Has the patient been transferred to another facility for care?

Psychiatric Outpatient Care

Psychiatric outpatient care encompasses a wide range of therapeutic modalities that are usually based in an office setting. Psychiatric evaluations, psychotherapy, psychoeducation, treatment of addictive disorders, family therapy, behavioral therapy, psychopharmacology and many other modalities are conducted in the psychiatric outpatient setting. Individuals engaged in treatments in this setting are no imminent danger to themselves or others and are generally functional in their social and occupational/school roles. The issues addressed may be of a focal nature in a time-limited framework, be addressed in long-term psychotherapy or psychopharmacological maintenance. Often, outpatient care is used to maintain the gains made at a higher level of care or to continue the work initiated at a higher level of care.

Admission Criteria

I. Has a mental health professional determined that this level of care is appropriate for this patient? If so, what are the identified symptoms, degree of impairment, and diagnosis?

II. **One of the following must be answered yes:**

A. Does the patient have a psychiatric illness evidenced by a reduced level of functioning and/or subjective distress in response to an acute event?

B. Does the patient have signs and symptoms of a psychiatric illness that are causing reduced function and/or subjective distress?

C. If the patient has a history of psychiatric illness and is in remission, will the patient regress without this level of care?

D. Has a comprehensive evaluation been conducted that includes the following elements: psychiatric diagnosis, medical diagnosis; psychological, educational, social and vocational factors?

Continued Care Criteria

I. Does the patient have a current psychiatric diagnosis or a provisional diagnosis?

II. **One of the following must be answered yes:**

A. Does the patient exhibit one or more of the symptoms that prompted admission?

B. Can the patient be expected to benefit from this level of care?

C. Has the patient developed new symptoms that can be managed effectively at this level of care?

D. Given the patient's history, will withdrawal of treatment result in decompensation or regression?

III. **All of the following must be answered yes:**

A. Is the patient an active participant in treatment and discharge planning?

B. Has a psychiatrist reviewed and approved the treatment plan?

C. Does the treatment plan include a discharge plan? (Are the goals and objectives defined and measurable?)

D. Has the treatment plan been changed to meet the changing needs of the patient?

E. Is the care the patient is receiving based on a multidisciplinary, individualized treatment team approach?

Discharge Criteria

I. Has the patient completed treatment as evidenced by a reduction or absence of the symptoms that originally indicated this level of treatment?

OR

II. Has the patient withdrawn from treatment against advice and does not meet criteria for involuntary treatment?

Specific Clinical Information - Narrative

- Diagnosis
- Medications
  - Names
  - Amounts
  - Response
  - Side effects
- Treatment Plan
  - Biological interventions
  - Psychological interventions
    - Individual therapy
    - Family therapy
    - Psychoeducational treatment
  - Social interventions
    - Vocational advocacy training / counseling
    - Housing
    - Community and social involvement
- Plans developed for discharge

Psychiatric Evaluation

Types of Evaluations

General Psychiatric Evaluation

- Face-to-face interview with patient. (Several meetings may be necessary.)
- For children and adolescents interviewing the child, adolescent and family members/caretakers is essential to data collection.
- For adults, information from family members is important
- Interview data integrated with data from:
  - Physician contact and medical records
  - Physical examination
  - Diagnostic tests
  - Corroborating sources: vocational/school personnel and records
  - Complexity determines time spent in the interviewing process
  - The level of cooperation of the patient in the interviewing process must be ascertained and documented.

Aims

- To establish a psychiatric diagnosis
- To collect sufficient data to permit case formulation
  - To determine any immediate need for intervention(s)
  - Revision of a pre-existing treatment plan

Emergency Evaluation

Prompted by

- Thoughts or feelings intolerable to patient
- Violence to self, others, or property
- Threats of harm to others

- Failure to care for self
- Deterioration of mental status
- Bizarre or confused behavior
- Intense expression of distress

Aims

- To establish a provisional diagnosis that accounts for the emergency
- To identify other diagnostic possibilities that may be causative or contributory to the emergency situation
- To establish the role, if any, of physical illness(es) contributing to the emergency
- To identify social, environmental and cultural issues that are relevant to immediate treatment decisions
- To determine the patient's willingness to cooperate with psychiatric assessment and treatment
- To establish the need for safety precautions and to establish a plan to insure the safety of the patient
- To determine the need for involuntary treatment
- To develop a plan for immediate treatment and disposition

Special Considerations

Physical illnesses, substance abuse and use, toxins, and other issues must be considered.

Domains of Evaluation

Reason for Evaluation

- Chief complaint in detail, using the patient's words to describe the problem(s)
- Reason for hospitalization, if hospitalized

History of Present Illness

- Chronologically organized history of current symptoms or syndromes

- Recent exacerbations or remissions
- Details of previous treatments
- Response to treatment
- Precipitating, aggravating or other factors influencing the current situation

Past Psychiatric History

- Chronological summary of all past episodes of mental illness
  - Established diagnoses
  - Periods of significant impairment or symptoms even if no treatment sought or given
  - Pharmacological treatment, ECT (Electroconvulsive Therapy)
- Treatment offered:
  - Responses to treatments
  - Effectiveness
  - Side effects
  - Adherence
- Salient features from past medical record(s)

General Non-psychiatric Medical History

- Diagnoses and history
- Treatments
- Hospitalizations
- Medications
- Health problems as a source of significant emotional distress
- Important injuries or trauma
- Allergies, drug sensitivities
- Exposure to toxins (for example, lead exposure or toxicity)
- Chronic pain
- Illnesses for which the patient might have an increased risk, such as illnesses common in the family of origin

FOR CHILDREN AND ADOLESCENTS

- Exposure to chickenpox or measles in past three weeks
- Immunization records
  - Specific attention should be given to family history of hypertension, cardiac arrthymia, myocardial infarction, sudden death, hypothyroidism or hyperthyroidism, seizure disorder, tuberculosis, recent chicken pox or measles infections, or severe illnesses resulting in physical disability.

Substance Abuse

- Past and present use of legal and illegal substances
- Quantity
- Frequency of use
- Route of administration
- Pattern of use
- Consequences of use (legal, occupational, relationships)
- Tolerance and withdrawal symptoms
- Association with psychiatric symptoms
- May require numerous interviews to obtain an accurate history

Personal History

- Review of developmental milestones and coping with challenges of developmental stages
- Patient's response to normal life transitions and major events
- Level of formal education
- Cultural and religious influences and support
- Involvement with criminal justice
- Sexual history
- History of abuse or trauma
- Level of functioning in family and social roles
- Number and ages of children; for youth, status of siblings and parents

- For adults, ability to meet the needs of children in general and during psychiatric crises
- For children and adolescents, specific attention should be given to a family psychiatric history of mood disorders, psychotic disorders, substance abuse disorders, attention deficit hyperactivity disorder, disruptive behavior disorders, learning disabilities, tic disorders, Tourette's Syndrome, obsessive compulsive disorder, or psychiatric disability.

Social History

- Living arrangements
- Currently important relationships
- Role of relationships in patient's behavioral health (stressors or resources)
- Involvement with governmental social agencies, if any, status of involvement

Occupational History

FOR ADULTS

- Sequence of jobs
- Current employment
- Reasons for job changes
- Job stressors
- Military experience

FOR CHILDREN AND ADOLESCENTS

- Academic history
- Grades and performance in school
- Child's view of school
- History of identified problems with learning or academic skills.

Family History

- Non-psychiatric medical and psychiatric history of family of origin; extended family if pertinent
- History of treatment

- History of response to treatment
- Concerns about current health of family, if any

Review of Systems

- Symptoms of illness(es) not covered in history of present illness
- Symptoms of disease(s) for which the patient may be at particular risk

Physical Exam

- General appearance and nutritional status
- Vital signs (temperature, heart rate, blood pressure, weight, height)
- Head and neck, heart, lungs, abdomen and extremities
- Neurological status
- Motor abnormalities
- Reflexes
- Skin (excoriations, pigmentation changes, scars)
- Particular attention to any area or organ system that is a source of patient complaints
- Screening for disorders for which the patient may be at risk

Mental Status Examination

The systematic collection of observed and elicited data

- Current signs and symptoms of psychiatric disorders
- Core elements
  - Appearance and behavior
  - Mood and affect
  - Speech and language
    - Rate, rhythm, flow of ideas, pathological features
  - Motoric activity
    - Description

- Current thought and perceptions
  - Worries, concerns, thoughts, impulses and perceptual experiences
  - Cognitive themes
  - Thoughts and perceptions
  - Cognitive and perceptual symptoms characteristic of certain disorders:
    - Hallucinations
    - Delusions
    - Ideas of reference
    - Obsessions
    - Compulsions
  - Associations
    - Loose associations
    - Idiosyncratic associations
  - Understanding of current situation
  - Cognitive status
    - Level of consciousness
    - Orientation
    - Attention and concentration
    - Memory
    - Fund of information
    - Calculation
    - Abstract reasoning
    - Executive functions
    - Judgement

Functional status

FOR ADULTS

- Activities of daily living
  - Eating, bathroom, dressing
  - Driving, taking medications, managing money, keeping house, communicating, child care

FOR CHILDREN AND ADOLESCENTS

- Self-care activities as appropriate for age
- Interaction with peers and family
- Capacity for play
- Level of interactive communication

Assessment

Case Formulation

The formulation interweaves the biological, psychological and social factors contributing to the patient's difficulties with those that indicate potential success in a treatment setting. The comprehensive formulation leads to accurate diagnosis and to appropriate treatment planning. Components of the formulation include predisposing factors, perpetuating factors and precipitating factors. The patient's personal strengths and community supports are important to consider in the formulation. The items on the following list are also important considerations when collecting information for the formulation.

- Adaptive strengths
- Support available in patient's environment
- Stressors
- Individual issues
  - Issues of development
  - Culture
  - Ethnicity

- Gender
- Sexual orientation
- Familial/genetic patterns
- Social class
- Religious/spiritual issues
- Physical and social environmental influences on patient's behavior or symptoms
- Ability to form and maintain relationships

Diagnosis

- Differential diagnosis based on DSM-IV criteria
- All 5 axes must be addressed

Initial Treatment Plan

- Explicit statement of diagnostic, therapeutic and rehabilitative goals for treatment of behavioral health problems and nonpsychiatric medical conditions.
- For all patients the initial treatment plan contains interventional planning in the biologic, psychologic and social domains.
- For all patients, the initial treatment plan includes a post-discharge therapeutic plan.
- Specifies further observations to be made, diagnostic tests, observations and therapies to be applied.
- Considerations of risk and benefits
  - Risky or unusual treatment
  - Patient's motivation or capacity to benefit may be in question
  - Level of family support and commitment to the patient and her/his treatment
  - Involuntary treatment
  - External constraints limit available treatment options (define, if noted)

Suicide Assessment

Presence of suicidal thoughts or feelings

- Describe the thoughts and feelings in detail.
- Investigate the length of time the suicidal ideation has been present.
- Evaluate how long the suicidal ideation has been present.
- Evaluate if the suicidal thoughts require an action by the patient or are passive in nature.
- Investigate the intrusiveness and persistence of the suicidal ideation.
- Evaluate the level of control the patient has over the thoughts and any actions associated with the thoughts.

Meaning and motivation

- Investigate the motivation for considering suicide and the motivation to resist the ideation.
- Discuss any specific reasons the patient gives that prevent a suicide attempt.
- Investigate if the suicidal ideation is to hurt someone else, is an escape, is an attempt to punish self or is a manipulation of a person(s) or a system.
- Evaluate the patient for feigning suicidality for secondary gain, such as obtaining hospitalization as housing or escaping from legal difficulties.

Suicidal plans

- Evaluate if a plan has been developed.
- If a plan has been developed ask about the following items:
  - Method
  - Place
  - Time
  - Means and availability (consider possibility of misinformation)

- Feasibility of plan
- Intended goal

- Evaluate the lethality of planned actions:
  - Objectively assess the danger of the described means to the patient's life.
  - Objectively question the patient's conception of lethality.
  - Special attention should be paid to violent, irreversible methods that can result in an immediate death (shooting, jumping in front of train, etc).
  - Evaluate the nature and extent of any preparation the patient has done for the suicide attempt.
  - Investigate whether the patient has rehearsed the planned suicide attempt.
  - Evaluate the likelihood of rescue following the suicide attempt.

History of Overt Suicidal/Self-destructive Behavior

- Evaluate suicidal behaviors that have occurred in the past.
- Have the patient describe in detail any past suicidal behavior.
- Investigate any past self-mutilating / injurious behaviors, such as a wrist-cutting.

Current Physiological, Cognitive, Affective Status

- Evaluate the patient's capacity to act.
  - Suicide requires the ability to organize and the energy to implement a plan.
  - Suicide potential may be increased with improved energy from recovery from depression or lowered inhibition as with intoxication.
  - Evaluate the degree of hopelessness, as it is a key psychological factor in suicide intent and behavior.
- Evaluate the presence of depression or despair.
- Evaluate the patient's physiological state for increasing the potential for suicide.
  - Intoxication or withdrawal can lead to an acute increase in suicidal risk.
  - Chronic use leads to a chronically elevated risk of suicide.

Coping Potential

- Evaluate the recent stressors in the patient's life.
- Evaluate the patient's capacity for self-regulation of impulses.
- Evaluate the patient's capacity to participate in treatment, comply with treatment and to form an alliance with a treatment team.

Psychiatric Diagnoses

DSM-IV Diagnoses

1. Schizophrenia
2. Schizoaffective Disorder
3. Brief Psychotic Disorder
4. Major Depressive Disorder
5. Bipolar Affective Disorder I
6. Bipolar Affective Disorder II
7. Posttraumatic Stress Disorder
8. Acute Stress Disorder
9. Anorexia Nervosa
10. Intermittent Explosive Disorder
11. Antisocial Personality Disorder
12. Borderline Personality Disorder

Child and Adolescent Diagnoses

1. Attention Deficit/Hyperactivity Disorder
2. Oppositional Defiant Disorder
3. Conduct Disorder
4. Pervasive Developmental Disorders
   - Autism
   - Asperger's Disorder
   - Rett's Disorder
   - Childhood Disintegrative Disorder
5. Special Considerations for Mood Disorders in Children and Adolescents

Schizophrenia

DSM-IV Diagnostic Criteria for Schizophrenia

A. Have two or more of the following been present for a significant portion of time during a one-month period, (less, if successfully treated)?

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms such as flat affect, poverty of speech and thought, no motivation, etc. (Only one of the above is required, if the delusions are bizarre, hallucinations consist of a running commentary on the behavior or thoughts of the person, or two or more voices converse with one another.)

B. Since the onset of the disturbance has there been a deterioration of social functioning, interpersonal relations, or self care?

C. Have the signs of illness been present on a continuous basis for 6 months?

D. Have Schizoaffective Disorder and Mood Disorder with Psychotic Features been ruled out?

Treatment Planning

Specific Considerations

TREATMENT PLAN

- The diagnosis should be firmly established.
- Schizophrenia is a chronic, lifelong condition that requires numerous interventions of varying levels; the symptoms at a given point in time dictate the acute treatment plan.
- Involuntary hospitalization is commonly required in this population.
- The initial goals of treatment are:
  - Reduction of psychotic symptoms to a level that allows a lower level of care, or a return to a home environment with outpatient follow-up

- Prevention of harm to the patient, others, or property
- Development of an effective regimen of medication that:
  - Is effective in reducing the patient's psychotic symptoms
  - Has few or tolerable side effects
  - Will promote compliance with the medication

- The mainstay of initial and long-term treatment of schizophrenia is pharmacologic.

Pharmacologic management of schizophrenia

Specific considerations

- The newer antipsychotic medications should be used first.
- The older antipsychotic medications should be reserved for:
  - Stable patients who are responding well to these medications and are experiencing no major side effects
  - Patients who require IM medication for their management
  - Acute management of aggression and violence in some patients

INADEQUATE RESPONSE TO INITIAL TREATMENT

- The initial treatment should continue for 4-8 weeks before considering a change.
- If the inadequate response was with a conventional antipsychotic medication, then the patient should be switched to an atypical antipsychotic medication.
- If the inadequate response was to an atypical antipsychotic medication, then a trial on a different atypical antipsychotic medication should be initiated or the dose of the initial atypical antipsychotic medication should be optimized.
- If the inadequate response persists after several trials of conventional and atypical antipsychotic medications, the patient should be tried on clozapine.

CHOICE OF ANTIPSYCHOTIC MEDICATION SHOULD BE BASED ON:

- Acceptability to patient
- Prior drug response
- Side effect profile
- Long-term treatment planning

CLOZAPINE

- This medication should be offered to:
  - Patients whose positive symptoms do not respond to two different classes of antipsychotic medications
  - Patients with Schizophrenia or Schizoaffective Disorder who have persistent violence or other psychotic symptoms that have not responded to trial of two different antipsychotic medications
  - Patients who experience intolerable side effects to other antipsychotic medications
- The lack of response should be defined as persistent symptoms after 2, six-week trials of maximum tolerated doses of antipsychotic medications from two different chemical classes (at least one atypical).
- An adequate clozapine trial is three months at a dose between 300-800 mg per day.
- Doses should be kept to the lowest dose that produces a positive response.
- Patients who do not respond to lower doses of clozapine should have a blood level drawn and the dose slowly raised to 800 mg/day.

ADJUNCTIVE PHARMACOTHERAPIES

Depending on the specific symptoms of the patient, any of the following may be used in combination with antipsychotic medications to control these symptoms:

- Lithium: manic-like symptoms
- Benzodiazepines: anxiety, violence
- Anticonvulsants: manic-like symptoms, hostility, impulsivity
- Other antipsychotic medications in combination with clozapine
- Two atypical antipsychotic medications simultaneously
- Antidepressants: depression

ELECTROCONVULSIVE THERAPY-ECT

If a patient has not responded to antipsychotic medication medications then the patient should be considered for ECT if:

- The patient has been ill less than a year.
- The patient has been ill for more than a year, but is in an early exacerbation.
- Affective or catatonic features are prominent.

SUBSTANCE ABUSE

- All patients should be screened for substance abuse
- Substance abuse is common in this patient population, especially cocaine abuse.

Non-pharmacologic management of Schizophrenia

Specific Considerations

- Individual and Group Therapy
- Combinations of support, reality orientation, education, behavioral and cognitive skills training designed to address the specific deficits of the schizophrenic patient should be offered.
- Interpretative treatment or treatments that use regression as a therapeutic means should not be used in this patient population.
- Family Intervention
  - Offer support
  - Skills training
  - Education
  - Problem-solving skills

Discharge plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
- A specific appointment is made before discharge and patient is aware of appointment.
- Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Family education, if indicated, is conducted before discharge.
- Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

ANTIPSYCHOTIC MEDICATIONS AND SIDE EFFECTS

Side Effect	Least likely to cause	Most likely to cause
Sedation	Risperidone [Risperdal] Ziprasidone High potency conventional antipsychotics [such as Haldol]	Low potency conventional antipsychotics [such as Thorazine, Mellaril] Clozapine [Clorazil]
Weight Gain	Ziprasidone Risperidone [Risperdal]	Clozapine [Clorazil] Olanzapine [Zyprexa]
Extra-pyramidal Side Effects	Clozapine [Clorazil] Quetiapine [Seroquel] Olanzapine [Zyprexa] Ziprasidone Risperidone [Risperdal]	Mid- and high-potency conventional antipsychotics
Cognitive Side Effects	Atypical antipsychotics	Low-potency conventional antipsychotics
Anticholinergic Side Effects	Risperidone [Risperdal] Ziprasidone Quetiapine [Seroquel] High potency conventional antipsychotics [such as Haldol]	Low-potency conventional antipsychotics
Sexual/Reproductive system Side Effects	Quetiapine [Seroquel Olanzapine [Zyprexa]] Ziprasidone Clozapine [Clorazil]	Conventional Antipsychotics
Cardiovascular Side Effects	Risperidone [Risperdal] Olanzapine [Zyprexa] High potency conventional antipsychotics [such as Haldol] Quetiapine [Seroquel]	Low-potency conventional antipsychotics
Tardive Dyskinesia	Clozapine [Clorazil] Quetiapine [Seroquel] Olanzapine [Zyprexa]] Ziprasidone	Conventional antipsychotics
Recurrence of Neuroleptic Malignant Syndrome	Olanzapine [Zyprexa] Clozapine [Clorazil] Quetiapine [Seroquel] Ziprasidone Risperidone [Risperdal]	Conventional antipsychotics

Schizoaffective Disorder

DSM-IV Diagnostic Criteria for Schizoaffective Disorder

A. Has there been an uninterrupted period of illness when with a Major Depressive Disorder, a Manic Episode or a Mixed Episode was concurrent with Criterion A for Schizophrenia?

B. Have delusions and hallucinations been present for at least two weeks during the same period of illness in the absence of prominent mood symptoms?

C. Have symptoms that meet the mood episode been present for a substantial portion of the illness?

Treatment Planning

Specific Considerations

DIAGNOSIS

- The accurate diagnosis of this condition is difficult due to the complexity of the symptoms, the careful delineation of the time frames of symptoms and overlapping symptomatology that must be present for this diagnosis to be made.
- The DSM-IV diagnostic criteria are somewhat nonspecific and a spectrum of diagnoses and subsets of diagnoses may be included in this disorder.
- When substance abuse, intoxication or withdrawal are part of the clinical presentation, then the diagnosis should not be made.
- The most accurate diagnosis is derived from a review of the entire course of illness and not limited to the present symptomatology.

TREATMENT

Pharmacology

Medications from many drug classes have been used in the treatment of individuals with this diagnosis and the published results have been mixed and controversial. This probably reflects the over-inclusiveness of the diagnosis, allowing patients with very different symptoms to carry the same diagnosis. These patients would respond differently to different medications.

Antipsychotic medication

- Data indicates that antipsychotic medications used alone are the best available treatment.
- Atypical antidepressants may have an advantage over the older conventional antipsychotic medication.
- No evidence to support that the use of antidepressants with antipsychotic medication is advantageous.

Antidepressant medication

- Data indicates that in this group of patients these medications are only useful once the psychosis is stabilized and the patient has a full depressive syndrome.
- Antidepressant medications seem to have little value if used when only depressive symptoms are present.
- Antidepressant medication used while the patient is actively psychotic may worsen the psychosis.

Lithium

- Its use in this group of patients is especially controversial. Some authors favor its use; others feel that the patients it benefits do not meet current criteria for Schizoaffective Disorder.
- The Practice Guidelines for Schizophrenia from the American Psychiatric Association states that there is some evidence to support the use of lithium; a recent review does not agree with this conclusion (See Bibliography).

Anticonvulsant medication

- No controlled data supports the use of this group of medications in this patient population.

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Brief Psychotic Disorder

DSM-IV Diagnostic Criteria

A. Are one or more of the following present?

1. Delusions
2. Hallucinations
3. Disorganized speech (i. e. frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior

B. Has the episode lasted at least one day but not longer than one month?

1. Is there an eventual return to normal?

Treatment

Specific Considerations

- This is a time-limited disorder often associated with a significant stressor, but may occur without stressors.
- Of special concern is maintaining the safety of the patient during the psychotic episode.
- Antipsychotic medication may be required during the active phase of the illness.
- Once the episode has resolved, medication will no longer be required.
- Once the episode resolves, there should be no residual symptoms if the diagnosis is correct.
- Families and concerned friends should be reassured of the eventual return to the pre-episode status.

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Family education, if indicated, is conducted before discharge.
- Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged, if needed.
- Case management, if indicated, is arranged.

Mood Disorders: Major Depression

DSM-IV Diagnostic Criteria for Major Depressive Episode

For children and adolescents, see Special Considerations in the section on child and adolescent disorders

One of the following must be present for at least two weeks, nearly every day, most of the day:

- Depressed mood most of the day,

OR

- Loss of interest or pleasure in most activities most of the day

At least four of the following must be present for at least two weeks, nearly every day, most of the time:

- Greater than 5% weight loss or gain; clearly increased or decreased appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness, inappropriate guilt or low self-esteem
- Diminished concentration or indecisiveness
- Recurrent thoughts of death or suicide

Signs/symptoms (all must be yes)

- Must result in a functional impairment and/or emotional distress.
- Must not be due to a substance abuse disorder
- Must not be due to a medical disorder

Treatment goals—acute phase of treatment

- Reduce and remove (if possible) all signs and signs/symptoms of depression
- Restore occupational and psychosocial functioning
- Reduce the likelihood of relapse and recurrence

Treatment Plan

Specific considerations

In addition to establishing the diagnosis of depression, the patient's risk for suicide must be thoroughly assessed.

- Intent
- Extent of plans
- Availability of means
- Lethality of available means
- Previous attempts
  - Number of previous attempts
  - Severity of previous attempts
- Factors that increase the risk of suicide are:
  - Psychosis
  - Severe anxiety
  - Panic attacks
  - Substance abuse

Medications

ANTIDEPRESSANT MEDICATION

- For moderate to severe depression, antidepressant medication should be used in the initial phase of treatment, unless ECT is planned.
- All true antidepressant medications require at least 4-6 weeks before an assessment of their effectiveness can be completed.
- All currently available antidepressant medications are effective. Thus the selection of the specific antidepressant medication depends on:
  - Patient preference
  - Previous positive response to a specific antidepressant medication
  - Family response to a specific antidepressant medication

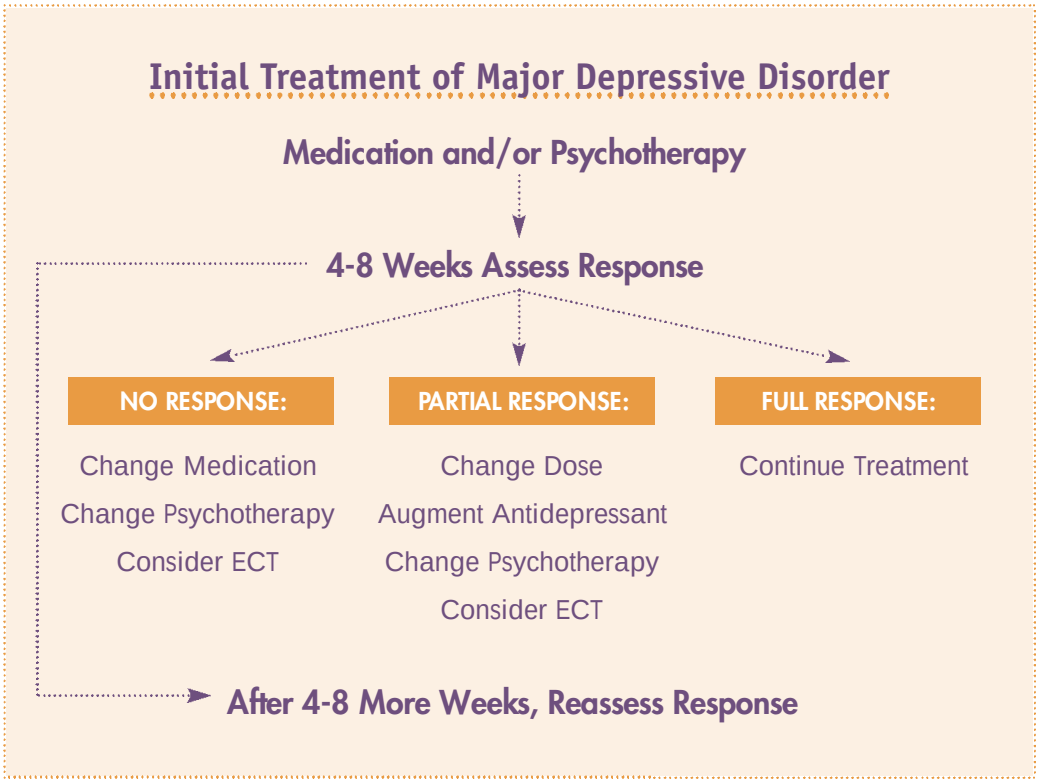
- Safety of use (lethality of overdose)
- Side effects:
  - Side effects tend to occur early in treatment (immediately to within a few days after beginning treatment)
  - Safety and tolerability of side effects
  - Management of side effects
  - Cost
- Medical disorders
- Other medications taken by the patient

IMPLEMENTATION OF ANTIDEPRESSANT MEDICATION TREATMENT

- Most antidepressant medications require starting at a low dose and increasing to a therapeutic dose over a period of days to weeks.
- Side effects, safety and compliance must be carefully monitored at this phase of treatment.
- Obtaining informed consent is recommended prior to initiating treatment.

ANTIDEPRESSANT MEDICATIONS

Generic Name	Brand Name	Start Dose (total milligrams per day)	Usual Dose (total milligrams per day)
Amitriptyline	Elavil	25-50	100-300
Bupropion	Wellbutrin	150	300
Citalopram	Celexa	20	20-60
Clomipramine	Anafranil	25	100-250
Desipramine	Norpramin	25-50	100-300
Doxepin	Sinequan	25-50	100-300
Fluoxetine	Prozac	20	20-60
Fluvoxamine	Luvox	50	50-300
Imipramine	Tofranil	25-50	100-300
Maprotiline	Ludiomil	50	100-225
Mirtazapine	Remeron	15	15-45
Nefazodone	Serzone	50	150-300
Nortriptyline	Norpramin	25	50-200
Paroxetine	Paxil	20	20-60
Phenelzine	Nardil	15	15-90
Protriptyline	Vivactyl	10	15-60
Sertraline	Zoloft	50	50-200
Trazodone	Desryl	50	75-300
Trimipramine	Surmontil	25-50	100-300
Venlafaxine	Effexor	37.5	75-225



FAILURE TO RESPOND

- If not at least moderate improvement is not observed after 6-8 weeks of treatment, a reappraisal of the treatment plan should be conducted.

Psychotherapy

- Cognitive behavioral therapy and interpersonal therapy have the best documented effectiveness in the treatment of depression.
- Psychodynamic therapy is often used in the treatment, but its effectiveness at symptom reduction has been less well studied than cognitive-behavioral therapy and interpersonal therapy.

Hospitalization

SHORT-TERM GOALS FOR ACUTE HOSPITALIZATION

- Sufficient resolution of symptoms to allow a return to home or a lower level of care:
  - Self-care acceptable

- Suicide risk has been reduced by symptom reduction and addressing external factors contributing to suicidal risk
- Medications are effective and side effects, if any, are tolerable
- Functionality in family, school, and occupational roles is improved
- Proactively to prevent recurrence of symptoms (for example, taking medications)

LONG-TERM GOALS IDENTIFIED WHILE HOSPITALIZED

- Complete sustained resolution of symptoms
- Absence of suicidal ideation
- Origins of depression explored and understood
- Higher level of adaptation attained as evidenced by:
  - Improved function in social and occupational roles
  - Understanding of factors contributing to onset of depression are used to act proactively to prevent recurrence of symptoms (for example, taking medications).

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient and family education about medications, signs of depression worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Bipolar Affective Disorders

DSM-IV Diagnostic Criteria for Manic Episode

For children and adolescents, see Special Considerations in the section on child and adolescent disorders

A. Has there been a distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least one week? (any duration if hospitalization is necessary)

B. During the period of mood disturbance, have three or more (four, if mood is irritable) of the following persisted and have been present to a significant degree?

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or experiencing thoughts as racing
5. Distractible
6. Increased goal directed activity or psychomotor agitation
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences.

C. Is the mood disturbance severe enough to cause a marked impairment in usual activities or to require hospitalization to prevent harm to self or are psychotic features present?

DSM-IV Diagnostic Criteria for Hypomanic Episode

A. Is there evidence of a persistently elevated, expansive, or irritable mood, lasting at least 4 days that is clearly different from a normal non-depressed mood?

B. During the period of mood disturbance, have three or more (four, if mood is irritable) of the following persisted and been present to a significant degree?

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. More talkative than usual or pressure to keep talking

4. Flight of ideas or experience that thoughts are racing
5. Distractible
6. Increased goal directed activity
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences

C Is the episode a clear change from functioning when the person is not symptomatic?

D Are the disturbance in mood and the change in functioning observable by others?

E Is the episode not severe enough to cause marked impairment in social or occupational functioning, to result in hospitalization and are there no psychotic features?

DSM-IV Diagnostic Criteria for Bipolar I Disorder

A Are the criteria (except for duration) met of a Manic, Hypomanic, or Major Depressive Episode?

B Has there been at least one Manic Episode in the patient's past?

C Are the mood symptoms causing clinically significant distress or impairment in social, occupational or other important areas of functioning?

D Are the mood symptoms in Criteria A and B better accounted for by Schizoaffective Disorder? **Must be no.**

E Are the mood symptoms superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder, NOS? **Must be no.**

F Are the mood symptoms listed in Criteria A and B due to the direct effects of a substance or of a physical illness? **Must be no.**

DSM-IV Diagnostic Criteria for Bipolar II Disorder

- **A** Is there the presence, or is there history of one or more Major Depressive Episodes?
- **B** Is there the presence or history of at least one Hypomanic Episode?
- **C** Is the current clinical presentation and the history free of any Manic Episodes?
- **D** Are the mood symptoms causing clinically significant distress or impairment in social, occupational or other important areas of functioning?
- **E** Are the mood symptoms in Criteria A and B better accounted for by Schizoaffective Disorder? **Must be no.**
- **F** Are the mood symptoms superimposed on Schizophrenia,Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder, NOS? **Must be no.**

Treatment

Specific Considerations

- Individuals experiencing a Manic Episode with psychotic features can be among the most aggressive and dangerous patients on a psychiatric unit.
- Settings accepting these patients must be prepared to deal promptly and effectively with the patient's behavior to insure the safety of the patient, the other patients on the unit and the staff on the unit.
- These patients may be especially lacking in insight about their disorder and deny its existence.
- Some patients enjoy the experience of mania and are reluctant to prevent its recurrence.
- The Manic Episode is usually part of the clinical picture of Bipolar I Disorder; and the Manic Episode may be followed by a Depressive Episode.
- Compliance with treatment may be especially problematic since these patients feel that nothing is wrong with them.
- Detailed education about the nature, treatment and prognosis is important for these patients and their families.
- Education of these patients enhances their ability to detect sub-clinical symptoms that may herald the onset of a Manic Episode.

- Reports of these symptoms should be taken seriously and the patient should be closely monitored.
- Reports of changed behavior in the patient by individuals who know the patient well should be taken seriously and active interventions considered.

- During Manic Episodes the patient may engage in behaviors that result in severe negative consequences (excessive spending, inappropriate sexual expression, violence, etc.)
  - Patients should seek psychiatric management at the first indication of a Manic Episode.
  - Prompt, effective psychiatric management should be instituted immediately.
- The mainstay of treatment of these patients is pharmacologic.

MEDICATIONS USED IN THE TREATMENT OF MANIC EPISODE

Generic Name	Brand Name(s)	Dose	Side Effects/ Adverse Effects	Comments
Lithium	Eskalith, Lithobid	900 – 1800 mg daily, divided into two or three doses	Increased urination, increased fluid intake, hypothyroidism, weight gain, tremor, GI distress	Effective for about 70% of Bipolars. Narrow therapeutic range. Requires serum monitoring. Serious problems with overdose
Valproate, Valproic Acid	Depakote	Start dose is 750 mg, divided into 3 doses, Increase dose to achieve 50 -100 micrograms/ml blood level	GI distress, liver toxicity	Effective for many Bipolars. Wide therapeutic range. May require serum monitoring. Requires monitoring of liver enzymes
Carbamazepine	Tegretol	400-600 mg daily, divided into 2 doses; increase by 200 mg increments to a maximum dose of 1600 mg/24hrs	Rashes, bone marrow suppression, low serum sodium, elderly more sensitive	Rarely used today.
Clonazepam	Klonopin	Dose ranges not well established	Sedation, disinhibition	Possible abuse and dependency
Tiagabine	Gabatril	Starting dose is 1 mg/day increasing slowly up to 8 -10 mg/day	Dizziness, lightheadedness, asthenia, sedation, nausea, decreased attention and concentration, confusion	Use is only as an "add-on" drug to supplement other first line treatments of Bipolar Disorder
Lamotrigine	Lamictal	Starting dose should not exceed 25mg/day and may be slowly increased to up to more than 100 mg/day. Specific doses not established	Nausea, dizziness, headache, blurred vision. Severe, serious rash may rarely occur; medication must be discontinued and not restarted.	Initial studies indicate that this medication may be a valuable addition in the treatment of mania
Gabapentin	Neurontin	Total daily doses 900 - 3000 mg given in 3 or 4 doses	Dizziness, sedation, fatigue, ataxia	Use is only as an "add-on" drug to supplement other first line treatments of Bipolar Disorder.
Topiramate	Topamax	Start at 50 mg/day; increase 50 mg/week to total therapeutic dose of 400 mg given in two doses	Asthenia	Use is only as an "add-on" drug to supplement other first line treatments of Bipolar Disorder.

Anxiety Disorders: Post-Traumatic Stress Disorder

DSM-IV Diagnostic Criteria for Post-Traumatic Stress Disorder

A Has the person been exposed to traumatic event in which both of the following were present?

1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or to the physical integrity of oneself.
2. The person's response involved intense fear, helplessness, or horror.

B Has the traumatic event been re-experienced in one or more of the following ways?

1. Recurrent and intrusive distressing recollections of the event, including images thoughts or perceptions.
2. Recurrent distressing dreams of the event
3. Acting or feeling as if the traumatic event were recurring
4. Intense psychological distress to internal or external cues that symbolize or resemble an aspect of the event.
5. Reacting on a physical level to internal or external cues that symbolize or resemble an aspect of the event.

C Has there been persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by three or more of the following?

1. Efforts to avoid activities, places or people that arouse recollections of the event
2. Efforts to avoid thoughts, feelings or conversations that are associated with the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feelings of detachment or estrangement from others
6. Restricted range of affect
7. Sense of a foreshortened future

D Does the person have persistent symptoms of increased arousal as indicated by two or more of the following?

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

E Have the symptoms in Criteria B, C and D been present for more than one month?

F Did the symptoms cause significant distress or impairment in important areas of life function?

Treatment Planning

- The patient with a diagnosis of PTSD will most often present for inpatient services when experiencing a loss of control, resulting in violent thoughts or behaviors or suicidal ideation.
- Substance-abuse-related issues may also result in a presentation for hospitalization.
- Depression may be the presenting diagnosis.
- PTSD is frequently comorbid with other disorders, and symptoms of it should be investigated.
- The initial phase of treatment is to reduce the presenting symptoms to a level that allows the patient to go to a lower level of care.

Medications

- Antidepressant medications are usually the most effective for this condition.
- Sertraline (Zoloft) has been specifically approved by the FDA for the treatment of PTSD.
- Older studies indicate that the sedating tricyclic antidepressant medications were helpful, especially Imipramine (Tofranil).
- Benzodiazepines have a negative or no effect on these patients.

Psychotherapy

- It has been a cornerstone of the treatment of this disorder.
- Usually long term outpatient psychotherapy is required.
- Numerous models of psychotherapy have been tried, with varying levels of success. The guiding principles in most treatments have been exposure to the original (or recreated) event(s) in a hierarchical fashion, and the use of social supports. There has been little systematic research on this aspect of treatment.

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Anxiety Disorders: Acute Stress Disorder

DSM-IV Diagnostic Criteria for Acute Stress Disorder

A Has the person been exposed to a traumatic event in which both of the following were present?

1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or to the physical integrity of oneself.
2. The response involves intense fear, helplessness or horror.

B Did the person, while experiencing the event or after experiencing the distressing event, have three or more of the following dissociative symptoms?

1. A subjective sense of numbing, detachment, or absence of emotional responsiveness
2. A reduction in awareness of his/her surroundings
3. Derealization
4. Depersonalization
5. Dissociative amnesia

C Is the traumatic event persistently re-experienced in at least one of the following ways?

1. Recurrent images
2. Thoughts
3. Dreams
4. Illusions
5. Flashback episodes
6. A sense of reliving the experience
7. Distress at reminder of the traumatic event

D. Marked avoidance of stimuli that arouse recollections of the event

1. Thoughts
2. Feelings
3. Conversations
4. Activities
5. Places
6. People

E. Marked symptoms of anxiety or increased arousal

1. Difficulty sleeping
2. Irritability
3. Poor concentration
4. Hypervigilance
5. Exaggerated startle response
6. Motor restlessness

F. Does the disturbance cause significant distress or impairment in social, occupational or other important areas of functioning or impair the person's ability to pursue some necessary task?

G. Has the disturbance lasted at least two days and occurred within 4 weeks of the traumatic event?

Treatment Planning

- Many individuals with this diagnosis have experienced a disaster, natural or man-made.
- Prompt intervention (psychotherapeutic and pharmacological) may reduce the sequelae of this diagnosis and prevent PTSD.
- Most individuals will not require hospitalization.
- Individuals with pre-existing conditions or special sensitivities may require hospitalization to regain coping skills following an event resulting in this diagnosis.

Medications

- Sleep problems may be especially prominent and require medication.
- Benzodiazepines for acute anxiety have not been shown to be helpful.
- Aside from purely symptomatic relief, medications play a minor role in the management of this disorder.

Psychotherapy

- Acute intervention immediately after the event is key to reduce the psychological sequelae of the event.
- Special trauma teams may be mobilized to assist large groups of people following an event.
- For individuals requiring hospitalization, prompt assessment and intervention must occur.

Discharge Plan

- Referral / connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient and family education about: medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Eating Disorders: Anorexia Nervosa

DSM-IV Criteria for Anorexia Nervosa

A. Does the person refuse to maintain body weight at or above a minimally normal weight for age and height? (less than 85% of expected weight)

B. Is there an intense fear of gaining weight or becoming fat, even though the person is underweight?

C. Is there a disturbance in the way one's body is experienced in terms of weight or shape? Is there undue influence of body weight or shape on self-evaluation? Is there denial about the seriousness of the weight loss?

D. In post-menarcheal females, have three consecutive menstrual cycles been missed?

Treatment Planning

Specific Considerations

Pretreatment evaluation is essential for determining the appropriate level of care.

PHYSICAL PARAMETERS

- Weight
  - Rapidity of weight loss
  - Current weight as compared to age and size normative data
- Cardiac Status
  - Irregular, weak, slow pulse
  - Marked orthostatic blood pressure drop
  - Peripheral vasoconstriction
  - Q-Tc prolongation (dangerous sign)
- Metabolic Status
  - Dehydration
  - Electrolyte abnormalities
  - Low serum phosphorus
  - Hypoglycemia (rare)

DECISION TO HOSPITALIZE ON A PSYCHIATRIC UNIT IS BASED ON:

- Rapid or persistent decline in oral intake
- Decline in weight despite outpatient and partial hospitalization interventions
- Presence of additional stressors that interfere with the patient's ability to eat
- Prior knowledge of a weight at which instability is likely to occur
- Co-morbid psychiatric problems that merit hospitalization

DECISION TO HOSPITALIZE ON A PSYCHIATRIC VERSUS A MEDICAL UNIT:

- Patient's general medical status
- Skills and ability of psychiatric and medical staffs
- Availability of suitable intensive outpatient, partial and day hospitalization
- Aftercare for the patient's general medical and psychiatric problems

PSYCHIATRIC MANAGEMENT

- Establish and maintain a therapeutic alliance.
- Coordinate care with other clinicians treating the patient.
- Assess and monitor eating disorder symptoms and behavior.
- Assess and monitor patient's general medical condition.
- Assess and monitor the patient's psychiatric status and safety.
- Provide family assessment and treatment.

AIMS OF TREATMENT

- Restore patient to healthy weight, normal menses, and normal ovulation in females, and normal physical and sexual growth and development in children and adolescents.
- Treat physical complications.
- Enhance patient's motivation to cooperate in the restoration of healthy eating patterns and to participate in treatment.
- Provide education regarding healthy eating patterns and to participate in treatment.

- Correct core maladaptive thoughts, attitudes, and feelings related to the eating disorder.
- Treat associated psychiatric conditions, especially related to mood regulation, self-esteem, and behavior.
- Enlist family and school support and provide family counseling and therapy.
- Prevent relapse.

NUTRITIONAL REHABILITATION

- Inpatient
- Establish healthy target weights.
- Have expected rates of controlled weight gain (2-3 lb/week for inpatient, 0.5-1 lb. for outpatient).
- Intake should begin at about 1000-1600 cal/day and should be advanced progressively.
- Patients must be carefully observed for discarding food, vomiting, exercising frequently, or increased nonexercise activity.
- Medical monitoring during nutritional rehabilitation:
  - Vital signs (blood pressure, pulse, respiratory rate)
  - Food and fluid intake and output
  - Monitoring of electrolytes (including phosphorus)
  - Observation for rapid weight gain
  - Observation for edema and congestive heart failure
  - Observation for gastrointestinal symptoms (especially bloating and constipation.)
  - If weight is less than 70% of standard weight (severely malnourished)
- Concerns about body image, health risks associated with eating disorders and provision of general ongoing support is also part of nutritional rehabilitation.

Medications

- Psychiatric medications should not be used as the sole or primary treatment.
- After weight gain, the patient can be assessed for antidepressant medication.
  - Major Depression or Dysthymic Disorder may be present.
  - The selective serotonin re-uptake inhibitors (Prozac, Celexa, Zoloft. Paxil, Luvox) may be helpful, though the data from controlled studies are mixed.
  - Patients with evidence of Obsessive-Compulsive symptoms may also respond positively to the SSRIs.

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Disorders of Impulse Control: Intermittent Explosive Disorder

DSM-IV Diagnostic Criteria for Intermittent Explosive Disorder

A. Are there discrete episodes of failure to resist aggressive impulses that result in serious acts of assault or destruction of property?

B. Is the degree of aggression expressed during the episodes grossly out of proportion to the any precipitating psychosocial stressors?

C. Have other diagnoses and substance use/abuse been ruled out as a cause of the symptoms?

Treatment Plan

Specific considerations

- There is little literature on this disorder.
- Some authors feel this may be a variant of mania ("micromania").
- During the episode, the patient may be markedly violent and dangerous to others.
- The episodes are usually short, 20-30 minutes.
- Usually, the patient comes to the attention of behavioral health after the episode has passed.
- Episodes may be occasionally witnessed in an inpatient setting.
- Episodes may result in arrest and/ or incarceration.

Medications

- Most psychiatric medications, and some non-psychiatric medications, have been used in the treatment of this disorder. (See Section on Bipolar Affective Disorders for more information on these medications.)

- Medications used in the treatment disorder include:
  - Lithium
  - Anticonvulsants
    - Carbamazepine [Tegretol]
    - Valproate [Depakote]
    - Clonazepam [Klonopin]
    - Gabapentin [Neurontin]
    - Lamotrigine [Lamictal]
    - Topiramate [Topamax]
    - Tiagabine [Gabatril]
  - Antidepressant Medications [See Section on Major Depressive Disorder for more information on these medications]. The selective serotonin re-uptake inhibitors have been occasionally effective.
    - Sertraline [Zoloft]
    - Paroxetine [Paxil]
    - Fluoxetine [Prozac]
    - Citalopram [Celexa]
    - Fluvoxamine [Luvox]
  - Miscellaneous
    - Antiarrythymics
    - Propranolol [Inderal]

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged.
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Personality Disorders: Antisocial Personality Disorder

DSM-IV Diagnostic Criteria for Antisocial Personality Disorder

A Is there a pattern of disregard for and a violation of the rights of others, occurring from the age of 15, as indicated by three or more of the following?

1. Failure to conform to the social norms with respect to the law, as indicated by acts that are grounds for arrest
2. Deceitfulness, repeated lying, exploiting others for personal profit or pleasure
3. Impulsivity or failure to plan ahead
4. Irritability or aggressiveness as indicated by repeated physical fights
5. Reckless disregard for the safety of others
6. Consistent irresponsibility, failure to honor financial responsibility
7. Lack of remorse, indifference to having hurt, mistreated, or stolen from another

B Is the individual age 18 years or older?

C Is there evidence of Conduct Disorder with onset before age 15 years?

D Did the antisocial behavior occur only during the course of an episode of Schizophrenia, or a Manic episode? **(Must be no for diagnosis.)**

Treatment Plan

Specific Considerations

- Personality disorders are lifelong characteristic ways of behaving, responding to stimuli, and interacting with others.
- Personality disorders are notoriously difficult to treat.
  - During periods of stress, these individuals may need to be hospitalized due to disorganized behavior, severe emotional distress, or severe acting out.
  - Individuals with this disorder are most often hospitalized when this disorder is comorbid with another disorder, frequently substance abuse.

- These individuals may feign symptomatogy to be admitted to avoid the consequences of their behavior.
- Inpatient treatment is focussed on symptom reduction and behavioral containment.
- Behavioral therapy approaches may be the most effective with these patients; insight oriented psychotherapy has little or no usefulness in these patients.
- Medication is not a primary treatment for this disorder.
- Potentially addicting medications or medications that can be abused should be avoided in this patient population.
- Manipulation, splitting, and exploitation of others are often seen in the inpatient setting.
- Feigned suicidal ideation to obtain admission is common in this population.
- Occasionally, individuals with this disorder may intentionally harm themselves to obtain admissions or narcotic analgesics. The harm is rarely life threatening or based on true suicidal ideation or intent.
- Treatment options for this population should be limited and clear.

Discharge Plan

- Referral/connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Family education, if indicated, is conducted before discharge.
- Patient and family education about medications, signs of condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Borderline Personality Disorder

DSM-IV Diagnostic Criteria for Borderline Personality Disorder

A Is there a pervasive pattern of instability of interpersonal relationships, self-image, and affects and a marked impulsivity beginning in early adulthood and present in a variety of contexts as indicated by five or more of the following?

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between the extremes of idealization and devaluation
3. Identity disturbance as indicated by a markedly and persistently unstable self-image
4. Impulsivity in at least two areas that are self-damaging, such as excessive spending, reckless driving, binge eating, substance abuse. (Do not include suicidal behavior in item 5).
5. Recurrent suicidal behavior, gestures, or threats, or self mutilating behaviors
6. Affective instability due to marked reactivity of mood (intense episodic dysphoria, irritability, or anxiety usually lasting a few hours, but not more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate intense anger or difficulty controlling anger (for example, frequent displays of temper, constant anger, recurrent physical fights)
9. Transient stress related paranoid ideation or severe dissociative symptoms

Treatment

Specific considerations

- Usually the need for inpatient treatment is the result of suicidal ideation, although brief psychotic episodes or substance abuse may be the primary reason for admission or may be co-morbid with suicidal ideation.
- Treatment of patients with borderline personality disorder may be exceptionally difficult, with many setbacks and admissions.

- Treatment plans should have highly specific behavioral goals for the patient.
- These patients may be difficult to remove from an inpatient setting with increased symptomatology developing as discharge approaches.
- Discharge should be planned well in advance and should be known by the patient.
- The manipulative behaviors of these patients may be especially problematic and require behavioral contracts.
- If possible, admission should be avoided.

Discharge Plan

- Referral / connection to outpatient source of treatment that is at a level of care that meets the needs of the patient.
  - A specific appointment is made before discharge and patient is aware of appointment.
  - Patient has means to get to appointment, and, if not, transportation is arranged
- Appropriate living circumstances are arranged.
- Community supports are identified for patient.
- Patient and family education about medications, signs of patient's condition worsening, availability of emergency services, etc., is conducted before discharge.
- Crisis plan for patient is developed and communicated to all involved in patient's care.
- Access to medications is arranged.
- Case management, if indicated, is arranged.

Child and Adolescent Psychiatric Care

The specific criteria for child and adolescent psychiatric care described in this chapter are meant to supplement the narrative description of levels of care in Chapter 2 of this guide - Psychiatric Care. The criteria outlined below should not be applied without first reading the the narrative description of levels of care in Chapter 2 - Psychiatric Care.

Child and Adolescent Psychiatric Inpatient Hospitalization

Medical Necessity Criteria for Admission

For admission both of the following criteria A and B must be met.

A For the diagnostic evaluation, have the following conditions been met?
(All answers must be yes for admission.)

1. Within 24 hours of admission, has a multiaxial, face to face diagnostic evaluation been done by either:

   - A licensed physician whose diagnostic evaluation is confirmed by a:
     - Child and adolescent psychiatrist?
     - Board Certified psychiatrist?

   OR

   - Child and adolescent psychiatrist?
   - Board Certified psychiatrist?

   AND

2. The diagnosing psychiatrist prescribes inpatient psychiatric care

   AND

3. Documentation that psychiatric inpatient treatment is necessary because

   - The child has a severe psychiatric disorder

   AND/OR

- The child has a behavioral disorder that may pose a risk for others

AND

4. Documentation that treatment in a less restrictive setting has not been successful, or has been considered as a treatment setting and rejected by the diagnosing psychiatrist as inadequate to meet the needs of the patient.

AND

5. A strengths-based evaluation has been accomplished with the strengths of the family, community and culture taken into consideration either:

   - Before admission

   OR

   - Within 48 hours of admission, if the admission is an emergency

B Has the severity of the symptoms been evaluated and documented, and do they meet the following criteria?

1. There is a significant risk of danger represented by any of the following
   - Child is in danger of self harm
   - Child may harm others
   - Child may destroy property which is
     - Life threatening

     OR

     - Occurs in combination with any of the following three criteria:

2. For the developmental level, the judgement of the child is impaired to a degree that the child's:
   - Interpersonal skills
   - Self-maintenance in the home/school/ community environment

   is/are severely compromised.

3. Complications that endanger the well being of the child exist.
   - The child's diminished capacity for self-care may produce complications in the child's psychiatric disorder or its treatment.
   - The child's psychiatric disorder prevents the treatment of a coexisting physical illness in a less intensive level of care.

4. The inpatient psychiatric treatment is required to prevent deterioration of the child's status, or is required to increase the likelihood of improvement of the child's condition.

Requirements for Continued Stay

For a continued stay the following criteria must be met.

A **Diagnostic Evaluation and Documentation**

1. Has the treating psychiatrist updated and revised the initial evaluation by conducting a face to face interview with the child?

AND

2. Has the treating psychiatrist prescribed the inpatient setting as the appropriate setting for the treatment of the child?

B **Severity of Symptoms**

1. Does the treatment plan with updated severity of illness indicators support the continued stay because of the benefit the child is experiencing and/or is there a risk of symptoms re-emerging or worsening if the child is placed in a lower level of care?

AND

2. Is the child making progress towards goals but more progress must be made before the child can be transitioned to a lower level of care?

OR

3. Are the symptoms that made admission necessary still sufficiently severe to require continued care on an inpatient unit?

OR

4. Have new symptoms developed that meet admission criteria?

Discharge Criteria

- Does the child's status no longer meet the severity of symptoms in the continued stay criteria? (If yes, the child must be discharged.)

Child and Adolescent Residential Treatment

Admission Criteria

Must meet A and B, or C

A **The answers to the following six questions must be yes.**

1. Has a psychiatrist done a diagnostic evaluation for a JCAHO accredited facility, or if the facility is not JCAHO accredited, has a psychiatrist or a licensed psychologist done the evaluation?
2. Has the psychiatrist or the psychologist prescribed residential treatment as the appropriate treatment for the child?
3. Does the severity of the child's psychiatric disorder and or risk of harm to self or others require 24 hour a day supervision and observation?
4. Has a lower level of care been tried without success or has careful consideration been given to a lower level of care, but found not able to meet the needs of the child?
5. Has an interagency team recommended residential treatment for the child?
6. Has a strengths-based evaluation been completed before admission?

B **Do the presenting history and psychiatric/psychological evaluation include at least one of the following?**

1. Suicidal and/or homicidal ideation
2. Impulsivity and/or aggression
3. Psycho-physiological disorder (for example: anorexia)
4. Psychomotor retardation or excitement
5. Impairment due to an affective disorder (for example: withdrawn, labile)
6. Psychosocial functional impairment
7. Thought disorder
8. Cognitive impairment

C Does the child's condition as outlined below require further observation to clarify the child's status? (Allowable for 15 days per calendar year).

1. Have family members, school or community members described symptoms in the child that:

   - Have not been observed in an inpatient setting?

   OR

   - Have been denied by the child in an outpatient or partial hospital treatment?

   OR

2. Have the child's symptoms not sufficiently improved despite comprehensive care at a lower level of care, which has included the participation of an inter-agency team?

Continued Stay

Must meet A and B

A **Diagnostic Evaluation**

1. Has the initial evaluation been revised and updating following a face-to-face examination by the treating psychiatrist or psychologist?

AND

2. Have less restrictive environments been considered in consultation with the Interagency Service Planning Team?

AND

3. Is there clinically determined likelihood that without continued care at the residential level, the child will experience a recurrence of symptoms?

AND

4. If other alternative services have been rejected in favor of continued stay at the residential treatment level have these reasons been documented?

AND

5. Has the treating psychiatrist/psychologist prescribed the residential treatment level as the appropriate treatment after a face-to-face examination of the child?

B Severity of Symptoms

1. Have the severity of illness indicators and the updated treatment plan supported the continued stay in residential treatment to prevent a recurrence of symptoms?
2. Has the treatment team recommended continued stay and documented the need for the child's further improvement?
3. Will more progress in the child's status be required before a transition to a lower level of care is advisable?
4. Are the symptoms or behaviors that required admission still of such severity as to warrant continued care in the residential setting?
5. Have new symptoms developed that meet admission criteria?

C Discharge Criteria

1. If the child was admitted under Admission Criteria A and C, has the child been discharged within 15 days of admission? If not has a psychiatric examination of the child documented eligibility under Criterion B of the admission criteria?
2. If the child does not meet Criterion B of Continued Stay Criteria, has the child been discharged?

Child and Adolescent Partial Hospital Treatment

Admission Criteria

Must meet A and B, or C

A Diagnostic Evaluation

1. Has a psychiatrist or a psychologist done a multiaxial diagnostic evaluation?

AND

2. Do the behaviors of the child indicate a risk of safety for self or others and/or decreased functioning?
   - Does the behavior require observation and treatment but does not require 24-hour day supervision?
   - Has treatment at a lower level of care been unsuccessful or have treatment alternatives at a lower level of care been considered and rejected?

AND

3. Has the treatment team recommended partial hospitalization as the most appropriate setting for the care of the child?

AND

4. Has an interagency planning team been incorporated into the treatment team if the child is removed from the regular schoolroom all or part of the day?

AND

5. Has a strengths-based assessment of the child been completed prior to admission or within 5 days of admission?

AND

6. Has the involvement (or non-involvement) of the parents been documented and presented to the interagency team?

B Severity of Symptoms

Has the presenting history or the psychiatric examination of the child included at least one of the following?

- Suicidal/homicidal ideation
- Impulsivity and/or aggression
- Psycho-physiological condition (for example: anorexia)
- Psychomotor retardation or excitement
- Impairment due to an Affective Disorder (withdrawal, lability)
- Psychosocial functional impairment
- Thought Disorder
- Cognitive impairment

C Observation

1. Does the behavior or impairment of the child require further observation for clarification of the nature and severity of the child's condition? Allowable for 15 days per year.

   - Have problematic behaviors described by members of he family, the community or the school persisted but:
     - Have not been observed on a psychiatric inpatient unit?
     - Has the child denied the reported problematic behaviors in outpatient treatment?

OR

2. Has the child's condition not improved at a lower level of care and the inter-agency team recommended partial hospitalization?

Continued Stay

A Diagnostic Evaluation

1. Has the initial evaluation been revised and updating following a face-to-face examination by the treating psychiatrist or psychologist?

AND

2. Have less restrictive environments been considered in consultation with the Interagency Service Planning Team?

AND

3. Is there clinically determined likelihood that without continued care at the partial hospitalization level, the child will experience a recurrence of symptoms?

AND

4. If other alternative services have been rejected in favor of continued stay at the partial hospitalization treatment level, have these reasons been documented?

B Severity of Symptoms

1. Have the severity of illness indicators and the updated treatment plan supported the continued stay in partial hospital program to prevent a recurrence of symptoms?

2. Has the treatment team recommended continued stay and documented the need for the child's further improvement?

AND

3. Will more progress in the child's status be required before a transition to a lower level of care is advisable?

OR

4. Are the symptoms or behaviors that required admission still of such severity as to warrant continued care in the residential setting?

OR

5. Have new symptoms developed that meet admission criteria?

C Discharge Criteria

1. If the child was admitted under Admission Criteria A and C, has the child been discharged within 15 days of admission? If not has a psychiatric examination of the child documented eligibility under Criterion B of the admission criteria?

2. If the child does not meet Criterion B of Continued Stay Criteria, has the child been discharged?

Child and Adolescent Psychiatric Outpatient Treatment

Admission Criteria

Must meet A and B

DIAGNOSTIC EVALUATION

A Has a diagnosis made by a mental health professional been reviewed by a psychiatrist or a licensed psychologist?

AND

B Do the behaviors of the child indicate lessened risk to self or others and the child does not require inpatient or residential levels of care?

SEVERITY OF SYMPTOMS

A Has this level of care been recommended by the treatment team director?

AND

B Is there a serious and persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder?

- Is treatment required to alleviate symptoms and/or behaviors?
- Will treatment be required to prevent relapse in the child with symptoms that are in partial or complete remission?

OR

C Are there significant psychosocial stressors and/or physical illness that increase the risk for a decrease in the functioning of the child?

OR

D Have the child's symptoms improved at a higher level of care, but outpatient care is required to sustain and reinforce the gains made at a higher level of care?

OR

E Is medication monitoring required to care for the child appropriately?

Continued Stay

Must meet criteria for Diagnostic Evaluation and Severity of Symptoms

DIAGNOSTIC EVALUATION

A. Have the treatment plan and diagnosis been reviewed and approved by a psychiatrist or licensed psychologist?

OR

B. Is there significant family involvement in the treatment process except where prohibited or when family involvement would be clinically counter-productive?

SEVERITY OF SYMPTOMS

A. Is the child making progress towards goals?

OR

B. Are natural community supports insufficient to stabilize the child's condition?

OR

C. Have new symptoms or behaviors developed that meet admission criteria?

DISCHARGE

✦ Has the child been discharged if criteria in severity of symptoms have not been met, or if indicated by progress attained?

COMMONWEALTH OF PENNSYLVANIA – HEALTHCHOICES

APPENDIX T (PART B)

BEHAVIORAL HEALTH REHABILITATION SERVICES UNDER EPSDT: Home/Community Services

TABLE 1: SEVERITY LEVELS AND SERVICE CORRELATES WITH CORRESPONDING PROPORTIONAL ORDERING OF TREATMENT HOURS

All services are to be determined on an individual basis for the child or adolescent

(Table does not represent EPSDT psychosocial rehabilitative services provided on provider sites, such as After-school and Summer Therapeutic Activities Programs)

LEVEL 1 (LEAST)	LEVEL 2 (MODERATE)	LEVEL 3 (INTENSIVE)	LEVEL 4 (HIGHLY INTENSIVE)
1 to _ hours of Professional & 1 to _ hours of Therapeutic Support Services (Must meet A, B, and C; OR D)	_ to _ hours of Professional & _ to _ hours of Therapeutic Support Services (Must meet A, B, and C; OR D)	_ to _ hours of Professional & _ to _ hours of Therapeutic Support Services (Must meet A, B, and C)	_ to _ hours of Professional & _ to _ hours of Therapeutic Support Services (Must meet A, B, and C)
I. & II. [COMBINED] DIAGNOSTIC INDICATORS BY LEVEL			
A Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the interagency team, **AND**	A Risk of harming [self, others, or property] is assessed low in the child's current problematic behavior or functional impairment and presenting history; **AND** psychiatric or psychological examination must include:	A Severe functional impairment is assessed in the child's problematic behavior in the home, school, or community; there is risk of an out- of-home or out- of- school placement; may be risk of danger of child harming him/ herself, others, and/or demonstrated destruction to property; **AND**	A High risk of out-of-home placement, or demonstrated risk of endangerment, involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness; and/or the severe functional impairment in the home, school, or community, **AND**
1. CHILDREN WITH A DIAGNOSTIC INDICATOR ON AXIS I			
a. There is serious and/or persistent impairment of developmental progression and/ or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/ or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/ or behaviors which are in partial or complete remission;	**a.** Assessment of at least one (1) of the following: 1. Suicidal homicidal ideation 2. Impulsivity and/or aggression 3. Psycho-physiological condition, (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation 5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment	**a.** Assessment of at least one (1) of the following: 1. Suicidal/ homicidal threats or intensive ideation 2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e. bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation. 5. Affect/Function impairment (i. e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment	**a.** Assessment of at least one (1) of the following: 1. Suicidal/homicidal threatening behavior or intensive ideation 2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation. 5. Affect/Function impairment (i. e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment
OR	**AND/OR**	**AND/OR**	**AND**
b. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level require home/ community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission; **OR** (continued on next page)	**b.** Presence of very impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/ or self-maintenance in home/ school/ community is/ are highly compromised, are not attributable to mental retardation;	**b.** There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/ or self-maintenance in home/school /community is/ are severely compromised, are not attributable to mental retardation;	**b.** There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/ or self-maintenance in home/school /community is/ are severely compromised, are not attributable to mental retardation;

LEVEL 1 (LEAST)	LEVEL 2 (MODERATE)	LEVEL 3 (INTENSIVE)	LEVEL 4 (HIGHLY INTENSIVE)
1. CHILDREN WITH A DIAGNOSTIC INDICATOR ON AXIS I(continued)			
c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reinforce stability; **OR** **d.** Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription; **MEETS 1. AND/OR**	MEETS 1. AND/OR		
2. CHILDREN WITH A DIAGNOSTIC INDICATOR ON AXIS II (without a diagnosis on Axis I)			
a. There is an onset of remarkable behaviors that could escalate to a crisis. **b.** Behavior presents serious risk of self injury, or in jury to others, or destruction of environment; **AND**	**a.** There is an onset of remarkable or crisis behaviors. **b.** Behavior has resulted in self-injury, or injury to others, or destruction to environment; **AND**		
c. There is significant change from baseline behavior, or amplification in exhibited behaviors, as indicated by the frequency, intensity, duration, of the behavior(s), and/or locations where the behavior(s) occur(s); **AND/OR** **d.** Requires medication and home/community based monitoring of medications to help the family, and the child, consistent with the child's age and cognitive abilities, to understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;			

B Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, **AND** effectively reduced by the implementation of a behavior management plan in the professional judgment of the advising physician or mental health professional, as a result of:

1. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; **AND**

2. there is documented commitment by the primary care givers (usually parent/ guardian) to the therapeutic plan. **AND**

3. If endangerment/ destruction is a relevant feature of the presenting problem, both adolescent and primary caregiver develop a safety plan that at least the caregiver signs.

AND

C The severity and expression of the child's symptoms are such that:

1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above;

AND

2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

(continued on next page)

LEVEL 1 (LEAST)	LEVEL 2 (MODERATE)	LEVEL 3 (INTENSIVE)	LEVEL 4 (HIGHLY INTENSIVE)
D OBSERVATION - 15 days **1.** Troubling symptoms of the child (described by family/school/ others) persist though • not observed on a psychiatric inpatient unit, **OR** • they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides the opportunity to assess and treat the child; **OR** **2.** Child's symptoms have not sufficiently improved despite responsible comprehensive treatment in other levels of care, involving the interagency team.			

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integration objectives including development of the child/ adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

Whenever service is provided for a term greater than three (3) months, there must be at least a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing home/community service.

1. Child must be reevaluated and continue to meet criteria for admission (I);

AND

2. Child shows:
- **a.** measured improvement and/ or begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation);

OR

- **b.** increased or continued behavioral or emotional disturbance with continued expectation for improvement (show rationale in the treatment plan);

AND

3. Review includes consideration/ evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources.

4. Treatment plan must be updated addressing the presenting problem within the context of the psychosocial stressor(s)/event(s); indicating that service should be:
- **a.** continued with a reduced number of hours as a result of the amelioration of original indication for service, and/ or activity of community members and services, and/ or the child's network of family and friends;

OR

- **b.** increased due to changes in the context and/ or adjustments in the treatment plan;

AND

5. Interagency service plan must be updated to reflect the recommendation to continue care and be attached to the treatment plan

Attention Deficit/Hyperactivity Disorder

DSM-IV Diagnostic Criteria for Attention Deficit/Hyperactivity Disorder (ADHD)

A Either 1 or 2:

1. Have six or more of the following symptoms of inattention persisted for a period of at least 6 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 in the workplace (not due to oppositional behavior or failure to understand instructions)
   - 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. Have six or more of the following symptoms of hyperactivity/impulsivity persisted for a period of at least 6 months to a degree that is maladaptive and inconsistent with developmental 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 or climbs excessively in situations in which it is inappropriate (in adolescents and adults is limited to subjective feeling of restlessness)

- 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 blurts out answers before questions have been completed
- Often has difficulty waiting turn
- Often interrupts or intrudes in others (for example, butts into conversation or games).

B. Were some of the inattention/hyperactivity-impulsivity symptoms causing impairment before 7 years of age?

C. Is some impairment from the symptoms present in two or more settings?

D. Is there clear evidence of clinically significant impairment in social, academic, or occupational functioning?

Treatment

Specific Considerations

- 3-5% of children have ADHD.
- Recent studies indicate that less than 14% of children with ADHD receive indicated treatment.
- More boys than girls have the disorder (4:1).
- Girls with ADHD are less likely than boys to be hyperactive and are often not diagnosed early enough.
- ADHD is manifested by an impairment of attention and executive functioning that results in inattention, lack of planning and organizational skills, impulsivity and possibly hyperactivity.
- Children with ADHD frequently have comorbid psychiatric conditions
  - In early childhood, learning disorders, Oppositional Defiant Disorder, Obsessive Compulsive Disorder, and Tourette's Disorder.
  - In late childhood and early adolescence, Conduct Disorder, Bipolar and Major Depressive Disorder, and substance abuse may emerge as well.

- Children with long-standing difficulties with attention and organization have compounded problems with social skill development, demoralization, and low self-esteem.
- As ADHD is heritable disorder, one or more parents may have ADHD.

PSYCHOSOCIAL

- Coordination with a child's parents, pediatrician, teachers and other supports in the community is essential.
- Most children with ADHD benefit from an individualized educational program whether or not they have comorbid learning problems.
- Frequent monitoring of symptoms can be facilitated by direct clinical observation and completion of Conner's Global Index for Parents (Conners-P) and teachers (Teachers-C).
- Parent and child psychoeducation is essential.
- Support groups for parents and/or children may be helpful.
- Parents should be taught behavioral modification techniques and effective limit setting.
- Children can learn strategies for managing impulsivity, organizational planning and social skills.

PHARMACOTHERAPY

- Comorbid psychiatric disorders should be treated as indicated.
- Stimulants including methylphenidate [Ritalin] or dextroamphetamine [Dexadrine] are first line choices.
- Pemoline, a stimulant, may be used if liver functions are followed at baseline and biweekly, thereafter, as a second line choice.
- Second and third line choices are implemented when first lines fail. They should not to be used to augment first line choices.
- Tricyclic antidepressants including imipramine [Tofranil] or nortriptyline [Norpramin] may be used as second line agents, after stimulants.
  - Blood levels may need to be monitored since wide variations may occur.
  - Baseline EKG and follow up EKG may be indicated in certain patients.
- Some physicians prefer to use buproprion [Wellbutrin] to minimize the need to monitor cardiac status required with the tricyclic antidepressants.
- If stimulants or antidepressants prove to be ineffective or are accompanied by unacceptable side effects, clonidine and/or an alpha agonist can be used. Orthostatic blood pressure and pulse should be measured frequently.

Oppositional Defiant Disorder

A. Is there a pattern of negativistic, hostile and defiant behavior lasting at least six months, during which four (or more) of following are present?

- Often loses temper
- Often argues with adults
- Often actively defies or refuses to comply with adults' requests or rules
- Often deliberately annoys people
- Often blames others for his or her mistakes or misbehavior
- Is often touchy or easily annoyed by others
- Is often angry and resentful
- Is often spiteful or vindictive

B. Does the disturbance cause clinically significant impairment in social, academic or occupational functioning?

Treatment

Specific Considerations

- Oppositional Defiant Disorder [ODD] can represent a time-limited disorder, if identified early and treated aggressively.
- Some children with ODD go on to develop Conduct Disorder.
- Collaboration of parents, teachers, and other caretakers in implementing intervention strategies is essential.
- Treatment of comorbid ADHD, learning problems, mood and anxiety disorders maximizes efficacy of ODD specific treatment.

Psychosocial Intervention

- Focused examination of triggers of oppositional behavior leads to development of behavioral modification protocols utilizing positive reinforcement and “time out” for cognitive reframing.
- Social skills training serves to enhance strengths and the development of prosocial behavior.

Pharmacotherapy

- Has a limited role in ODD.
- May be used to target specific symptoms including irritability, low frustration tolerance and/or hyperactivity.
- Stimulants, clonidine and low dose atypical neuroleptics have been used as time limited adjuncts to behavioral interventions.

Conduct Disorder

DSM-IV Diagnostic Criteria for Conduct Disorder

A A repetitive and persistent pattern of behavior in which the basic rights of others, or major age-appropriate societal norms or rules are violated.

For Diagnosis, have three of the following been present in the last 12 months, one of which has been present in the past 6 months?

Aggression to people or animals

- Often bullies, threatens or intimidates others
- Often initiates fights
- Has used a weapon that can cause serious physical harm to others (for example, bat, brick, broken bottle, knife, gun)
- Has been physically cruel to people
- Has been physically cruel to animals
- Has stolen while confronting a victim (for example: mugging, purse snatching, extortion, armed robbery)
- Has forced someone into sexual activity

Destruction of property

- Has deliberately engaged in fire setting with the intention of causing serious damage
- Has deliberately destroyed others' property (in a manner other than fire-setting)

Deceitfulness or theft

- Has broken into someone else's car, building or house
- Often lies to obtain goods or favors or to avoid obligations (cons others)
- Has stolen items of nontrivial value without confronting victim (for example, shop lifting, but without breaking and entering, forgery)

Serious violations of rules

- Often stays out at night despite parental prohibitions, beginning before age 13
- Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

- Is often truant from school, beginning before age 13

B. Does the disturbance in behavior cause clinically significant impairment in social, academic or occupational functioning?

C. If the individual is over age 18, criteria are not met for Antisocial Personality Disorder.

Specific Considerations

- Antisocial behavior may be manifest briefly in children during the course of normal development.
- Strict diagnostic criteria must be met to endorse the diagnosis of Conduct Disorder.
- Conduct Disorder is one of the most prevalent childhood psychiatric disorders with a prevalence of 1.5-3.4% of children and adolescents.
- Most children with Conduct Disorder present late in childhood or early adolescence, although it may occur as early as 5 or 6 years.
- Conduct Disorder is a severe and complex form of psychopathology with patients presenting with impairment in several functional domains.
- To be successful, psychiatric care must be multimodal and address multiple domains of dysfunction over an extended period of time.
- More boys than girls present with Conduct Disorder.
- Predisposing factors include genetic vulnerability, temperament, the biologic effect of neglect, abuse and socioeconomic disadvantage.

Treatment

- The multimodal treatment should address all areas of functional impairment as indicated.
- Aggressive school, family and social interventions are essential.
- Common comorbid psychiatric disorders (Attention Deficit/Hyperactivity Disorder, developmental disorders, substance use, mood disorders, or intermittent disorders) should be treated.
- Family interventions should include parental guidance, training and family therapy.
- Emphasis should be on identifying the strengths of a youth and the family.
- Consistency and clearly defined consequences are essential.
- Individual and group therapy may be helpful.
- Psychosocial skills-building is key.
- Pharmacotherapy is indicated for target symptom management.
- Lithium, valproic acid [Depakote], clonidine, and atypical antipsychotics [such as risperidone, olanzapine, quetiapine] have been used to treat aggression.
- Coordination with the juvenile justice system is essential, if the youth has committed an offense.

Pervasive Developmental Disorders

- Autistic Disorder
- Rett's Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder, NOS

Of the Pervasive Developmental Spectrum of Disorders, Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorder are most prevalent. The diagnostic criteria and suggested treatments follow.

Autistic Disorder

A. Are there a total of six or more items from 1, 2 and 3, with at least two from 1, and one each from 2 and 3?

1. Qualitative impairment in social interaction, as manifested by at least two of the following
   - Marked impairment in the use of nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
   - Failure to develop peer relationships appropriate to developmental level
   - A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (for example, by a lack of showing, bringing or pointing out objects of interest)
   - Lack of social or emotional reciprocity
2. Qualitative impairments in communication as manifested by at least one of the following:
   - Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
   - In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

- Stereotyped or repetitive use of language or idiosyncratic language
- Lack of varied, spontaneous make believe play or social imitative play appropriate to the developmental level

3. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
   - Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
   - Apparently inflexible adherence to specific, nonfunctional routines and rituals
   - Stereotyped and repetitive motor mannerisms(for example: hand or finger twisting or complex whole body movements)

B Are there delays or abnormal functioning in at least one of the following areas, with onset prior to three years of age?

1. Social interaction
2. Language as used in social communication
3. Symbolic or imaginative play

Rett's Disorder

A Are all of the following present?

1. Apparently normal prenatal and perinatal development
2. Apparently normal psychomotor development during the first five months after birth
3. Normal head circumference at birth

B Have all of the following occurred after a period of normal development?

1. Slowing of head growth between ages of 5 and 48 months.
2. Loss of previously acquired hand skills between ages of 5 and 30 months with the development of stereotyped hand movements, such as hand wringing or hand washing
3. Loss of social engagement early in the course (although often social interaction develops later)
4. Appearance of poorly coordinated gait or trunk movements

5. Severely impaired expressive and receptive language development with severe psychomotor retardation

Childhood Disintegrative Disorder

A. Has there been apparently normal development for at least the first two years of life as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play and adaptive behavior?

B. Has there been a loss of at least two of these previously acquired skills?

1. Expressive or receptive language
2. Social skill or adaptive behavior
3. Bowel or bladder control
4. Play
5. Motor skills

C. Are there abnormalities of functioning in at least two of the following areas?

1. Qualitative impairments in social interaction
   - Impairment in nonverbal behaviors
   - Failure to develop peer relationships
   - Lack of social or emotional reciprocity
2. Qualitative impairments in communications
   - Delay or lack of spoken language
   - Inability to initiate or sustain a conversation
   - Stereotyped and repetitive use of language
   - Lack of varied make-believe play
3. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, including motor stereotypes and mannerisms

Asperger's Disorder

A Is there qualitative impairment in social interaction, as manifested by at least two of the following?

1. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body posture, and gestures to regulate social interaction.
2. Failure to develop peer relationships appropriate to developmental level.
3. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people
4. Lack of emotional reciprocity

B Are there restricted, repetitive and stereotyped patterns of behavior, interests, and activities as manifested by at least one of the following?

1. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
2. Apparently inflexible adherence to specific, nonfunctional rituals or routines.
3. Stereotyped and repetitive motor mannerisms
4. Persistent preoccupation with parts of objects

C The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D There is no clinically significant delay in language development.

E There is no clinically significant delay in cognitive development or in the development of age appropriate self help skills, adaptive behavior (other than social interaction) and curiosity about the environment.

Pervasive Developmental Disorder, NOS

This category should be used when there is a severe and pervasive impairment in the development of:

- Reciprocal social interaction

OR

- Verbal or nonverbal interaction

OR WHEN

- Stereotyped behavior, interests, and activities are present

BUT

- The criteria for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorders are not met.

Treatment

SPECIAL CONSIDERATIONS

- Pervasive Developmental Spectrum Disorders are characterized by impairment in social, communicative, and cognitive skills and may be associated with mental retardation.
- 0.1% of children have autism, 1.0% have Pervasive Developmental Disorder, NOS.
- Impairment, first noted in infancy, may be compounded by mood and behavioral disruption in grade school and adolescent years.
- Initially a comprehensive evaluation of growth and developmental patterns, social, communicative and cognitive development is essential.
- Strengths of the child, parents, family members and community must be assessed and used to maximally support parents caring for a child with Pervasive Developmental Disorder.
- Medical assessment should include physical examination, screening for treatable disorders, audiological, visual, and neurologic assessment. Speech and language assessments are essential. Psychological testing, occupational, and physical therapy assessments may be indicated.
- Comorbid psychiatric conditions include Obsessive-Compulsive Disorder, verbal and motor stereotypes and tics, high levels of anxiety and occasionally psychosis.

PSYCHOSOCIAL

- Special educational services including speech, language, occupational and physical therapies should be provided through preschool and other school settings.
- Behavioral health interventions include parent education, parent training in behavior modification techniques and parent/sibling support groups.

PHARMACOTHERAPY

- Used for treatment of target symptoms.
- Atypical neuroleptics, particularly risperidone [Risperdal], have been used to diminish aggressive or disruptive behavior.
- Selective serotonin reuptake inhibitors (SSRIs), particularly fluoxetine [Prozac] and sertraline [Zoloft] have effectively diminished generalized anxiety, Obsessive Compulsive Disorder symptoms and self-injurious behavior.
- Clonidine and stimulants have been used to diminish inattentiveness

Special considerations for certain disorders when diagnosed in Children and Adolescents

Depressive, Major Depressive and Dysthymic Disorders

- Both Major Depressive Disorder (MDD) and Dysthymic Disorder (DD) are common and recurrent disorders in children and adolescents.
- These disorders are frequently associated with a high risk of suicide and comorbid substance abuse.
- MDD effects 2% of children and 4-8% of adolescents.
- In childhood, girls and boys are equally effected.
- In adolescence, girls are twice as likely to experience MDD than boys.
- Children presenting with neurovegetative signs of depression may also exhibit symptoms of anxiety, somatic complaints, temper tantrums, irritability, and auditory hallucinations.
- Adolescents may present with atypical depressive symptoms including increased sleep, appetite disturbance, delusions, suicidal ideation, behavioral disruption, and auditory hallucinations.

Treatment

- Intensity, duration and frequency should be determined by level of acuity.

Psychosocial

- Cognitive Behavioral Therapy (CBT) is the only evidenced-based intervention proven to be effective in treating adolescent MDD.
- Psychoeducation for children, adolescents and family members is key.
- Supportive and dynamic individual work is found to be helpful in addressing patient specific issues.

Pharmacotherapy

- While tricyclic antidepressants (TCAs) have been found effective in treating children and adolescents with MDD, SSRIs have fewer cardiotoxic effects and require less monitoring of cardiac status.

- SSRIs, especially fluoxetine [Prozac] and sertraline [Zoloft] are effective antidepressants for children and adolescents.
- Adequate doses for a period of 4-6 weeks should be used prior to raising the dose or adding additional agents.

Bipolar Disorder

- 20% of adults with Bipolar Disorder experienced their first episode between the ages of 15-19 years.
- Very early onset occurs prior to age 13.
- Early onset occurs prior to age 18.
- Mapping of a life chart characterizing the course of the illness including frequency, duration, and severity of episodes and treatment response is essential.
- First episodes may be manic or depressive in youth.
- Boys and girls are equally effected.
- 20 - 30% of children and adolescents with a Major Depressive Episode will go on to develop Bipolar Disorder.
- Risk factors for developing a manic episode before age 18:
  - Rapid onset depression episodes accompanied by psychomotor retardation and psychosis
  - Family history of mood disorders, particularly Bipolar Disorder
  - History of hypomania or mania when treated with antidepressants
- Children with mania may have fluctuating symptoms of psychomotor agitation, labile mood, disorganization of thought, depressive symptoms and psychosis.
- Adolescents with mania may have mixed manic and depressive features, mood incongruent hallucinations, paranoia and thought disorder.
- Youths with Bipolar Disorder may have premorbid ADHD, Conduct Disorder or normal histories.

Treatment

PHARMACOTHERAPY

- Treatment should be phase specific.
- Anti-manic agents may require 4-6 weeks to reach maximum efficacy.
- Antidepressants may trigger a manic episode requiring treatment.
- Multiple medication changes and additions should be avoided.

MOOD STABILIZERS

- Lithium
  - Therapeutic serum levels in children and adolescents are the same as adults (0.6-1.2mEq/L).
  - Post-pubertal adolescents tolerate doses similar to adults.
  - Children generally have higher glomerular clearance than adults and require higher doses.
  - Starting dose is typically 30mg/kg/day in divided doses
- Anticonvulsant Mood Stabilizers
  - Valproate [Depakote]
    - Effective for youth with rapid cycling
    - More effective for treatment and prophylaxis of mania than depression
    - Therapeutic range is anticonvulsant (50-100 micrograms/ml) in serum
  - Carbamazepine [Tegretol]
    - Therapeutic range is anticonvulsant (4-12 micrograms/ml) in serum
    - Adolescent girls may develop polycystic ovary disease and should be monitored for menstrual abnormalities.
  - Benzodiazepines [Valium, Librium, Ativan, Restoril, Xanax]
    - No evidence-based studies support the use of benzodiazepines in children and adolescents.
    - Alprazolam [Xanax] may induce mania

- Neuroleptics
  - While no evidence-based studies support the use of neuroleptics in early onset mania, short-term use of atypical antipsychotics has been shown effective in case reports.
- Electroconvulsive Therapy (ECT)
  - May prove effective for youth with medication refractory symptoms, catatonia, pregnancy or neuroleptic malignant syndrome

Psychosocial Treatments

- Psychoeducation of child, adolescent, and family is necessary
- Relapse prevention strategies to minimize medication noncompliance are essential
- Individual and family psychotherapy to address essential individual's family specific issues.
- Treatment of comorbid substance abuse, disruptive disorders and/or suicidality is key.

Clinical Pearls

1. Typically, psychotic symptoms do not occur in isolation. For example, having command auditory hallucinations that tell the patient to kill himself in the absence of any other psychotic symptoms would be very unlikely. This clinical picture would require a thorough evaluation to support this finding. If additional clinical material was lacking, then consideration should be given to malingering.
2. A psychiatric diagnosis that is made near the time a patient used a substance or while the patient is intoxicated or in active withdrawal can often be considered to be invalid unless the diagnosis was made in the past when substance use did not interfere with the diagnostic process.
3. Children are not little adults.
4. When you hear hoofbeats, think of horses, not zebras.
5. Things are common because they are common.
6. Once you are a pickle, there's no going back to being a cucumber.
7. The first person an addict will try to deceive about the amount of substance being abused and the consequences of such abuse is him/herself.

Bibliography

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. American Psychiatric Association, Washington, D.C. 1994.

HealthChoices Behavioral Health Services, Guidelines for Mental Health Medical Necessity Criteria, Appendix T, Parts A, B, C.

Friedman, M. J., A., Guide to the Literature on Pharmacotherapy for PTSD. PTSD Research Quarterly (2000) 11:1.

Graham, A. W., Schultz, T. K., eds. Principles of Addiction Medicine 2nd Edition, American Association of Addiction Medicine, Chevy Chase, MD 1998.

Hyer, L., McCraine, E. W., Peralme, M. A., Psychotherapeutic Treatment of Chronic PTSD. PTSD Research Quarterly (1993) 4:2.

Jacobs, D., ed. Harvard Medical School Guide to Suicide Assessment and Intervention. Jossey-Bass, San Francisco, 1999.

Levinson, D. F., Umapathy, C., Mustaq, M. Treatment of Schizoaffective and Schizophrenia with Mood Symptoms. Am J Psych (1999) 156:8.

McElroy, S. L., Recognition and Treatment of Intermittent Explosive Disorder. J Clin Psychiatry (1999) 60 suppl.15:12-16.

Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Revision), American Psychiatric Association. Am J Psych 157:4 Supplement, April 2000.

Practice Guidelines for the Treatment of Patients with Eating Disorders (Revision), American Psychiatric Association. Am J Psych 157:1 Supplement, January 2000.

Practice Guideline for the Treatment of Patients with Schizophrenia, American Psychiatric Association. Am J Psych 154:4 Supplement, April 1997.

Practice Guideline for the Psychiatric Evaluation of Adults, American Psychiatric Association. Am J Psych 152:11 Supplement, November 1995.

Practice Guideline for the Treatment of Patients with Bipolar Disorder, American Psychiatric Association. Am J Psych 151:12 Supplement December 1994.

Glossary

Acuity: In relation to patients, the severity of their condition or symptoms

Adherence: Usually related to the degree to which a patient follows treatment recommendations such as attending clinic, taking medications, etc.

ADLs (Activities of daily living): Refers to activities such as personal hygiene, driving, obtaining food, etc.

Affect: The outward expression of emotion as evidenced by facial expression, body language, tone of voice, etc.

Agonist: Refers to the activity of a substance on a receptor in the brain to initiate an effect, in contrast to antagonist that inhibits certain effects.

Alleviate: To reduce, to eliminate

Anhedonia: Loss of interest in pleasurable activities

Anticholinergic: A side effect that may occur with certain psychiatric medications, usually antidepressant medication and antipsychotic medication causing symptoms such as dry mouth, blurred vision, constipation.

Arrhythmia: Irregular heart beat

Asthenia: Characteristics of individuals with this disorder include easy fatigability, low energy level, lack of enthusiasm, marked incapacity for enjoyment, and over-sensitivity to physical and emotional stress.

Atypical: Not of the usual kind or type

Audiological: Refers to the sense of hearing

Autonomic Nervous System: that part of the nervous system that controls, to some degree, the heart rate, respiratory rate, and the blood pressure; may produce withdrawal symptoms in individuals addicted to substances.

Biopsychosocial: The relationship between the biological, psychological and sociological aspects of a patient; evaluations should deal with these aspects to be considered complete

Catatonic: Usually seen in schizophrenics, a syndrome in which the patient has extreme muscle rigidity does not move and/or has peculiar postures.

CIWA-Ar: Clinical Institute Withdrawal Assessment - Alcohol revised. A structured scale that indicates the severity of withdrawal symptoms, used to determine need for medication in detoxification settings in some alcohol withdrawal medication plans.

Cognitive: the mental activities associated with thinking, learning and memory.

Comorbid, co-occurring: Have two or more psychiatric, substance abuse and/or medical occurring at the same time.

Compliance: see Adherence

Compulsions: A ritual behavior that reduces discomfort, but is carried out in a rigid or pressured fashion. For example: checking to see if the doors are locked before going to bed three times in exactly the same way.

Craving: Usually in reference to addicts, the experience of an intense desire to use drugs.

Decompensation: The appearance or reappearance of symptoms, often in response to stress or noncompliance with treatment recommendations.

Delirium: A disorder caused by abnormal brain metabolism or exposure to toxins

Delusion: A fixed false belief that cannot altered by reasonable discussion or presenting evidence that is contrary to the belief.

Depersonalization: A feeling of loss of one's identity

Derailment: A symptom of a thought disorder in which one constantly gets "off the track" in thoughts or speech.

Derealization: An alteration in the perception of one's environment in which things that are ordinarily familiar become strange or unreal.

Developmental milestone: Refers to specific behaviors occurring at certain ages, such as walking, talking, etc.

Dissociation: An unconscious process that involves the separation of one mental process from the rest of the mental processes, resulting in independent functioning of the separated processes and the loss of the usual relationship of mental processes.

Dysphoria: A general feeling of dissatisfaction, unpleasantness or discomfort

ECT: Electroconvulsive treatment

Edema: An accumulation of watery fluid in tissues

Estrangement: To become distant, unfriendly, or unsympathetic

Excoriations: Scratches on the skin

Executive functions: The mental functions that allow for careful decision-making, good impulse control, socially appropriate behavior, etc.

Fasciculation: Involuntary twitching of muscle groups

Flight of ideas: Rapidly moving from one idea to another, usually the ideas are loosely connected, but a connection can be detected. Commonly seen in a manic episode

Fund of information: The expected general information that one expects from a person about recent events, his/her personal situation, how to perform mental and physical tasks, etc. Usually varies with educational level.

GI (gastrointestinal): Refers to the stomach and intestines

Grand mal seizures: A seizure characterized by the sudden contraction of muscles with a fall to the ground, a loss of consciousness, followed by a gradual recovery. The patient has no memory of the seizure.

Hallucination: Having a perceptual (sight, hearing, taste, feeling, etc) experience in the absence of a real stimulus.

Hypersomnia: Excessive sleeping

Hypervigilance: Excessive attention to the environment, scanning for potential danger.

Hypoglycemia: Decreased blood sugar

Ideas of reference: The experience of general stimuli in the environment having specific reference to the individual. For example, believing people on television are speaking directly to oneself.

Idiosyncratic: Something that has special specific meaning only to oneself

Illusion: The misinterpretation of a real stimulus

IM: intramuscular, usually in reference to an injection that places medication in a large muscle

Imminent: About to happen in the immediate future.

Incontinence: Inability to prevent excretion of urine and or feces

Insomnia: Inability to sleep

Ischemia: Reduced blood flow to a specific area due to an obstruction.

JCAHO: Joint Commission on the Accreditation of Health Organizations

Lethality: Level of danger of producing death

Maladaptive: Usually in reference to a behavior or behaviors that do not serve the individual in adjusting effectively to particular situations

Menarcheal: Referring to the age when girls have their first menstrual period.

Mood: A sustained internal emotional state that is not altered by external factors.

Motor, motoric: Refers to movement of the body, for example walking is a motor activity.

Multiaxial: Refers to the five axes of assessment used in the DSM-IV Manual for the description of the patient's situation.

Myocardial: Refers to the heart, specifically heart muscle

Negativistic: Used in reference to Schizophrenia, that characteristic of refusing to cooperate with simple requests for no apparent reason.

Neuroleptic Malignant Syndrome: A serious medical condition resulting from the use of certain antipsychotics in individuals. The cause is unknown, and, if not promptly treated, can result in death.

Neuroleptic medication: A term used interchangeably with antipsychotic medication

Neurovegetative: Refers to psychiatric symptoms causing physical symptoms, such as, poor sleep and appetite, often seen in depressed individuals.

Norms: A model or pattern considered typical for a group

Obsessions: Intrusive thoughts ideas that are experienced as unwelcome and ideas that evoke anxiety and discomfort.

Opiate: Refers to a group of drugs that include heroin, morphine, and many others

Orientation: refers to knowledge of one's identity, current date and approximate time, location and situation

Orthostatic: With blood pressure, a decrease in blood pressure when an individual arises from a lying or seated position to a standing position. Fainting or falling may result. Some medications can cause this effect.

Perceptual: Refers to the fives senses: touch, taste, sight, hearing and smell

Psychoactive: In reference to substances, any substance that can cause an effect on the brain.

Psychomotor: Relating to the psychological processes associated with muscle movement, for example, gesturing when speaking.

Psychopharmacology: The science of the study and application of medications in the treatment of psychiatric disorders

Psychosis: A general term for a mental disturbance that involved severe disruption of normal mental organization, the ability to communicate, the ability to recognize reality, and relate to others.

Reciprocity: The ability to give back something

Regression: A return to a more primitive mode of behaving, thinking and relating that is a diminution of the individual's adaptation to life

Stereotyped: Constant or persistent repetition of meaningless movement or gestures

Tactile: Involving the sense of touch

Tardive Dyskinesia: An irreversible neurological condition characterized by involuntary muscle movements. Caused by certain antipsychotic medications

Tics: Repetitive, involuntary muscle movements usually involving the face

Toxins: Any substance that can harm or kill cells

Transient: Temporary, not permanent

Tremor: Trembling, shaking movement usually of hands, fingers, or feet

Vasoconstriction: Narrowing of blood vessels

Vital signs: Pulse, blood pressure, and rate of breathing