



Behavioral Health Screening in Primary Care Settings

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the Behavioral Health Screening in Primary Care Settings. The CPG outlines the organizations that WellCare aligns with regarding the topic and relevant Measureable Health Outcomes.

OVERVIEW

The purpose of this guideline is to assist primary care in developing systems that support effective assessment, diagnosis and ongoing management of initial and recurrent major depression and persistent depressive disorder in adults age 18 and over, and assist patients to achieve remission of symptoms, reduce relapse and return to previous level of functioning.¹ In addition, information on screening for anxiety is included and for alcohol and substance use (including smoking). **Members should be screened by providers annually; this includes children and adolescents. To best serve members, communication and coordination between PCPs and behavioral health providers is vital to achieve medication reconciliation and integrated care.**

Major depressive disorder (MDD) is a common and significant health care problem. It is the leading cause of disability among adults in high income countries and is associated with increased mortality due to suicide and impaired ability to manage other health issues.¹ Major depression is a treatable cause of pain, suffering, disability and death, yet primary care clinicians detect major depression in only one-third to one-half of their patients with major depression. Additionally, more than 80% of patients with depression have a medical comorbidity. Usual care for depression in the primary care setting has resulted in only about half of depressed adults getting treated and only 20-40% showing substantial improvement over 12 months.²

Depressive disorders are common in primary care settings and are associated with substantial morbidity and disability for individuals, as well as direct and indirect costs to society. Yet, depression is a highly treatable condition, and the goal of treatment is complete recovery. Approximately 70-80% of antidepressants are prescribed in primary care, making it critical that clinicians know how to use them and have a system that supports best practices.² We believe that all primary care providers should be equipped to screen for depression and to assure timely and adequate treatment, either in their own practices or through an established system of referral to mental health professionals.³ Depression is a potentially life-threatening disorder that affects approximately 14.8 million Americans 18 years of age and older in a given year. Depression also affects many people younger than age 18. The STAR*D (Sequenced Treatment Alternatives to Relieve Depression) study found that nearly 40% had their first depressive episode before age 18.³

Depression is among the leading causes of disability in persons 15 years and older. It affects individuals, families, businesses, and society and is common in patients seeking care in the primary care setting. Depression is also common in postpartum and pregnant women and affects not only the woman but her child as well.¹ Depression has a major effect on quality of life for the patient and affects family members, especially children. Depression also imposes a significant economic burden through direct and indirect costs. In the United States, an estimated \$22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated \$23 billion in 2011.¹

At any given time, 9% of the population has a depressive disorder, and 3.4% has major depression. In a 12-month time period, 6.6% of the U.S. population will have experienced major depression, and 16.6% of the population will experience depression in their lifetime. Additionally, major depression was second only to back and neck pain for having the greatest effect on disability days, at 386.6 million U.S. days per year. In another WHO study of more than 240,000 people across 60 countries, depression was shown to produce the greatest decrease in quality of health compared to several other chronic diseases. Health scores worsened when depression was a comorbid condition, and the most disabling combination was depression and diabetes.²

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the United States Preventive Services Task Force (USPSTF), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), American College of Preventive Medicine (ACPM), Community Preventive Services Task Force (CPSTF), and the Institute for Clinical Systems Improvement (ICSI). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to Behavioral Health Screening in Primary Care Settings, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the USPSTF, AAFP, AAP, ACOG, ACPM, CPSTF, and ICSI on the topic of Behavioral Health Screening in Primary Care Settings. The following are highlights from their recommendations.

UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF)⁴

[Depression in Adults: Screening](#)

The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.⁴

[Depression in Children and Adolescents: Screening](#)

The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.⁵

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)

The **American Academy of Family Physicians (AAFP)** screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The AAFP recommends screening for major depressive disorder (MDD) in adolescents 12-18 years of age when adequate systems are in place for diagnosis, treatment, and monitoring. Recommendations align with those published by the USPSTF.⁶

AMERICAN ACADEMY OF PEDIATRICS (AAP)

The **American Academy of Pediatrics (AAP)** recommends that pediatricians screen mothers for postpartum depression at the infant's 1-, 2-, and 4-month visits.⁷ In addition, the *Mental Health Screening and Assessment Tools for Primary Care* table was published in collaboration with the AAP. It provides a listing of mental health screening and

assessment tools, with a summary of psychometric testing properties, cultural considerations, costs, and key references. It includes tools that are proprietary and those that are freely accessible. Tools are also included that may be used for primary care assessment of children's global functioning and assessment of children presenting with the most common problems encountered in primary care (e.g, anxiety, depression, inattention and impulsivity, disruptive behavior or aggression, substance abuse, learning difficulties, and symptoms of social-emotional disturbance in young children). Tools are also available to identify risks in the psychosocial environment, prior exposure to trauma, and problems with the child's developmental trajectory and cognitive development. For additional information click [here](#).⁸

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG)

The **American College of Obstetricians and Gynecologists (ACOG)** recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms. Screening must be coupled with appropriate follow-up and treatment when indicated (practices should be prepared to initiate medical therapy, refer patients to appropriate care, or both), and systems should be in place to ensure follow-up for diagnosis and treatment.⁹

AMERICAN COLLEGE OF PREVENTIVE MEDICINE (ACPM)

The **American College of Preventive Medicine (ACPM)** supports screening for depression by primary care clinicians of all adults. Further, the ACPM recommends that all primary care clinicians have systems in place (within the primary care setting or through collaborations with mental health professionals) to ensure the accurate diagnosis and treatment of this condition. This aligns with recommendations published by the USPSTF in 2016.³

COMMUNITY PREVENTIVE SERVICES TASK FORCE (CPSTF)

The **Community Preventive Services Task Force (CPSTF)** recommends collaborative care for the management of depressive disorders based on strong evidence of effectiveness in improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression. The collaboration also improves the routine screening and diagnosis of depressive disorders, as well as the management of diagnosed depression.¹⁰

INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT (ICSI)

The **Institute for Clinical Systems Improvement (ICSI)** recommends that clinicians use a standardized instrument to screen for depression if it is suspected based on risk factors or presentation.¹

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The AHRQ aligns with USPSTF screening recommendations on depression.

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement*.

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Care Management

PCPs provide about 70% of all mental health treatment in the USA. About 25% of adults experience a mental illness a year and more than half of them do not receive treatment. Integrating behavioral health services in primary care can get patients back to work sooner, increase compliance with medical treatment, lower medical costs and possibly even reduce physician burnout. PCPs should screen and diagnose their patients, provide care to patients with mild to moderate behavioral health concerns and refer out to mental health professionals for severe or complex cases while collaborating with the professional and sharing clinical information such as medications. Many providers are now adding behavioral health professionals to their staff as patients are more likely to attend follow up appointments as the stigma of seeing a behavioral health professional is removed and quality of care outcomes improve. High-risk populations can be addressed by incorporating behavioral health screenings into well-child checkups, screening all pregnant and perinatal women for depression and substance abuse and providing guidance and coaching to parents as part of

pediatric care to ensure children’s social and emotional needs are being met. If behavioral health professionals cannot be located in the same office then easy consultation with a behavioral health professional should be available.¹¹

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **Symptoms:** Member will have >20% reduction in PHQ9 score within 90 days.
- **Engagement:** Member will utilize Cobalt for managing behavioral health symptoms at least 30 minutes a week within 90 days as evidenced by Cobalt reports
- **Adherence:** Member will have a reduction in HEDIS Care Gaps by >20% within 90 days as evidenced by medical claims and HEDIS Care Gaps data (annual preventive care visit, diabetic retinal eye exams etc.)
- **Adherence:** Member will attend >80% of scheduled PCP appointments within 90 days as evidenced by medical claims or provider report
- **Adherence:** Member will be adherent with prescribed medications >80% of the time within 90 days as evidenced by pharmacy claims and member report
- **Utilization:** Member will have a reduction of ER visits and/or inpatient admissions related to behavioral health issues by >20% within 90 days

CASE MANAGEMENT GOALS

Goals should target specific care gaps and/or adherence issues, and measure the member’s progress towards self-management and adherence which lead to the targeted health outcomes above.

- **Symptoms:** Member will obtain mood journal and verbalize how to track BH symptoms within 60 days
- **Engagement:** Member will verbalize 2 ways in which they can better manage their medical condition within 60 days
- **Engagement:** Member will be connected to at least one appropriate community resource within 30 days
- **Engagement:** Member will be connected to an employment, volunteer or recreational opportunity within 60 days
- **Engagement:** Member will have a Crisis/Safety Plan implemented by provider within 30 days as evidenced by provider or member report
- **Adherence:** Member will be prescribed appropriate medication to manage BH symptoms by PCP or BH provider within 30 days
- **Adherence:** Member will verbalize when, why and how member should be taking {prescribed medication} within 30 days
- **Adherence:** Member will be screened for mental health and/or substance abuse disorders at PCP office within 30 days as evidenced by medical claims
- **Adherence:** Member will have a PCP appointment scheduled within 30 days

CASE MANAGEMENT OBJECTIVES

- Link member to a Primary Care Provider that also provides mental health services such as a provider linked to a community hospital or a Federally Qualified Health Center
- Inform member’s PCP about mental health resources in the area including mobile crisis response if available in the area
- Ensure member has transportation to PCP and BH providers
- Encourage member to sign ROIs for PCP and BH professionals to communicate and collaborate with one other and for CM to communicate with providers regarding BH needs of member
- Educate member and caregivers on BH diagnosis including symptoms, self-management practices and treatment options with risks and benefits
- Educate on the importance of sleep hygiene, diet, exercise and supportive relationships on overall physical and mental health
- Refer member to therapist if needed
- Ensure member has a medication evaluation by PCP or BH professional
- Encourage member to attend PCP appointments and see if member is eligible for any Healthy Rewards benefits through their plan

- Communicate with PCP regarding what treatments are available in member's plan and refer member to BH providers that are in-network
- Refer member to community resources including programs to help with finances, smoking cessation programs and weight loss programs
- Assess member's support system and refer to support and self-help groups as needed
- Screen for safety concerns such as domestic violence or other unsafe living conditions and work with PCP to get a referral for a home health social work visit if needed
- Screen member for suicidal ideations including plan, means, and past attempts and follow crisis step action if needed
- Communicate with PCP information about past BH medications and treatment if written consent is given
- Use Motivational Interviewing techniques with members to improve treatment adherence
- Educate member on medical condition and self-management practices
- Refer member to support group for medical and/or BH condition
- Communicate regularly with members of the ICT
- Assess for psychosocial concerns and refer to community resources to address housing, food, employment, and social concerns
- Refer to Cobalt
- Educate member on the importance of avoiding substance misuse

MEDICAL BEHAVIORAL INTEGRATION

More than 68% of adults with a behavioral health disorder have at least one comorbid medical disorder and 29% of people with a medical disorder also have a comorbid behavioral health disorder. People diagnosed with a mental health disorder have higher rates of diabetes, cardiovascular disease or pulmonary disease than the general population. In addition to having higher rates of chronic medical conditions than the general population, people diagnosed with depression as well as other behavioral health conditions often have instances of reduced compliance and poorer overall health outcomes. Patients diagnosed with a serious mental illness die on average 25 years earlier than the general population. The most common causes for death in this population are cardiovascular disease, respiratory disease and diabetes. One reason that the rate of developing these medical conditions is higher in the behavioral health population is that psychotropic medications can cause weight gain, obesity and type 2 diabetes. The primary care office is also an appropriate place to provide behavioral health care because many acute and chronic medical conditions such as chronic pain, COPD and obesity involve psychosocial concerns and health behaviors. Some medications prescribed for medical conditions also have the possibility of exacerbating an underlying behavioral health condition. In addition, each additional comorbid medical condition someone is diagnosed with increases the likelihood of developing depression so behavioral health and medical conditions are linked on many levels and should best be treated in an integrated and holistic manner.¹²

MEMBER EDUCATIONAL RESOURCES

There are currently no Krames educational materials available for this topic. Providers may wish to provide the resources below to members who may find the information useful:

Depression and Anxiety Disorders

- Anxiety and Depression Association of America - <http://www.adaa.org/>
- National Alliance on Mental Illness (NAMI-WA) - www.namiwa.org
- National Institute of Mental Health (NIMH) - <http://www.nimh.nih.gov/health/topics/depression/index.shtml>
- National Institute of Mental Health (NIMH) - <http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>

Alcohol and Substance Abuse

- National Institute on Drug Abuse (NIDA) - Patients & Families - <http://www.drugabuse.gov/patients-families>
- National Institute on Drug Abuse (NIDA) - Parents & Educators - <http://www.drugabuse.gov/parents-educators>
- National Institute on Drug Abuse (NIDA) - Students & Young Adults - <http://www.drugabuse.gov/students-young-adults>
- Alcoholics Anonymous - www.aa.org
- National Institute on Alcohol Abuse and Alcoholism (NIAAA) - <http://www.niaaa.nih.gov/alcohol-health>
- Narcotics Anonymous - www.na.org

- Substance Abuse and Mental Health Services Administration (SAMHSA) - <http://www.samhsa.gov/Treatment/>
NOTE: SAMHSA maintains a national registry of evidence-based programs and practices for substance abuse and mental health interventions (<http://nrpp.samhsa.gov>) that may be helpful for clinicians looking for models of how to implement depression screening.¹

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *ADHD (HS-1020); Anxiety Disorders (HS-1057); Behavioral Health Conditions and Substance Use in High Risk Pregnancy (HS-1040); Child and Adolescent Behavioral Health (HS-1049); Depressive Disorders Adults, Children & Adolescents (HS-1022); Post-Traumatic Stress Disorder (HS-1048); Substance Use Disorders (HS-1031); and Suicidal Behavior (HS-1027).*

Information related to behavioral health screening can be found in the following age-specific Preventive Health CPGs: *Adolescent (HS-1051); Adult (HS-1018); Older Adult (HS-1063); and Pediatric (HS-1019).*

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

References

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*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care 1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
5/3/2018	<ul style="list-style-type: none"> • Approved by MPC. No changes.
7/24/2017	<ul style="list-style-type: none"> • Approved by MPC. Includes sections on Care Management and Health Equity, Health Literacy, and Cultural Considerations.
4/7/2016	<ul style="list-style-type: none"> • Approved by MPC. New.

Addendum

CLINICAL CONSIDERATIONS¹

Assessment of Risk. The USPSTF recommends screening in all adults regardless of risk factors. However, a number of factors are associated with an increased risk of depression. Among general adult populations, prevalence rates vary by sex, age, race/ethnicity, education, marital status, geographic location, and employment status. Women, young and middle-aged adults, and nonwhite persons have higher rates of depression than their counterparts, as do persons who are undereducated, previously married, or unemployed. Other groups who are at increased risk of developing depression include persons with chronic illnesses (e.g., cancer or cardiovascular disease), other mental health disorders (including substance misuse), or a family history of psychiatric disorders.^{4,5}

Among older adults, risk factors for depression include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and a history of depression. However, the presence or absence of risk factors alone cannot distinguish patients with depression from those without depression. Other risks include a diagnosis of a chronic medical illness; patients with diabetes, cardiovascular disease and chronic pain are at higher risk for depression. Stressful life events such as the death of a loved one, relationship issues (e.g., divorce), job loss, or having a low income.¹³

Risk factors for depression during pregnancy and postpartum include poor self-esteem, child-care stress, prenatal anxiety, life stress, decreased social support, single/un-partnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.¹³

Screening Tests. Commonly used depression screening instruments include the Patient Health Questionnaire (PHQ) in various forms and the Hospital Anxiety and Depression Scales in adults, the Geriatric Depression Scale in older adults, and the Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant women. All positive screening results should lead to additional assessment that considers severity of depression and comorbid psychological problems (e.g., anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions.¹³

Screening Timing and Interval. There is little evidence regarding the optimal timing for screening. The optimum interval for screening for depression is also unknown; more evidence for all populations is needed to identify ideal screening intervals. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.¹³

Treatment. Effective treatment of depression in adults generally includes antidepressants or specific psychotherapy approaches (e.g., CBT or brief psychosocial counseling), alone or in combination. Given the potential harms to the fetus and newborn child from certain pharmacologic agents, clinicians are encouraged to consider CBT or other evidence-based counseling interventions when managing depression in pregnant or breastfeeding women.¹³

The Community Preventive Services Task Force (CPSTF) makes evidence-based recommendations on preventive services for community populations. They recommend collaborative care for the management of depressive disorders as part of a multicomponent, health care system–level intervention that uses case managers to link primary care providers, patients, and mental health specialists.¹⁰

DEPRESSION

Screening and Follow-up for Depression in Adults¹³

Common and recommended screening tools for depression are the PHQ-9 and the PHQ-2.

- **Patient Health Questionnaire-9 (PHQ-9)** is a nine question depression scale based on the nine diagnostic criteria for major depressive disorders in the *Diagnostic and Statistical Manual Fifth Edition* (DSM-5). The PHQ-9 is available in English and Spanish at: <http://www.wasbirt.com/content/screening-forms>
- **Patient Health Questionnaire-2 (PHQ-2)** is a “pre-screener” that inquires about the frequency of depressed mood and anhedonia that the individual has had over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9. The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a “first step” approach. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder. The PHQ-2 can be found at: http://www.cqaimh.org/pdf/tool_phq2.pdf

For additional screening tools visit <http://emedicine.medscape.com/article/1859039-overview#a1>.

PHQ-9 Scores and Proposed Treatment Actions for Depression in Adults¹³

PHQ-9 Score	Depression Severity	Proposed Treatment Recommendation
0-4	None – Minimal	None
5-9	Mild	Watchful waiting, repeat PHQ-9 at follow-up visit
10-14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15-19	Moderately Severe	Active treatment with pharmacotherapy or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

NOTE: Instructions for using PHQ Screeners: <http://www.phqscreeners.com/instructions/instructions.pdf>

Positive screenings should be followed up with a full assessment using standard diagnostic criteria such as those listed in the DSM-V. Ongoing monitoring of depression in adults includes the following:

- **Engagement Education:** Provide education and document that the patient and his/her family are actively engaged in self-management practices, based on understanding of the diagnosis, risk/benefits of treatment options, and consideration of patient preferences.
- **Ongoing Contacts:** Implement a system to assure ongoing contacts with the patient during the first 6-12 months of care (scheduled follow-up appointments, phone calls, etc.) and based on use of the PHQ-9 or other standardized screening tool used at each contact to track response to treatment.

Children and Adolescents

Evidence-based treatment guidelines from the literature are limited. Psychotherapy appears to be useful in most children and adolescents with mild to moderate depression. Because the risk of school failure and suicide is quite high in depressed children and adolescents, prompt referral or close collaboration with a mental health professional is often necessary. Depression among children and adolescents is common but frequently unrecognized. The clinical spectrum of the disease can range from simple sadness to a major depressive or bipolar disorder. Risk factors include a family history of depression and poor school performance. Evaluation should include a complete medical assessment to rule out underlying medical causes. A structured clinical interview and various rating scales such as the Pediatric Symptom Checklist are helpful in determining whether a child or adolescent is depressed.¹³

- **The Pediatric Symptom Checklist (PSC)** is a brief screening questionnaire that is used by pediatricians and other health professionals to improve the recognition and treatment of psychosocial problems in children. There are two versions of the checklist – for children ages 4 to 16, use the *PSC Pediatric Symptom Checklist* (by parent) and the *PSC by Youth (11-17)*. The National Quality Forum has given the PSC its full endorsement as a national standard for assessing quality and outcomes in child health and mental health care.
- **Patient Health Questionnaire-A (PHQ-A)** is a modified version of the PHQ-9 that was developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ. Available at

<http://www.uacap.org/uploads/3/2/5/0/3250432/phq-a.pdf>

- **Guidelines for Adolescent Depression in Primary Care (GLAD-PC)** is a toolkit to assist primary care providers identify adolescents with depression and determine and implement appropriate treatment strategies. It was developed in partnership with primary care providers. Available at <http://www.thereachinstitute.org/files/documents/GLAD-PCToolkit.pdf>

PSC Scoring Guidelines¹³

Age of Child	Cut Off Score	Proposed Recommendation
3-5 Years	24 or above = impaired (For this age group, the scores on elementary school related items 5,6,17, and 18 are ignored and a total score based on the 31 remaining items is computed.)	A positive score on the PSC suggests the need for further evaluation by a qualified health (M.D., R.N.) or mental health (Ph.D., LICSW, Psy.D.) professional.
6-18 years	28 or above = impaired	A positive score on the PSC suggests the need for further evaluation by a qualified health (M.D., R.N.) or mental health (Ph.D., LICSW, Psy.D.) professional.

Additional resources are available at:

- Partnership Access Line (PAL) Washington Partnership Access Line – <http://www.palforkids.org/>
- TeenScreen Primary Care: Screening Questionnaire Overview from the National Center for Mental Health Checkups at Columbia University - <http://www.nachc.org/client/TeenScreen%20Screening%20Questionnaire%20Overview%202%2017%2011.pdf>

GENERALIZED ANXIETY DISORDER (GAD)

GAD is more common in women than in men and prevalence rates are high in mid-life. Research has found that there is considerable co-morbidity with depression and that patients with this disorder often demonstrated a high degree of impairment and disability.

Screening and Follow-up for Generalized Anxiety Disorder in Adults

WellCare recommends the use of the GAD-7, the most common screening tool for GAD, for patients exhibiting patterns of persistent worry, anxiety symptoms, and inattention. This screening tool, available in English and Spanish, is available at WASBIRT: <http://www.wasbirt.com/content/screening-forms>

GAD-7 Scoring Guidelines & Proposed Intervention¹⁴

Score	Risk Level	Intervention
0	No to Low Risk Level	None, rescreen annually
5	Mild	Provide general feedback, repeat GAD-7 at follow up
10	Moderate	Further Evaluation Recommended and referral to mental health program
15+	Severe	Further Evaluation Recommended and referral to mental health program

Treatment for GAD in Adults

Treatment may include medications or psychotherapy, either alone or in combination. Cognitive behavioral therapy has been found to be particularly useful in the treatment of anxiety disorders.

Treatment for GAD in Children and Adolescents

Anxiety disorders affect one in eight children. Research shows that untreated children with anxiety disorders are at higher risk to perform poorly in school, miss out on important social experiences, and engage in substance abuse. Anxiety disorders also often co-occur with other disorders such as depression, eating disorders, and attention-deficit/hyperactivity disorder (ADHD).

Screening and Follow-up for Anxiety in Children and Adolescents¹⁵

- **Screen for Child Anxiety Related Disorders (SCARED)** – WellCare recommends the use of the SCARED for this disorder. The screener comes in two versions, one to be filled out by the parent and another version that can be filled out by the youth.*

* Parent version: <http://www.psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Parent.pdf>
 * Youth version go to: <http://www.psychiatry.pitt.edu/sites/default/files/Documents/assessments/SCARED%20Child%20with%20scoring.pdf>

Treatment Guidelines for Anxiety in Children and Adolescents

Treatment may include medications or psychotherapy, either alone or in combination. Cognitive behavioral therapy has been found to be particularly useful in the treatment of anxiety disorders. Cognitive-behavioral therapy (CBT) has been extensively studied and has shown good efficacy in treatment of childhood anxiety disorders. A combination of CBT and medication may be required for moderate to severely impairing anxiety disorders and may improve functioning better than either intervention alone. Selective serotonin reuptake inhibitors are currently the only medications that have consistently shown efficacy in treatment of anxiety disorders in children and adolescents.¹⁶

ALCOHOL MISUSE AND DEPENDENCE

Alcohol use disorders are medical conditions that doctors can identify when a patient's drinking causes distress or harm. According to the National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, approximately 18 million people in the United States have an alcohol use disorder, classified as either alcohol dependence (also known as alcoholism, alcohol abuse). Alcoholism, the more serious, is a disease that includes symptoms such as:

- Craving—a strong need, or urge, to drink.
- Loss of control—not being able to stop drinking once drinking has begun.
- Dependence—Withdrawal symptoms, such as nausea, sweating, shakiness, and negative emotional states such as anxiety, after stopping drinking.
- Tolerance—the need to drink greater amounts of alcohol to feel the same effect.

Screening and Follow-up for Alcohol Misuse and Dependence in Adults

The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.¹³ Many effective screening tools are available however WellCare recommends that PCP's utilize Screening, Brief Intervention, and Referral for Treatment (SBIRT) on an annual basis with all patients. Along with a pre-screener, screening tools for depression, anxiety, and drug use, the SBIRT model utilizes the Alcohol Use Disorders Identification Test or AUDIT to screen for alcohol use and has been shown to be effective in detecting alcohol abuse and dependence.¹⁷

Scoring and Proposed Treatment Actions for Alcohol Misuse and Dependence in Adults

A positive full screen on the AUDIT should be followed by a brief intervention. The scores that qualify as positive on the AUDIT differ based on gender and age. A positive full screen score on the AUDIT are as follows:

Audit Score	Population Effected	Proposed Action
Greater than or equal to 7	Females (18-65) and all persons 65 and older	Conduct a Brief Intervention counseling session, generally no more than 10 minutes, offering feedback and advice using motivational interviewing techniques. Develop and negotiate a plan that patient is willing to commit to.
Greater than or equal to 8	Males (18-65)	Conduct a Brief Intervention counseling session, generally no more than 10 minutes, offering feedback and advice using motivational interviewing techniques. Develop and negotiate a plan that patient is willing to commit to.

SAMHSA-HRSA SBIRT Interventions can be found at <http://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions>

Referral to Treatment for Alcohol Misuse and Dependence in Adults

After screening and providing a brief intervention, the third component of the SBIRT model is referral to treatment. The referral to treatment process consists of assisting a patient with accessing specialized treatment, selecting treatment facilities, and helping navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a specialty setting. Resources to assist with the referral to treatment process can be found at:

- **SAMHSA-HRSA-SBIRT-Referral to Treatment:** <http://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment>

DRUG ABUSE AND DEPENDENCE

Illicit drug use and abuse are serious problems among adolescents, adults, and pregnant women. According to the National Institute on Drug Abuse (NIDA) illicit drug use in America has been increasing. In 2012, an estimated 23.9 million Americans aged 12 or older—or 9.2 percent of the population—had used an illicit drug or abused a psychotherapeutic medication (such as a pain reliever, stimulant, or tranquilizer) in the past month. This is up from 8.3 percent in 2002.¹³

Screening and Follow-up for Drug Abuse and Dependence in Adults

Many effective screening tools are available, however WellCare recommends that PCP's utilize a brief screening procedure known as the "Screening, Brief Intervention, and Referral for Treatment (SBIRT)" on an annual basis with all patients. Along with a pre-screener, screening tools for depression, anxiety, and alcohol use, SBIRT utilizes the Drug Abuse Screening Test or DAST-10 to screen for drug use. The DAST-10 is a 10-item self-report instrument that can be used with adults and adolescents.

Scoring and Proposed Treatment Actions for Drug Abuse and Dependence in Adults

A positive full screen on the DAST should be followed by a brief intervention. A positive full screen score on the DAST is as follows:¹⁷

DAST Score	Population	Proposed Action
Greater than or equal to 1	All	Conduct a Brief Intervention counseling session, generally no more than 10 minutes, offering feedback and advice using motivational interviewing techniques. Develop and negotiate a plan that patient is willing to commit to.

Referral to Treatment for Drug Abuse and Dependence in Adults

After screening and providing a brief intervention, the third component of the SBIRT model is referral to treatment. The referral to treatment process consists of assisting a patient with accessing specialized treatment, selecting treatment facilities, and helping navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a specialty setting. Resources to assist with the referral to treatment process can be found at:

- **SAMHSA-HRSA-SBIRT-Referral to Treatment:** <http://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment>
- **Washington Screening, Brief Intervention and Referral to Treatment:** <http://www.wasbirt.com/content/find-services>
- **Practice Guideline for the Treatment of Patients With Substance Use Disorders, Second Edition -** <http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243188&PDFSource=6>

Children and Adolescents

Adolescent alcohol use remains a pervasive problem. The percentage of teenagers who drink alcohol is slowly declining; however, numbers are still quite high. Nearly 30 percent of adolescents report drinking by 8th grade, and 54 percent report being drunk at least once by 12th grade.¹³

Screening and Follow-up for Alcohol Use in Children and Adolescents

WellCare recommends that PCP's utilize one of the following screening tools to screen children and adolescents for alcohol use as early as 9 years of age.

- **Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide:** Produced in collaboration with the American Academy of Pediatrics, this guide offers a simple, quick, empirically derived tool for identifying youth at risk for alcohol-related problems. For use in Children and adolescents aged 9 – 18 years of age. http://www.integration.samhsa.gov/clinical-practice/sbirt/Guide_for_Youth_Screening_and_Brief_Intervention.pdf
- **The CRAFFT Screening Tool** is a validated 6-item behavioral health screening test for use with children under the age of 21 year
- s. <http://www.ceasar-boston.org/clinicians/crafft.php>

Drug Abuse and Dependence in Children and Adolescents

According to the American Academy of Child & Adolescent Psychiatry, the use of illegal drugs is increasing, especially among young teens. The average age of first marijuana use is 14, and alcohol use can start before age 12. The use of marijuana and alcohol in high school has become common. Drug use is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure, and poor judgment which may put teens at risk for accidents, violence, unplanned and unsafe sex, and suicide.¹³

Screening and Follow-up for Drug Use in Children and Adolescents

WellCare recommends that PCP's utilize one of the following tools to screen children and adolescents for drug use:

- **The CRAFFT Screening Tool**
- **Drug Abuse Screening Test or DAST-10:** a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. Available in English and Spanish at: <http://www.wasbirt.com/content/screening-forms>

Providers may also find the following useful:

- **Primary Care Provider Guide to using CRAFFT:** http://www.integration.samhsa.gov/clinical-practice/sbirt/adolescent_screening_brief_intervention_and_referral_to_treatment_for_alcohol.pdf
- **Additional information about the DAST screener**, including a longer version for adolescents: Guide for Using the Drug Abuse Screening Test (DAST), Harvey A. Skinner, Ph.D. York University, Toronto - http://www.emcdda.europa.eu/attachements.cfm/att_61480_EN_DAST%202008.pdf

OTHER CONSIDERATIONS

Implementation. The USPSTF recommends that screening be implemented with adequate systems in place. “Adequate systems in place” refers to having systems and clinical staff to ensure that patients are screened and, if they screen positive, are appropriately diagnosed and treated with evidence-based care or referred to a setting that can provide the necessary care. These essential functions can be provided through a wide range of different arrangements of clinician types and settings. In the available evidence, the lowest effective level of support consisted of a designated nurse who advised resident physicians of positive screening results and provided a protocol that facilitated referral to evidence-based behavioral treatment. At the highest level, support included screening; staff and clinician training (1- or 2-day workshops); clinician manuals; monthly training lectures; academic detailing; materials for clinicians, staff, and patients; an initial visit with a nurse specialist for assessment, education, and discussion of patient preferences and goals; a visit with a trained nurse specialist for follow-up assessment and ongoing support for medication adherence; a visit with a trained therapist for CBT; and a reduced copayment for patients referred for psychotherapy.⁴

Multidisciplinary team-based primary care that includes self-management support and care coordination has been shown to be effective in management of depression. These components of primary care are detailed in recommendations from the Community Preventive Services Task Force. It recommends collaborative care for the treatment of major depression in adults 18 years and older on the basis of strong evidence of effectiveness in improving short-term treatment outcomes. As defined, collaborative care and disease management of depressive disorders include a systematic, multicomponent, and team-based approach that “strengthens and supports self-care, while assuring that effective medical, preventive, and health maintenance interventions take place” to improve the quality and outcome of patient care.⁴

Costs. The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include emotional suffering, reduced quality of personal relationships, possible adverse effects from treatment, cost of mental health and medical visits and medications, time away from work and lost wages, and cost of transportation. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care.⁴

Research Needs and Gaps. Gaps in the evidence on screening for depression in older adults in primary care include a lack of information from large-scale randomized controlled trials (RCTs) in settings that are applicable to the US

population. More research is needed on the accuracy of screening tools in languages other than English and Spanish and to identify the timing and optimal screening interval in all populations. Data are lacking on both the accuracy of screening and the benefits and harms of treatment in pregnant women, as well as for the balance of benefits and harms of treatment with antidepressants in postpartum women. Finally, research is needed to assess barriers to establishing adequate systems of care and how these barriers can be addressed.⁴

WHEN TO REFER TO A BEHAVIORAL HEALTH PROVIDER

Complex Behavioral and Emotional Concerns

- Member has behavior or emotions that pose a threat or harm to the safety of self, a child, or others (e.g., suicidal behavior, severe aggressive behavior, an eating disorders that has escalated, or self-destructive behavior).
- Member has had a significant disruption in day-to-day functioning or loss of contact with family.
- Member has been recently hospitalized for treatment of psychiatric illness.
- Member has complex diagnostic issues.
- Member has a mood disorder and would benefit from CBT.

Complex Social and Environmental Concerns

- Member has a caretaker with serious emotional issues or a substance abuse problem, or there are other serious environmental issues such as a hostile divorce situation.
- Member has a history of abuse, neglect and/or removal from the home and has significant issues related to the abuse or neglect.
- Has a significant change in emotions or behavior for which there is no obvious precipitant (e.g., sudden onset of school avoidance, suicide attempt in an individual who was previously well-functioning).

Complex Medical Issues

- Member has only a partial response to a course of medications or is being treated with more than one psychotropic medication.
- Member has a family history that suggests treatment with psychotropic medications may have an adverse effect (e.g., prescribing stimulants for a child with a family history of schizophrenia or bipolar disorder, children under age 5 who require on-going use of a psychotropic medication).
- Member has a chronic medical condition and behavior or emotions prevent the medical condition from being treated properly.
- Member has had a course of treatment for 6-8 weeks with no meaningful improvement.