Behavioral Health Screening in Primary Care Settings

BACKGROUND

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]

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GUIDELINE HIERARCHY

CPGs are updated every two years 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 the 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 recommendation applies to adults 18 years and older. It does not apply to children and adolescents, who are addressed in a separate USPSTF recommendation statement.

Population. General adult population, including pregnant and postpartum women.

Recommendation. 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.

Grade. B – The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

The USPSTF found convincing evidence that screening improves the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women.

Benefits of Early Detection and Intervention and Treatment

The USPSTF found adequate evidence that programs combining depression screening with adequate support systems in place improve clinical outcomes (e.g., reduction or remission of depression symptoms) in adults, including pregnant and postpartum women.

The USPSTF found convincing evidence that treatment of adults and older adults with depression identified through screening in primary care settings with antidepressants, psychotherapy, or both decreases clinical morbidity.

The USPSTF also found adequate evidence that treatment with cognitive behavioral therapy (CBT) improves clinical outcomes in pregnant and postpartum women with depression.

Harms of Early Detection and Intervention and Treatment

The USPSTF found adequate evidence that the magnitude of harms of screening for depression in adults is small to none. The USPSTF found adequate evidence that the magnitude of harms of treatment with CBT in postpartum and pregnant women is small to none.

The USPSTF found that second-generation antidepressants (mostly selective serotonin reuptake inhibitors [SSRIs]) are associated with some harms, such as an increase in suicidal behaviors in adults aged 18 to 29 years and an increased risk of upper gastrointestinal bleeding in adults older than 70 years, with risk increasing with age; however, the magnitude of these risks is, on average, small. The USPSTF found evidence of potential serious fetal harms from pharmacologic treatment of depression in pregnant women, but the likelihood of these serious harms is low. Therefore, the USPSTF concludes that the overall magnitude of harms is small to moderate.

For additional information on the accuracy and effectiveness of screening and treatment, as well as the potential harms of screening and treatment, reference the USPSTF guideline available at www.uspreventiveservicestaskforce.org.

USPSTF Assessment and Scope of Review

The USPSTF concludes with at least moderate certainty that there is a moderate net benefit to screening for depression in adults, including older adults, who receive care in clinical practices that have adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up after screening. The USPSTF also concludes with at least moderate certainty that there is a moderate net benefit to screening for depression in pregnant and postpartum women who receive care in clinical practices that have CBT or other evidence-based counseling available after screening.

The USPSTF commissioned a systematic evidence review to update its 2009 recommendation, which focused on the direct evidence on the benefits and harms of screening for depression in adult populations, including older adults and pregnant and postpartum women. The USPSTF also reviewed the evidence on the accuracy of depression screening instruments and the benefits and harms of depression treatment in these populations.

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. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.[5] This aligns with recommendations published by the USPSTF in 2016.

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.[6]

The *Mental Health Screening and Assessment Tools for Primary Care* table in collaboration with the AAP. The table provides a listing of mental health screening and assessment tools, summarizing their psychometric testing properties, cultural considerations, costs, and key references. It includes tools that are proprietary and those that are freely accessible. In addition to screening tools, the table includes tools 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—anxiety, depression, inattention and impulsivity, disruptive behavior or aggression, substance abuse, learning difficulties, and symptoms of social-emotional disturbance in young children. Also included are tools 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 visit https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf [7]

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.[8]

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.[3] This aligns with recommendations published by the USPSTF in 2016.

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.[9]

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.[2,10]

CLINICAL CONSIDERATIONS[1]

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]

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.[11]

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.

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.

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.

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.

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.[9]

DEPRESSION

Screening and Follow-up for Depression in Adults[11]

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 Adults[11]

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.[11]

- **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 Guidelines [11]

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 Intervention [12]

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 Adolescents[13]

- **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.[14]

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.[11] 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.[15]

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.[11]

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:[15]

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.[11]

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 years. 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.[11]

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,_brieft_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.

MULTICULTURAL CONSIDERATIONS

Providers may also wish to utilize the *Cultural Formulation Interview (CFI).* The CFI was developed by the American Psychiatric Association (APA) and Diagnostic and Statistical Manual of Mental Disorders (DSM) Cross-Cultural Issues Subgroup (DCCIS) and is an evidence-based tool composed of a series of questionnaires that assist clinicians in making person-centered cultural assessments to inform diagnosis and treatment planning. The CFI is available at http://www.psychiatry.org.[16]

An additional resource that providers may wish to utilize is the Nathan Kline Institute (NKI) Center of Excellence in Culturally Competent Mental Health.[17] Visit http://ssrdqst.rfmh.org/cecc/ for Cultural Profiles, Data and Maps, Cultural Competency Tools, Diversity and Disparity Reports, as well as information on Religion, Culture, and Mental Health.

RESOURCES

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://nrepp.samhsa.gov) that may be helpful for clinicians looking for models of how to implement depression screening.[1]

MEASUREMENT OF COMPLIANCE

The following measures of compliance have been published by NCQA:

Antidepressant Medication Management (AMM). For effective acute phase treatment, WellCare will ensure AMM for members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication for at least 84 days (12 weeks).

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). WellCare will monitor adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following IET. This includes members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. For engagement of AOD treatment, this includes members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

RELATED CLINICAL PRACTICE GUIDELINES

Visit WellCare.com for additional behavioral health related Clinical Practice Guidelines.

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*Easy Choice Health Plan ~ Harmony Health Plan, Inc. ~ Missouri Care, Inc. ~ ‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.
WellCare Health Insurance of Illinois, Inc. ~ WellCare Health Plans of New Jersey, Inc. ~ WellCare Health Insurance of Arizona, Inc. ~ WellCare of Florida, Inc.
WellCare of Connecticut, Inc. ~ WellCare of Georgia, Inc. ~ WellCare of Kentucky, Inc. ~ WellCare of Louisiana, Inc. ~ WellCare of New York, Inc.
WellCare of South Carolina, Inc. ~ WellCare of Texas, Inc. ~ WellCare Prescription Insurance, Inc. ~ Windsor Health Plan ~ Windsor Rx Medicare Prescription Drug Plan*

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	**History and Revisions by the Medical Policy Committee**
4/7/2016	• Approved by MPC. New.