Comprehensive Assessment

Conduct a comprehensive assessment. Rule out medical causes of behavioral symptoms. Use validated measures to assess and track psychiatric symptoms and impairment.

A comprehensive mental health assessment includes:

- Assessment of risk of harm to self or others
  - Assessment of the full range of psychiatric symptoms and disorders, including co-morbid substance use, as well as impairment from these symptoms and disorders
  - A thorough mental status exam
  - A full medical history
  - A relevant medical work-up and physical examination
  - Assessment of substance use, including tobacco use
  - Assessment of family psychiatric history, which includes psychiatric symptoms/treatment of family members, including substance use and treatment
  - During initial evaluation, when appropriate and with permission, contact a family member or close friend for additional history (past psychiatric history and additional psychosocial history)
  - Assessment for social determinants of health (e.g., housing instability/homelessness, food insecurity, education level, employment status)
- Ongoing management of behavioral health conditions includes:
  - Use of measurement-based care to measure and monitor symptoms and side effects
  - Close follow-up after psychotherapeutic medication prescribing to assess medication tolerability
  - Assessment of benefits and risks of treatment, including review of boxed warnings
  - Patient education of the benefits and risks of treatment, including review of boxed warnings
  - Monitoring of physical health parameters (See Program publication *Monitoring Physical Health and Side-Effects of Psychotherapeutic Medications in Adults and Children: An Integrated Approach* available at http://floridabhcenter.org/)
  - Assessment of social support system (housing, family, other caregivers)
  - Evaluation of threats to continuity of care (financial burden, housing instability, access to medication, medication adherence, etc.)
  - Provision of patient tools/support for recovery and self-management
  - For any individual who presents with a depressive component to their psychiatric symptoms, we strongly recommend routine and systematic screening for bipolar disorders. We advise the use of either the Rapid Mood Screener or the Mood Disorder Questionnaire.

Notes:

- *Effort should be made to communicate between primary care providers, psychiatrists, case workers, and other team members to ensure integrated care*
- *Incorporate collaborative/shared treatment decision-making with patients, family and caregivers*
- *Written informed consent should be obtained from the patient or the individual legally able to consent to medical interventions (e.g., pharmacotherapy), and documented in the chart*

Adjunctive Psychosocial Treatments (As Indicated)

- Individual and family psychoeducation
- Cognitive-behavioral therapy (CBT)
- Interpersonal psychotherapy (IPT)
- Interpersonal and social rhythm therapy (IPSRT)
- Family-focused therapy
- Group psychoeducation (especially for bipolar disorder)
- Social skills training (especially in schizophrenia)
- Cognitive remediation/rehabilitation (to improve attention, memory, and/or executive function)

Note on pharmacogenomics testing: Limited data exists examining whether patient care that integrates pharmacogenomic test information results in better or safer treatment.

Measurement-Based Care

Questionnaires and rating scales are useful tools for diagnostic assessment and evaluation of treatment outcomes, and such instruments can be helpful in providing information to supplement clinical judgement. The integration of measurement scales into routine clinical practice is suggested for each of the conditions covered in this document. Clinicians should use rating scales to assess symptom severity during the initial evaluation/treatment, when medication changes are implemented, and/or when the patient reports a change in symptoms.

- Treatment targets need to be precisely defined.
- Effectiveness and safety/tolerability of the medication treatment must be systematically assessed by methodical use of appropriate rating scales and side-effect assessment protocols.

Internet links to the following scales are available on the Program website: https://floridabhcenter.org/.

- Beck Depression Inventory (BDI)
- Brief Psychiatric Rating Scale (BPRS)
- Clinical Global Impression (CGI) Scale
- Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS)
- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- Patient Health Questionnaire (PHQ-9)
- Positive and Negative Syndrome Scale (PANSS)
- Quick Inventory of Depression Symptomatology (QIDS)
- Young Mania Rating Scale (YMRS)

Table 1. Assessment Scales for Adult Behavioral Health Conditions

Measures	Bipolar Acute Depression	Bipolar Acute Mania	Bipolar 1 Cont/Main Therapy	Major Depression	Major Depression with Mixed Features	Major Depression with Psychosis	Schizophrenia
Beck Depression Inventory (BDI)	✔	—	—	✔	✔	✔	—
Brief Psychiatric Rating Scale (BPRS)	—	—	—	—	—	✔	✔
Clinical Global Impression (CGI) Scale	—	—	—	—	✔	—	✔
Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS)	—	—	—	—	—	✔	✔
Hamilton Rating Scale for Depression (HAM-D)	—	✔	—	—	—	✔	—
Montgomery-Asberg Depression Rating Scale (MADRS)	✔	✔	✔	—	✔	✔	—
Patient Health Questionnaire (PHQ-9)	✔	—	✔	✔	✔	—	—
Positive and Negative Syndrome Scale (PANSS)	—	—	—	—	—	✔	✔
Quick Inventory of Depression Symptomatology (QIDS)	✔	—	✔	✔	✔	—	—
Young Mania Rating Scale (YMRS)	✔	✔	✔	—	✔	—	—

Notes: The recommendations in this table are based on the evidence-base and clinical consensus. The Montgomery-Asberg Depression Rating Scale (MADRS) and Hamilton Rating Scale for Depression (HAM-D) can also used to assess symptoms of depression in major depressive disorder. Although the MADRS and HAM-D do not assess manic symptoms, these scales are recommended to evaluate depression symptoms in individuals presenting with bipolar mania (e.g., to rule out bipolar disorder – mixed features) and to assess for depressive symptoms among individuals on maintenance treatment for bipolar disorder.

List of Antipsychotic Medications Available in the United States:

- **First Generation Antipsychotics (FGAs):** chlorpromazine, fluphenazine*, haloperidol*, loxapine, perphenazine, thioridazine, thiothixene, and trifluoperazine
- **Second Generation Antipsychotics (SGAs):** aripiprazole*, asenapine, brexpiprazole, cariprazine, clozapine, iloperidone, lurasidone, lumateperone‡, olanzapine*‡, paliperidone*, quetiapine, risperidone*, and ziprasidone

Notes:

Medications indicated by a single asterisk (*) are available in long-acting injectable formulations (refer to list below).

‡Lumateperone was introduced in 2019. Olanzapine/samidorphan was introduced in 2021.

List of Long-Acting Injectable Antipsychotic (LAI) Medications Available in the United States:

- **First Generation Antipsychotics (FGAs):** fluphenazine decanoate, haloperidol decanoate
- **Second Generation Antipsychotics (SGAs):** aripiprazole monohydrate, aripiprazole lauroxil, olanzapine pamoate, paliperidone palmitate, risperidone microspheres

Treatment with Antipsychotic Medication

Selection of antipsychotic medication with well-informed patients should be made on the basis of evidence-based guideline recommendations for a particular behavioral health condition, prior individual treatment response, side-effect experience, medication side-effect profile, and long-term treatment planning. Treatment with antipsychotic medications should take into account the following:

- First generation antipsychotics (FGAs) and second generation antipsychotics (SGAs) are heterogeneous within the class and differ in many properties, such as efficacy, side-effects, and pharmacology.
- Antipsychotics carry extrapyramidal symptoms (EPS) liability and metabolic effects. Caution should be used in prescribing antipsychotic medication in the context of dementia, anxiety disorders, and impulse control disorders. For these conditions, antipsychotic utilization should be:
  - Aimed at target symptoms
  - Prescribed only after other alternative treatments have been tried
  - Used in the short-term
  - Monitored with periodic re-evaluation of benefits and risks
  - Prescribed at the minimal effective dose

Note: The Food and Drug Administration (FDA) has issued a boxed warning that elderly patients with dementia-related psychosis treated with FGAs or SGAs have an increased risk of death.

Achieving Optimal Outcomes with Currently Available Antipsychotics

STEP 1. Considerations for selecting the most appropriate antipsychotic for a particular patient:

- Broadly equivalent efficacy across agents for psychotic symptoms (note clozapine exception in schizophrenia)
- Individual variability in response
- No reliable pre-treatment predictor of individual response to different agents
- Different agents have different side-effects and safety profiles
- Individual patients have different vulnerabilities and preferences
- Potential risk of non-adherence to oral antipsychotics
- Objective is to achieve therapeutic objective without EPS

STEP 2. Good practice guidelines for ongoing antipsychotic treatment:

- Measurement-based individualized care
- Repeated assessment of efficacy using reliably defined treatment targets for psychotic symptoms (use standard rating scales, e.g. CRDPSS, CGI, BPRS, PANSS)
- Careful assessment and measurement of adverse effects
- Care consistent with health monitoring protocols
- Standard protocols customized to individual vulnerabilities/needs and specific agent
- Ongoing collaboration with patient in decision-making

Notes:

CRDPSS = Clinician-Rated Dimensions of Psychosis Symptom Severity; CGI = Clinical Global Impressions Scale; BPRS= Brief Psychiatric Rating Scale; PANSS = Positive and Negative Syndrome Scale

Box 1. Factors that Contribute to Poor Medication Adherence

Remember to Assess for Medication Adherence

Factors that contribute to poor medication adherence include:

- Poor health literacy
- Lack of involvement in the treatment decision-making process
- Complex drug regimens
- Ineffective communication about adverse effects
- Limited access to care

Considerations in Managing Inadequate Treatment Response

- Re-assess symptoms and diagnosis, including use of standardized diagnostic tools
- Assess treatment adherence, including tolerability of medications and potential drug-drug interactions
- Assess for adequate treatment trials, including dose/duration of treatment
- Switch treatment if initial trials are inadequate after re-assessment of symptoms, diagnosis, tolerability, and adequacy of treatment
- For schizophrenia spectrum disorders, consider LAI if nonadherent to oral medication; consider clozapine if refractory to treatment (see sections on Treatment of Schizophrenia and Treatment of Schizophrenia with LAIs)

Considerations for Transition from Pediatric to Adult Care

- Transition is the process that involves preparation steps before an individual leaves pediatric care and moves to an adult provider.
- Poor care coordination, lack of resources, and inadequate planning are some factors identified as obstacles to a smooth transition of care.
- Both pediatric and adult providers play a role in supporting individuals to ensure a smooth transition.
- Initiate conversation early to ease the transition.
- Recognize the role of developmental differences through adolescence and young adulthood on patient engagement and treatment adherence.

Resources

Below is a list of national and local resources for adults with serious mental illness (SMI).

National Resources:

- American Psychiatric Association: https://www.psychiatry.org/
- American Psychological Association: https://www.apa.org/
- Brain and Behavior Research Foundation: http://bbrfoundation.org/
- National Alliance on Mental Illness (NAMI): https://www.nami.org/
- National Council for Behavioral Health: https://www.thenationalcouncil.org/
- Depression and Bipolar Support Alliance (DBSA): http://www.dbsalliance.org/
- National Institute of Mental Health: https://www.nimh.nih.gov/index.shtml
- Mental Health America (MHA): http://www.mentalhealthamerica.net/
- Substance Abuse and Mental Health Services Administration (SAMHSA): http://www.samhsa.gov/
- Suicide Prevention Resource Center: http://www.sprc.org/
- U.S. Department of Health and Human Services: https://www.mentalhealth.gov/
- Hearing Voices Network: http://www.hearingvoicesusa.org/

Local Resources:

- Florida Center for Behavioral Health Improvements and Solutions: https://floridabhcenter.org/
- Aunt Bertha Web-Based Resource Guide: https://www.findhelp.org/
- Florida Academy of Family Physicians (FAFP): http://www.fafp.org/
- Florida Association of Nurse Practitioners (FLANP): http://flanp.org/
- Florida Council for Community Mental Health (FCCMH): http://www.fccmh.org/
- Florida Medical Association (FMA): http://www.flmedical.org/
- Florida Osteopathic Medical Association (FOMA): http://www.foma.org/
- Florida Psychiatric Society (FPS): http://www.floridapsych.org/
- Florida Society of Neurology (FSN): https://fsneuro.org/
- National Alliance on Mental Illness (NAMI) Florida: http://www.namiflorida.org/
- Peer Support Coalition of Florida: https://www.peersupportfl.org/

For updated links to resources, visit floridabhcenter.org.