

Mental Health Services In Primary Care

March 13, 2013

**PRECONFERENCE INSTITUTE
THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL**

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CRITICAL HEALTH DISPARITIES

- Today.
- Individuals with Serious Mental Illness are dying approximately 25 years earlier than the general population
 - Average age of death is 53
- An Oregon study found that those with co-occurring MH/SUD were at greatest risk
 - Average age of death is 45.1 years

Increased Mortality and Morbidity are Largely Due to Preventable Conditions

While suicide and injury account for about 30 – 40% of excess mortality, 60% of premature deaths are due to preventable medical conditions such as:

- Cardiovascular Disease
- Diabetes
- Respiratory Disease
- Infectious Disease

Causes of Excess Mortality in Persons with Serious Mental Illnesses

- Lifestyle Issues
 - Smoking
 - Poor diet
 - Reduced physical activity¹
- Social and Environmental Issues
 - Excess rates of poverty and social disadvantage²
- Poor quality of medical care³
- Poor quality of medical effects of psychotropic meds⁴

1. de Leon J, Diaz FJ. Schizophr Res 2005;76: 135–157, Compton M et al Harv Rev Psychiatry. 2006 Jul-Aug;14(4):212-22
2. Wilton et al Soc Sci Med 2004 58: 25-39
3. Mitchell A. Br J Psychiatry. 2009 Jun;194(6):491-9
4. Newcomer J. Journal of Clinical Psychiatry. 2007;68 Suppl 4:8-13. Review

Decisions for Integration

- Prevalence of psychiatric disorders in low-income primary care patients:

At least one psych dx: 51%

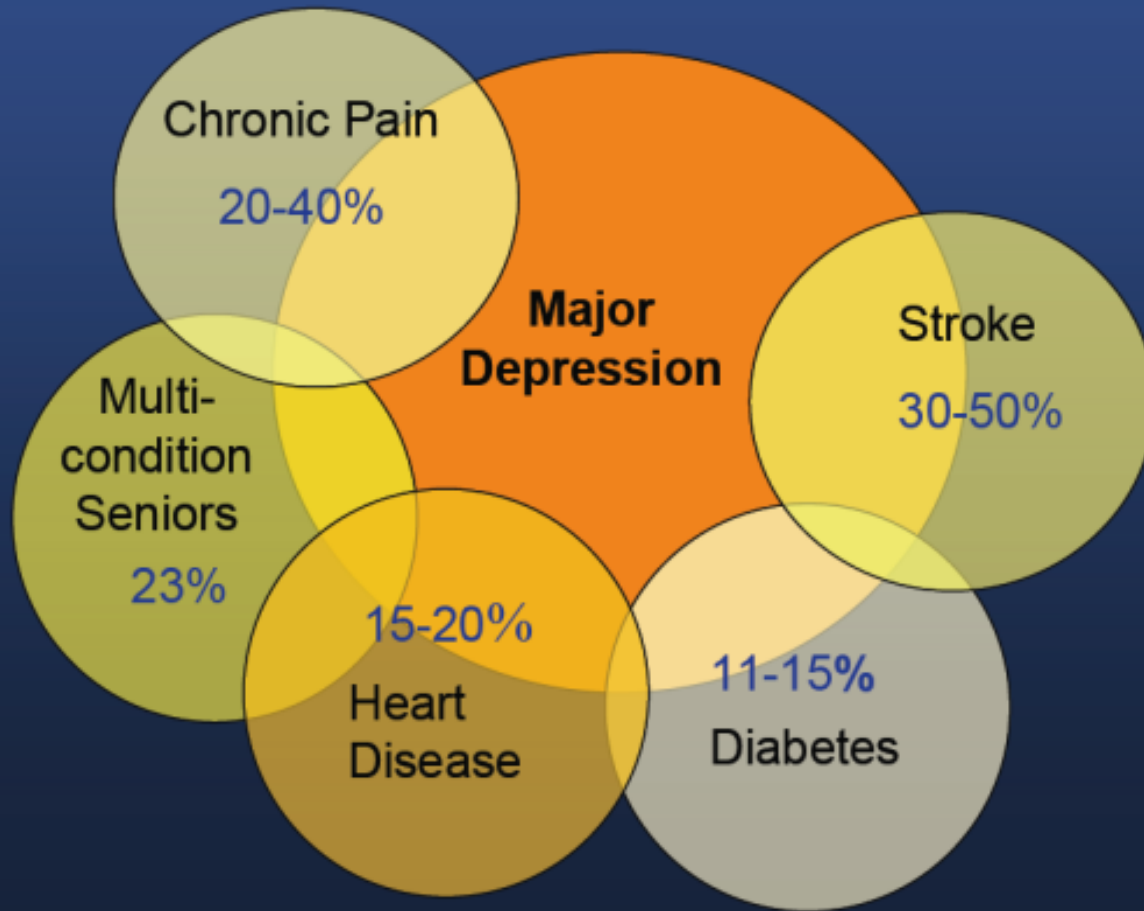
Mood disorder: 33%

Anxiety disorder: 36%

Alcohol abuse: 17%

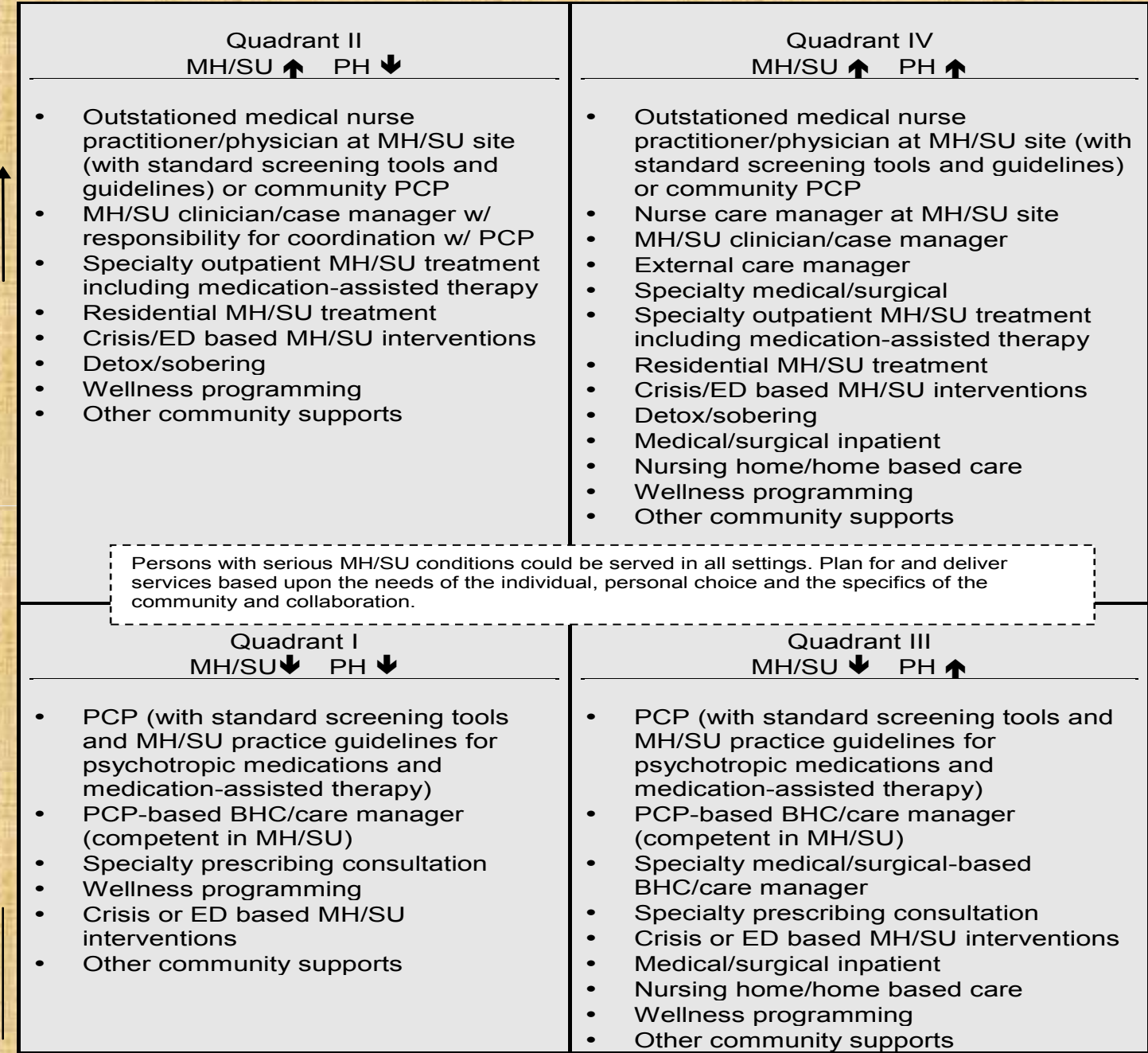
- Primary Care providers prescribe more anti-depressant and anti-anxiety medications than Mental Health providers!

Comorbidity



High

MH/SU Risk/Complexity



Physical Health Risk/Complexity

Low

High

Integration Project

- Treat mental health patients where they feel most comfortable
- Improved coordination of care
- Delay in obtaining outside treatment
- Less stigma
- Established patient relationship with Primary Care
- Majority of mental health treatment occurs in community health settings
- Unique patient issues – Who is the homeless patient?

Overview of Integration Project

- The purpose of integrated care at is to improve the assessment, diagnosis, and treatment of both behavioral health and medical disorders in one setting.
- Formalized screening process for mental health and behavioral health
- Improved clinical assessment
- Tracking of patient symptoms and outcomes
- Improved comprehensive clinical care of patients

Overview of Integration Project

Principles:

- Focused behavioral intervention in primary care -
When both mental health and substance use services are provided by the same person or team, the client has one treatment plan, one set of goals, and one relapse plan.
- Comprehensive screening and assessment of mental health and substance abuse disorders
- Embedded Behavioral Health Consultant on the Primary Care Team
- Behavioral medicine scope of practice
- Shared decision making - clients with co-occurring disorders decide what goals they want to pursue, how they want to proceed with treatment, and what their path to dual recovery will be
- Encourage patient responsibility for healthful living

Screening Tools

- Pre-screen form
- PHQ-9
- GAD-7
- AUDIT
- DAST- 10

Screening Tools

	Not at All	Several Days	More than Half the Days	Nearly Every Day
• The <u>past two weeks</u> , how often have you been bothered by little interest or pleasure in doing things?				
• The <u>past two weeks</u> , how often have you been bothered by feeling down, depressed, or hopeless?				
• The <u>past two weeks</u> , how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?				
• The <u>past two weeks</u> , how often have you been bothered by feeling nervous, anxious, or on edge?				
• The <u>past two weeks</u> , how often have you been bothered by not being able to stop or control worrying?				
• In the past <u>12 months</u> , have you used drugs other than those used for medical reasons?				
• How often during the past year have you found that you were not able to stop using drugs once you had started?				
• How often during the past year have you found that you were not able to stop drinking once you had started?				

Screening Tools – PHQ-9

- The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.
- Assesses symptoms and functional impairment to make a tentative depression diagnosis, and derives a severity score to help select and monitor treatment
- The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

Screening Tools – PHQ-9

1. Over the past two weeks, how often have you been bothered by any of the following problems (Make an "X" in the appropriate box)?

	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Screening Tools – GAD 7

- Robert L. Spitzer, MD (et. al) reports on their development of a new, quick and effective tool to measure anxiety in the May 22, 2006 edition of the Archives of Internal Medicine². The name of this anxiety inventory is the GAD-7 (the Generalized Anxiety Disorder-7 questions).
- The researchers conclude that the “GAD-7 is a valid and efficient tool” to screen for anxiety and to assess “its severity in clinical practice and research.” What is more impressive is that you can do this by answering seven short questions.

Screening Tools – GAD 7

GAD-7 Questionnaire

Over the past two weeks, how often have you been bothered by any of the following problems
(Make an “X” in the appropriate box)?

	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Feeling nervous, anxious, or on edge	0	1	2	3
b. Not being able to stop or control worrying	0	1	2	3
c. Worrying too much about different things	0	1	2	3
d. Trouble relaxing	0	1	2	3
e. Being so restless that it is hard to sit still	0	1	2	3
f. Becoming easily annoyed or irritable	0	1	2	3
g. Feeling afraid as if something awful might happen	0	1	2	3

Screening Tools - AUDIT

- AUDIT, the Alcohol Use Disorders Identification Test, and describes how to use it to identify persons with hazardous and harmful patterns of alcohol consumption. The AUDIT was developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It can help in identifying excessive drinking as the cause of the presenting illness. It also provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking.

Screening Tools - AUDIT

Alcohol Use Disorders Identification Test:	
<p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never (Skip to Q's 9 and 10) (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p>	<p>6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p>	<p>7. How often during the past year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>
<p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p><i>Skip to questions 9 and 10 if total for questions 2 and 3 = 0.</i></p>	<p>8. How often during the past year have you been unable to remember what happened the night before because of your drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p>
<p>4. How often during the past year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly</p>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p>

Screening Tools – DAST-10

- The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has “exhibited valid psychometric properties” and has been found to be “a sensitive screening instrument for the abuse of drugs other than alcohol.

Screening Tools – DAST-10

Drug Abuse Screening Test – DAST-10

These questions refer to the past 12 months.			
1.	Have you used drugs other than those used for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Screening Tools

- Beck Depression Inventory, Beck Anxiety Inventory
- CAGE, AUDIT, DAST, SBIRT, MAST
- Spanish Forms
- Cultural, gender, sexual orientation bias
- Using the results
- Tracking progress

Treatment

- Screening test only appropriate to use when treatment is available
 - Depression
 - Anxiety
 - Substance use disorder

Treatment: Medication?

- So many other effective treatments
- EB psychotherapies
- CBT, Problem-solving therapy studied and are effective
- Harder to make 'therapy' happen in primary care
- Often start with medication – may provide patients with enough relief to then be able to engage in therapy
- Overall comfort level of the PCP

Treatment: Not medication, Not Therapy

- Exercise is an anti-depressant
- Increased intensity = increased effect
- Co-morbidities can make this difficult to prescribe

Treatment: Medication

- Very brief overview
 - for prescribers and non-prescribers
- Standard care: the doctor does the meds and the therapist does the therapy
- Integrated care: everyone engaged with the patient provides treatment
 - Non-prescribers may touch the patient a whole lot more than the prescriber – and need to be able to say “hey, this is not working”

Treatment: Medication

- 10% of the population takes a med for depression – but half of them are not much better, but may be experiencing side effects

Medication Management

- 50% response – could you have started in a way to get a better initial response?
- Most patients will need 2-3 adjustments
 - Consider hypertension and medication management

Medication for Depression: Choosing

- SSRIs – many generic – PCPs quite comfortable with these
- SNRIs – generics
- TCAs (secondary and tertiary amines) secondary more tolerated
 - Avoid in older adults
- If a patient says something worked – that's a powerful piece of information
- Cheat sheet from UW Impact Program
 - Useful for both prescribers and non-prescribers
- Most get comfortable with a handful of meds and stick with those

Medication: Depression

- Avoid benzodiazepines – feel less anxious but don't correct any neurotransmitter imbalance
- Use enough med for enough time – push until side effects make prohibitive –
 - for 8-10 weeks at good dose with compliance and if does not work – then need to try another medication.

Medication: Considerations

- SSRI common side effects – GI, insomnia, tremor, headaches, sexual dysfunction
- SNRI – nausea more common, otherwise similar – may have some benefits with neuropathic pain
- Remeron – side effects sleep and weight gain (think of the elderly person not eating and not sleeping)
- Wellbutrin – to counteract sexual dysfunction – not for the really anxious patients, whereas the other meds are all indicated for anxiety as well, avoid in eating disorders – reduction of seizure threshold

Medication: Discontinuation

- How to stop the meds
- 4-9 months
- Repeated episodes 2 years and maybe lifetime
- Relapse prevention plan
- Slowly taper
 - SSRI Discontinuation Syndrome

Treatment: Medication

Take Home Points!

- Use enough medication:
 - Cost, patient preference, side effects and drug-interactions
- For the right length of time:
 - when do you just have to say it is not working?
- Be willing to change the medication
- Have another set of eyes on the patient – care manager, therapist
- Utilize the tools you have – we keep checking the blood pressure at every visit, right?...

Treatment: Adherence

- Pay careful attention to side effects
- Address worries about addiction
- Utilize care manager
 - Phone check-ins
 - Symptom scale
- Validation: “Taking a medication every day can be hard”
- Trust: “If you want to stop, let me help you with that”

Medication Treatment: Problems

- Unmask bipolar disorder
 - Mood stabilizers
- Activation => suicidality
- Co-morbidities
 - Substance use
 - Personality disorders
- Incomplete response

When to refer

- Patient not responding as one would expect
- Uncertain diagnosis
 - Are we dealing with bipolar?
 - Personality disorder
 - Substance use disorder
- Provider discomfort
- “psychiatric consultant weekly case review is very important and required to do integrated care” – well, what if your patients have no insurance and no psychiatrist wants to do this?

Psychiatrist

- Making the best use of this relationship
- Concern re: 'curbside consultation'
- Can offer PCP important reassurance

Integration Team

- Primary Care Provider
- Behavioralist
- Clinical Care Manager
- Case Manager
- Nurse
- Outreach Worker
- Psychiatrist

Staff Assessment

- Who is supportive?
- Who is resistant?
- Who needs training?
- Who wants training?
- Who is being under utilized?

Responsibilities of Medical Provider

- **CHECK** status and screening results BEFORE bringing patient to exam room
- **ASK** the patient if they were given any screening forms by the medical intake staff
- **SCORE** any forms that the patient has with them
- **TALK** to the patient about mental health issues and treatment plan/goals indicated by the forms
- **REFER** patient to next staff member via warm handoff
- **GIVE** scored screening forms to patient for next staff person
- **UPDATE** treatment plan in EMR

Responsibilities of Behavioralist

- **REVIEW** status and screening results before coming to exam room
- **SEE** patient before medical visit or after
- **QUICKLY** assess patient's needs
- **DETERMINE** level of intervention needed (brief counseling, crisis counseling, referral for on-going counseling or groups or a higher level of care)
- **TALK** to the patient about mental health issues and treatment plan/goals
- **REFER** patient to next staff member via warm handoff
- **GIVE** scored screening forms to patient for next staff person
- **UPDATE** treatment plan in EMR

Responsibilities of the Clinical Care Manager

- **MEET** with all patients who have screened positive to discuss treatment, goals, current circumstances, patient's questions **WHENEVER** they come to clinic
- **TRACK** treatment of mental health concerns with regular re-screens and patient compliance with appointments and referrals
- **OVERSEE** data entry into EMR
- **REVIEW** progress of individual patients' treatment goals
- **INFORM** staff of scheduled patients each morning through Morning Huddle
- **ENSURE** procedures are being followed by all staff through daily quality control and education interventions as needed
- **LEAD** regular staff meetings to report on quality control issues and enact staff-wide education interventions

Challenges & Barriers

- Patient involvement
 - Language, time, refusal, attrition, follow-up
- Clinic patient load
- Team meetings
- Clinical Training

Lessons Learned & Successes

- Positive staff participation & “buy-in”
- Full time Clinical Care Manager
- “Morning Huddle”
- Constant communication
- Staff recognition
- Warm handoffs
- Increased patient satisfaction
- Advocacy – Making system changes

Patient Discussion

Case Studies

Patient Discussion

- The “Resistant Patient”
- 63 year old male living in an abando. Diagnosed with HTN, Seizure d/o & Cellulites. Also diagnosed with Schizoaffective d/o and using cocaine and alcohol to reduce mental health symptoms.
- Receives \$700/month SSI
- 75 ED visits between Jan – June 2010
- “I’m not crazy”

Patient Discussion

- The “Siloed Patient”
- 44 year old woman living in the shelter. Insulin dependent diabetes & morbid obesity. History of cocaine dependence. Major Depressive Disorder & possible PTSD – History of trauma
- Community mental health weekly, substance abuse program weekly, primary medical care bimonthly.
- Full time job of “being sick.”

Patient Discussion

- The “Yearly Patient”
- 36 year old man couch-surfing from friend’s house to friend’s house. Needs medical clearance for a job.
- Recently out of jail for failure to pay child support. Last visit with his PCP was last year. Prescribed Zoloft – takes it intermittently. Has been referred to community mental health, but never goes. No insurance/Medicaid
- Daily marijuana use. Moderate depression
- Difficulty “adhering to” medications regimen, appointments and follow-up.
- His mother thinks he’s just “lazy.”



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Thanks for coming out!!!!

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