Mountain Plains (HHS Region 8)

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Pathways to Care – Building a Depression Follow-up Program

Presented by:
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SAMHSA
Substance Abuse and Mental Health Services Administration

Disclaimer and Funding Statement

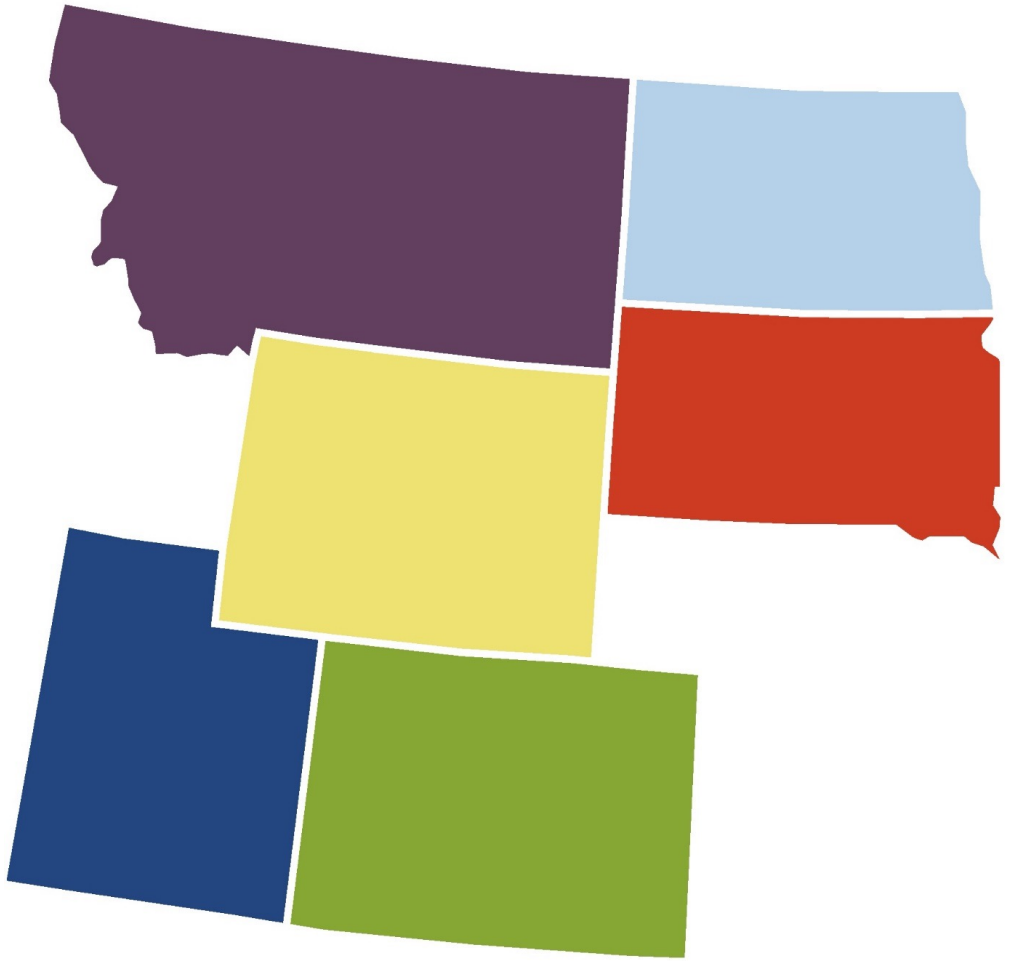
At the time of this presentation, Tom Coderre served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Andrew McLean and Robin Landwehr and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains MHTTC is supported by grant H79SM081792 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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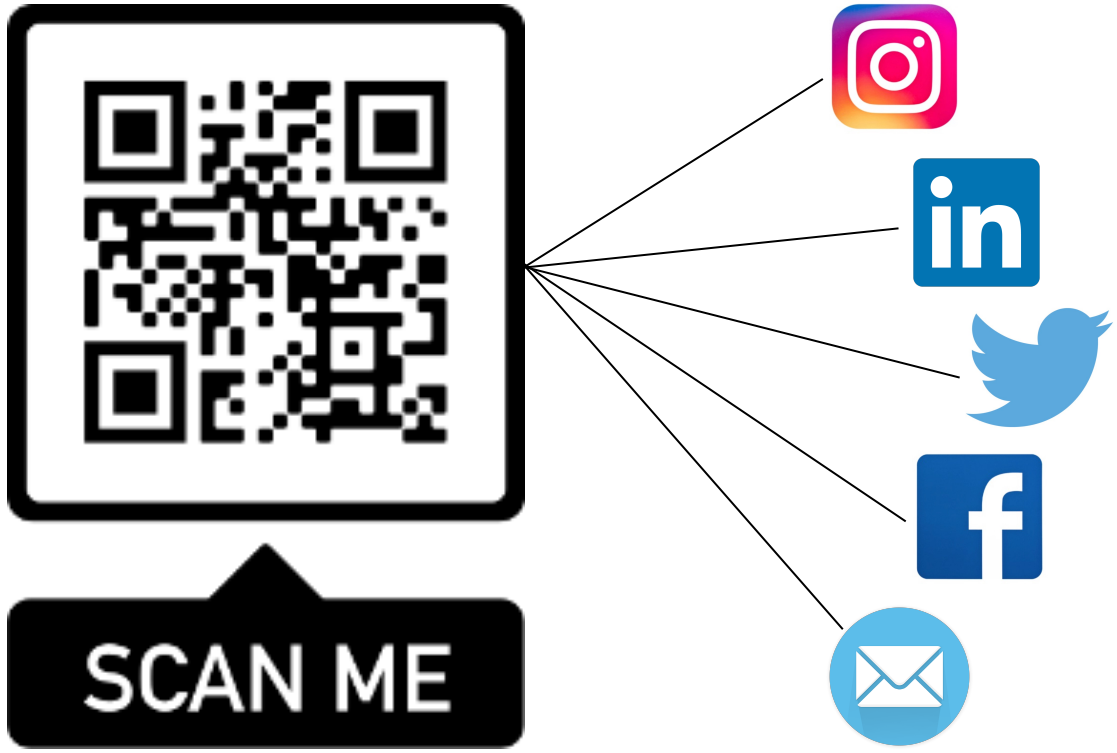

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Objectives

- Following the presentation, the participant should:

1. Be able to identify high-risk behavioral health patients

2. Be able to utilize a registry in order to track patient response to care

3. Have an understanding of the roles of providers in a collaborative care model

Who is a "high-risk" patient in a primary care clinic?

- While there are many conditions which may alert a provider to potential high-risk, today we are discussing depression.
- From a depression standpoint, we are usually talking about harm to self.

- This can be in the form of:
  - Suicidality
  - Inability to care for one's self

In some states, for civil commitment, the risk must be imminent; in other states, risk of harm can be predicted, based on previous behavior

Higher Risk Patients

Associations with suicide particularly when activity is reduced

- Back Pain (chronic pain in general)
- COPD
- HIV/AIDS
- Sleep Disorders
- Cancer
- Traumatic Brain Injury
- Epilepsy
- Migraine
- Renal Disease
- Heart Failure
- Multimorbidity

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity). *Co-morbidity* and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history:** of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

* *For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
* *Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- **Assessment** of risk level is based on clinical judgment, after completing steps 1-3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

Determining Capacity-4 Elements

- Understanding—the ability to comprehend and retain information
- Appreciation—the ability to appreciate the consequences of decisions
- Reasoning—the ability to make decisions based on values and beliefs
- Expressing a choice—the ability to make a selection and communicate decisions

Simple Cognitive Tests

- Folstein Mini Mental Status Exam (MMSE)
- Montreal Cognitive Assessment (MoCA)

Depression Scales

- PHQ-9 (PHQ-A for adolescents)
- Geriatric Depression Scale (GDS)
- Hamilton Depression Scale (HAM-D)
- Montgomery-Asberg Depression Rating Scale (MADRS)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Interpretation/PHQ-9 scoring

- Use clinical judgment, treat the patient, not the score….

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

C-SSRS

	Past 1 Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	**Life-time**	**Past 3 Months**
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Any YES indicates that someone should seek behavioral healthcare.
However, if the answer to 4, 5 or 6 is YES, seek immediate help: go to the emergency room, call 1-800-273-8255, text 741741 or call 911. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Columbia-Suicide Severity Rating Scale

Potential Interventions

- Moderate Risk
  - Brief intervention – psychoeducation about depression (worsening symptoms), provide resources
  - PCP may choose to start a medication
  - A referral to specialty mental health may be appropriate
  - Placed on the registry for monthly check-in to monitor for worsening of symptoms. Use of assessment tool. If patient moves to high risk, hospitalization may be necessary
  - Suicide prevention strategies (assessment)
  - Case management if available
  - Depression relapse plan

- High Risk
  - Placement on registry with BH follow-up weekly/biweekly until satisfied with low suicide risk
  - Biweekly Assessment Tool (PHQ-9)
  - PCP may choose to start medication
  - A referral for specialty mental health may be appropriate
  - Suicide prevention strategies (safety plan, contacting a family member, counseling on access to lethal means
  - Case management, if available
  - Depression relapse plan
    - Step down to monthly check-ins

What is a "registry?"

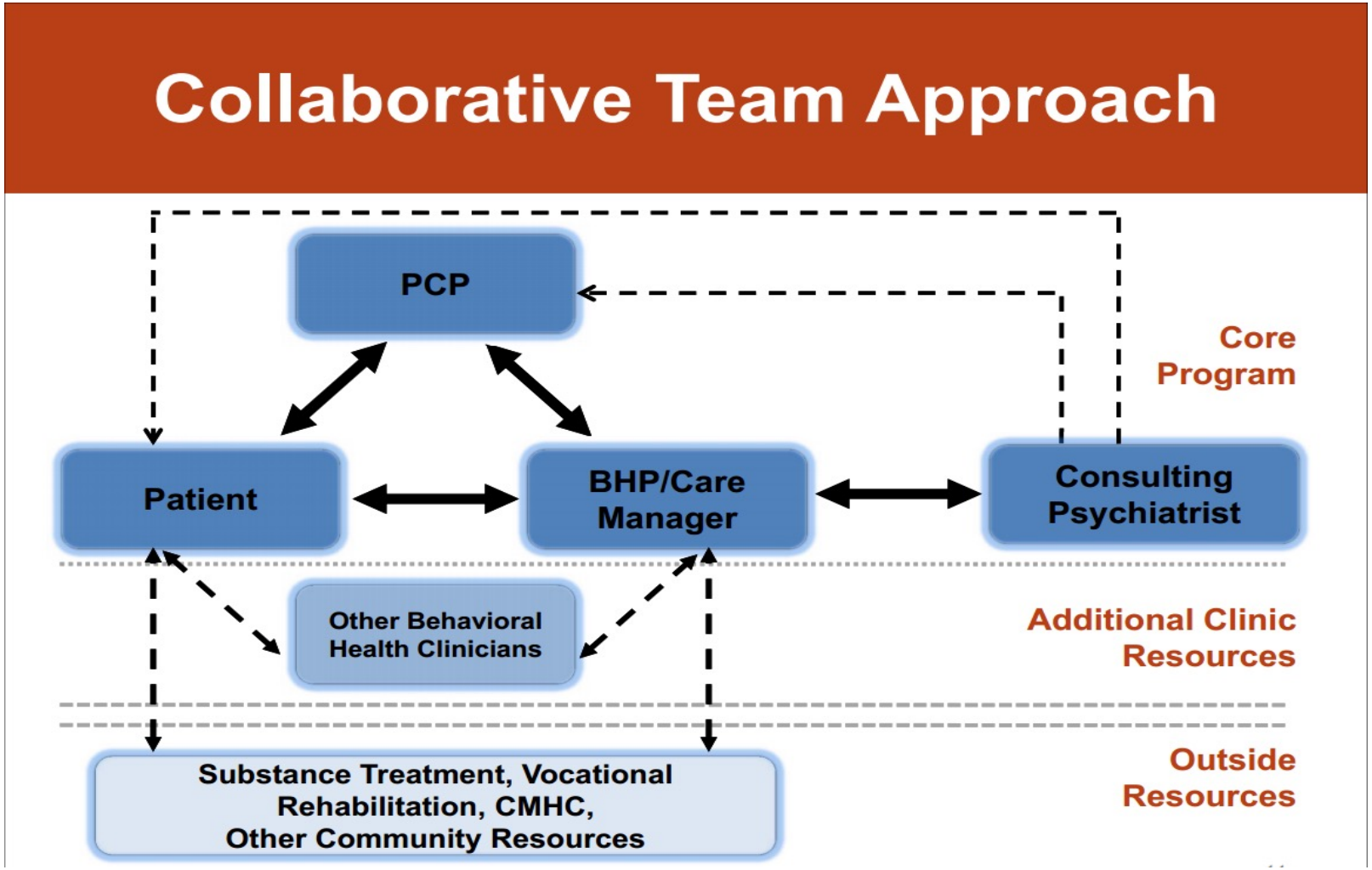
- A behavioral health registry is a tracking and reporting tool used for an identified population that can trace improvement/worsening of symptoms and evaluate outcomes
- Track treatment methods so that adjustments can easily be made based on patient progress. Adjustments are made based screening scores, patient self-report, clinical judgment.
- Ensure high risk patients do not "slip through the cracks"
- Registries can be very robust or simple based on your needs and capacity

Caseload Review

MRN	Name	Status	Date follow up due	Actual contact	PHQ-9	% change	GAD-7	% change
1236	Robert Sled	Active	12/1/21	12/4/21	15	0%	11	0%
			12/15/21	12/15/21	13	-13%	11	0%
			1/9/22	1/10/22	15	0	9	-18%
			1/23/22	1/23/22	13	-13%	6	-45%
			2/6/22	2/7/22	12	-20%	7	-36%
			2/20/22	2/20/22	11	-27%	7	-36%
			3/04/22	3/04/22	9	-40%	6	-45%

Roles

Collaborative care *optimizes* all behavioral health resources



Source: http://uwaims.org

Disciplines-(examples)not all-inclusive…

- RNs
- LPNs
- APRNs
- Social Workers
- Therapists
- Psychologists
- LACs
- Physicians
- PA-Cs
- OTs
- PTs

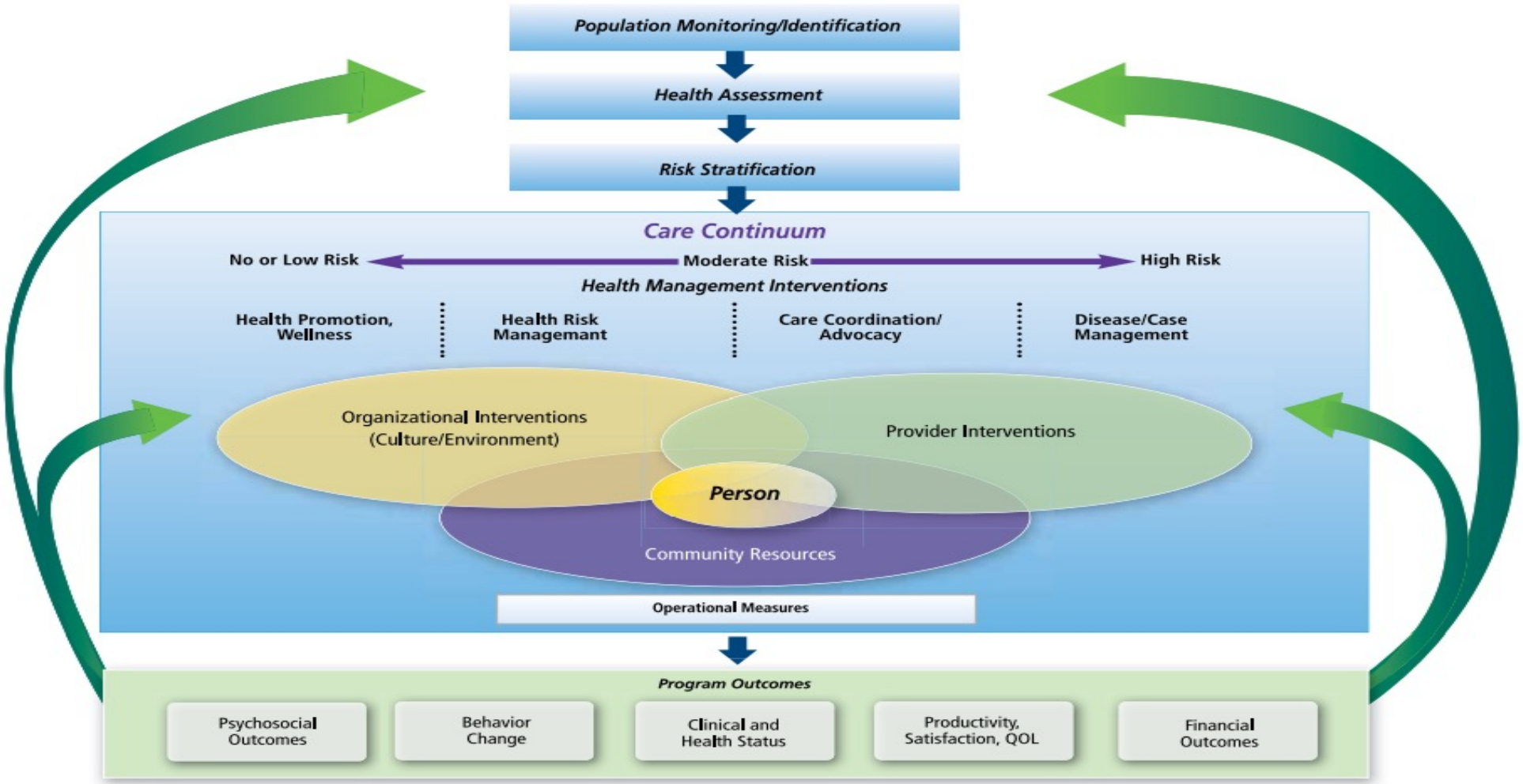
Collaborative Care Readiness Checklist

- https://aims.uw.edu/sites/default/files/Collaborative%20Care%20Readiness%20Checklist_010522.pdf
- There is a cost to the AIMS model, but it can be fully integrated into the EMR.

Other Models

- Care Continuum Alliance

Figure 1 – CCA Population Health Management Framework



Resources

Suicide Prevention Resources

Be a lifesaver

Visit
Your Primary Care Provider
Mental Health Professional
Walk-in Clinic
Emergency Department
Urgent Care Center

Find a mental health provider
findtreatment.samhsa.gov
mentalhealthamerica.net/finding-help

CrisisChat.org

Suicide Prevention Lifeline
1-800-273-TALK (8255)
Veterans: Press 1

Text TALK to 741741
Text with a trained crisis counselor from the Crisis Text Line for free, 24/7

911 Call 911 for emergencies

afsp.org/resources

American Foundation for Suicide Prevention

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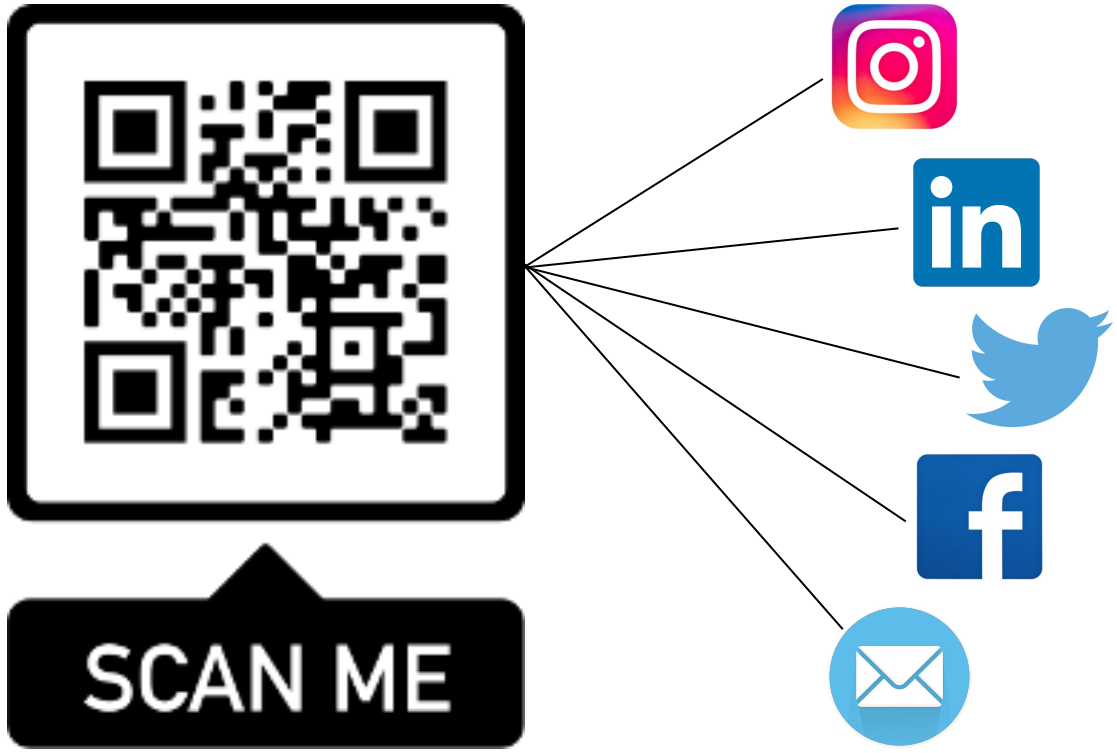

Questions? Comments?

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