INTREGRATED CARE FOR SPECIAL POPULATIONS

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PERINATAL POPULATION

BEHAVIORAL HEALTH IN PERINATAL POPULATIONS

- Over 50% of psychiatric patients are women
- Over 80% of women will have at least one pregnancy
- 50% of these are unplanned
- Rate of post partum depression PPD – 1 in 7
- Access to behavioral health services limited
- Few perinatal psychiatrists

NCRP – National Curriculum in Reproductive Psychiatry (ncrptraining.org)

EVIDENCE BASE

- MOMCare
  - Reduction in depression and anxiety response and remission
  - More likely to receive 4 or more mental health visits
  - More likely to adhere to medication treatment
  - Reduction in PTSD severity

COLLABORATIVE CARE FOR PERINATAL DEPRESSION IN SOCIOECONOMICALLY DISADVANTAGED WOMEN: A RANDOMIZED TRIAL Nancy K. Grote, Ph.D.,1∗ Wayne J. Katon, MD,2 et a; B.S.DEPRESSION AND ANXIETY 00:1–14 (2015)

KEY ADAPTATIONS: WOMEN'S HEALTH/PERINATAL COCM CONSIDERATIONS

- Clinic screening and recognition of perinatal behavioral health problems will need to be improved to facilitate appropriate referrals – workflows in OB may differ
- Clinics may need to decide which perinatal conditions will be treated in the medical / prenatal setting and which patients will be referred for direct care under a psychiatric provider.
- Clinics will benefit from care coordination with other ancillary support systems that care for perinatal patients such as home visiting nurses and public health maternity support services.
- Care coordination – mothers can deliver and then disappear – not show for their 6 week appointment either – coordinate with **peds for well baby checks**, PCP, etc
- Use of PHQ9 or EPDS?

Treating the Perinatal Population in the Collaborative Care Model (psychiatry.org)

KEY BHCM ADAPTATIONS IN PERINATAL SETTING

- To be knowledgeable around screening, diagnosing, and evidence-based treatment for common behavioral health challenges in perinatal populations including differentiating major depression from "baby blues"
- Training in assessment of perinatal psychiatric urgent and emergent situations such as postpartum psychosis, suicidal or infanticidal ideation.
- Training in evidence based behavioral interventions used to treat perinatal population such as CBT, behavioral activation, and problem solving therapy
- To include attention to parenting and to mother baby interaction in their intervention
- Educate at discharge from CoCM about risk of recurrence of post partum depression (PPD)
- Often more phone contact with busy, exhausted new moms

KEY ADAPTION: TREATMENT MODALITIES

TREATMENT	CONSIDERATIONS IN PREGNANCY
Behavioral activation	High risk pregnancy – how much activity allowed? busy mother- how much time to do scheduled activities?
Problem solving therapy	Obtaining support – especially during post partum
Cognitive behavioral therapy	Focus on transitions
Medications	Safety during pregnancy and lactation

PERFORMANCE METRICS FOR PERINATAL COCM

- Depression/Anxiety Response and Remission
  - 50% reduction anxiety (GAD-7) and depression (PHQ-9)
  - Remission anxiety (GAD-7 < 5) and depression (PHQ9 < 5)
- Preterm delivery rate
- Connection to care post delivery
- Low birth weight infants rate

PEDIATRIC COCM

WHY DO THIS?

The pandemic then brought on physical isolation, ongoing uncertainty, fear and grief. Centers for Disease Control and Prevention researchers quantified that toll in several reports.

They found between March and October 2020, emergency department visits for mental health emergencies rose by 24% for children ages 5- 11 years and 31% for children ages 12-17 years.

In addition, emergency department visits for suspected suicide attempts increased nearly 51% among girls ages 12-17 years in early 2021 compared to the same period in 2019.

AAP, AACAP, CHA declare national emergency in children's mental health

October 19, 2021

Article type: News

Topics: Adolescent Health/Medicine, Advocacy, Diversity, equity and inclusion, Psychiatry/Psychology, Psychosocial Issues

The AAP, American Academy of Child and Adolescent Psychiatry (AACAP) and Children's Hospital Association have declared a national emergency in children's mental health, citing the serious toll of the COVID-19 pandemic on top of existing challenges.

17718.pdf (silverchair-cdn.com)

INTEGRATED CARE EVIDENCE BASE

- Depression and ADHD most evidence to date
  - Significant reduction depression scores
  - ADHD improvement
  - Anxiety reduction
  - Behavioral disruption

PEDIATRICS Volume 135, number 4, April 2015

JAMA. 2014;312(8):809-816. doi:10.1001/jama.2014.9259

KEY ADAPTIONS

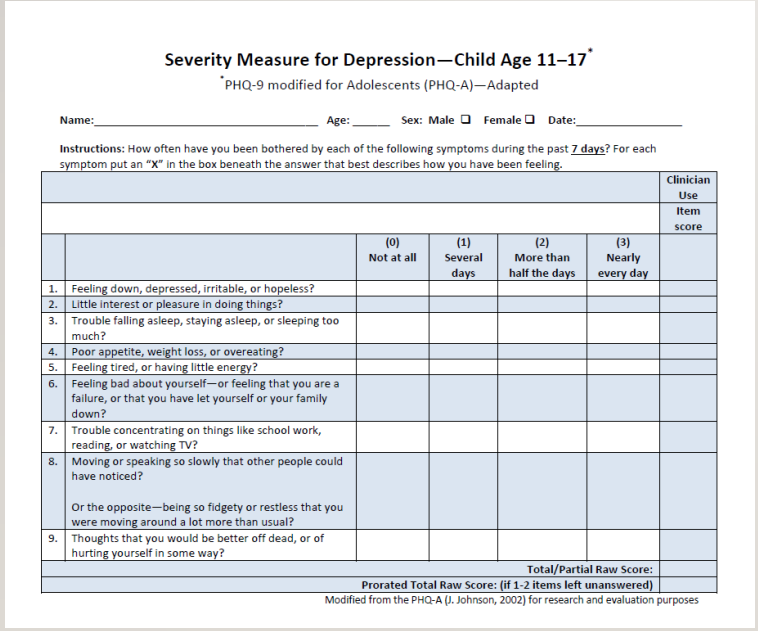
- ✓ Selection of screening measurement tools appropriate to the population
- ✓ Engaging parents
- ✓ Family medicine and pediatric clinicians
- ✓ Psychiatric consultant child and adolescent psychiatrist if possible
- ✓ Choose age range to treat with COCM – could include disruptive behavior, ADHD for example in addition to more common depression and anxiety

KEY ADAPTATIONS FOR BHCM

- BHCM should engage with **parents** as full partners in the child's treatment, empower them to be agents of change for their children, and be prepared to help parents access their own mental health services when needed.
- BHCM should be able and willing to interface with child-serving systems (ie **schools**, child protective services) and agencies to address social determinants of health
- BHCM need to be prepared to employ creative strategies to engage therapeutically with children

PEDIATRIC MEASUREMEMNT TOOLS

- PHQ-A – Depression
- Vanderbilt – ADHD
- SCARED
- Short Form Mood and Feelings Questionnaire



Severity Measure for Depression—Child Age 11–17*

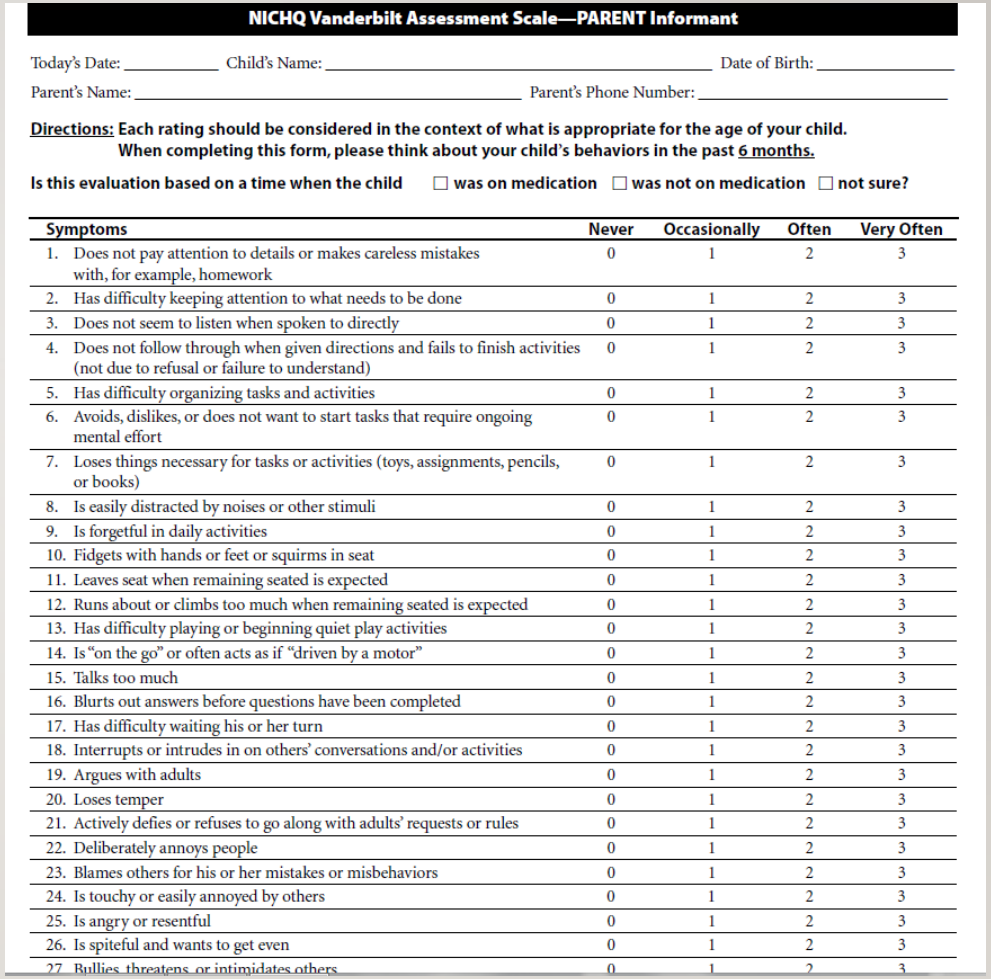
*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:**_____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes



NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3

MBC_Report_Final.pdf (mmhpi.org)

THERAPEUTIC INTERVENTIONS

- Anticipatory Guidance
- Stress management
- Relaxation/mindfulness
- Emotional regulation
- Behavioral modification
- Cognitive behavioral techniques
- Parent education
- Prepare for therapy referral if needed

Anticipatory Guidance

- Educating parents regarding normal social and emotional development
- Training parents in basic behavior-modification principles; establishment of consistent expectations and structure, clear limit-setting, praise, and positive reinforcement
- Teaching strategies to enhance parent-child relationships
- Teaching strategies to improve family cohesion and address sibling conflicts
- Coaching parents on bullying issues
- Educating parents about the impacts of toxic stress and traumatic experiences
- Helping parents become effective advocates for their children with regard to addressing special education needs

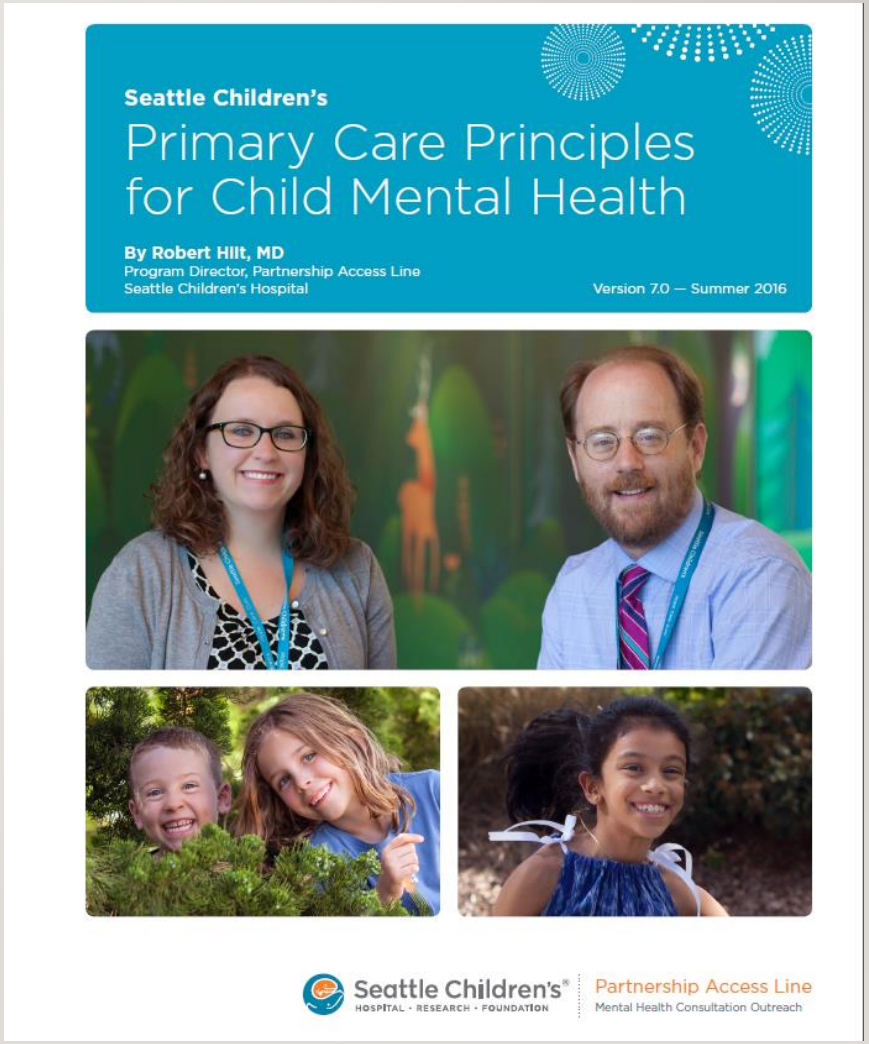
Photo unsplash

Resources for Perinatal COCM

- Screening Tools
- Brief Interventions
- Self-help materials
- Parent resources

MBC_Report_Final.pdf (mmhpi.org)

Pediatric CoCM Implementation Guide_Final (Reduced Size).pdf



www.seattlechildrens.org/pdf/PAL/WA/WA-care-guide.pdf

GERIATRIC POPULATION

GERIATRIC CONSIDERATIONS

- Important co-occurring medical conditions, those that may both mimic or complicate mental health conditions.
- Screening, diagnosis and management of dementia.
- Developmental issues of late life.
- Treating practitioners aware of the impact of aging on metabolism and effects of psychotropic medications.
- Behavioral health providers trained to screen, diagnose, and deliver evidence-based treatment for geriatric populations

APA-Treating-Geriatric-in-the-CoCM-Guide.pdf (psychiatry.org)

CARE TEAM WILL NEED:

- To engage with patients' caregivers through the process of evaluation and treatment.
- To focus on communication between primary care and other medical specialties for management of complex comorbid conditions.
- To be resourceful about remaining engaged with seniors with mobility and transportation issues.
- Knowledge of community resources for seniors.
- Knowledge about social issues likely to be important to seniors:
  - Financial security
  - Food security
  - Safety
  - Financial exploitation
  - Safe housing
  - Stress of role as caregiver

ADDITIONAL BEHAVIORAL HEALTH MEASURES TO CONSIDER

- Mini-Mental State Examination (MMSE)
- Mini-Cog
- Montreal
- Cognitive Assessment (MoCA)

- SAMHSA: Treatment of Depression in Older Adults Evidence-Based Practices (EBP) KIT
- Caregiver Action Network: Family Caregiver Toolbox

END

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