PRIMARY CARE COALITION OF MONTGOMERY COUNTY

Montgomery Cares Behavioral Health Program Update

Volume 1 Issue 2 June 2009

RAND Evaluation Identifies Mental Health As Priority Need for Montgomery Cares Patients

The 2009 RAND evaluation of Montgomery Cares recognized behavioral health care as an area of need and recommended that this area of service be expanded.

The RAND evaluation also identified problems encountered by clinics: "*clinics not involved in the behavioral health care pilot report that obtaining mental health care services for their patients is a significant problem and even that they are sometimes reluctant to diagnose depression because of a lack of available treatment options. Other clinics reported initiating care with medication therapy but not being able to offer follow-up appointments or other types of treatment.*

RAND Patient Self-Reports

- *13 percent reported fair or poor mental health*
- *16 percent reported current depression.*
- *22 percent reported either current depression or fair or poor self-rated mental health.*

Identifying and treating mental health in the primary care setting makes sense for many reasons. First, 60 percent of all visits to primary care provider have a psychosocial driver, indicating that patients perceive their medical provider as someone who can help. Many patients will not seek or obtain mental health treatment elsewhere due to stigma, access or other barriers.

Overall, 50 percent of all mental health care is provided by primary care providers, and 60 percent of all anti-depressants are prescribed by primary care providers.

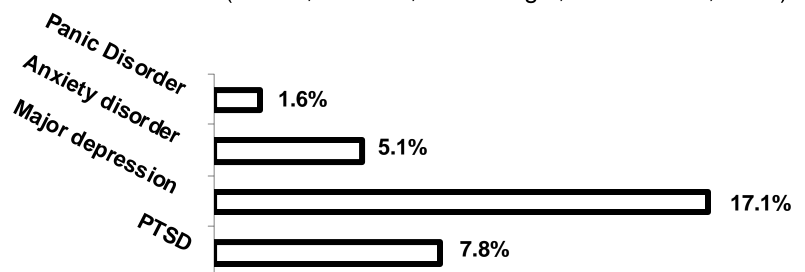
The most common mental health problems are depression and anxiety disorders which can be appropriately and safely treated by primary care providers. Evidence-based practices such as collaborative or integrated mental health have demonstrated that patients with depression can

Mental Health Disorders In the US Population

The responses of patients in the RAND evaluation are consistent with population-based studies, which have shown that:

- Nearly 50 percent of the US population (age 15-54) has experienced a lifetime mental disorder.
- 30 percent of the US population met diagnostic criteria for a mental disorder during the past year. (Kessler et al. 1994).

Common Mental Health Disorders in the US Population
(Blazer, Kessler, McGonagle, & Schwartz, 1994)



PHARMACOLOGIC TREATMENT OF POST TRAUMATIC STRESS DISORDER (PTSD)

Presented at Holy Cross clinic by Dr. Joyce Chung, Associate Professor of Psychiatry, Georgetown Department of Psychiatry at the Georgetown University Medical School. Dr. Chung is a consulting psychiatrist for the Behavioral Health Program.

There is increasing recognition of the prevalence of trauma exposure in the general population, and the resulting symptoms that many people suffer known as post-traumatic stress disorder (PTSD). Access to therapy is often limited and many patients present in the primary care setting with acute symptoms of PTSD, making the primary care setting the setting of choice to receive treatment for many patients. The Behavioral Health Program asks patients about trauma exposure, and then utilizes a 17 item PCL (Posttraumatic Stress Disorder Checklist) tool to score their level of symptomology and assist with diagnosis.

Psychopharmacological treatment has been shown to be beneficial for patients with PTSD, particularly for individuals such as torture survivors whose trauma occurred after their formative years. For individuals who were victims of early physical and sexual abuse or trauma medication may alleviate some of their symptomology but may not be effective in changing long-term learned behaviors that may be the result of early exposure to trauma.

As with depressive and other anxiety disorders, SSRIs are considered the first line treatment for PTSD and there have been double blind placebo controlled trials documenting their effectiveness. First-line treatment choice may be citalopram, fluoxotine, paroxetine or sertraline, depending on patient's response to the medication, side effects, or considerations such as drug-drug interactions. Use of an SSRI may also have the benefit of treating co-morbid conditions such as depression which tend to occur with PTSD.. Similar dosage and titration schedules would be used to treat PTSD as depression.

When SSRIs are not tolerated or prove ineffective other antidepressants can be used. Second line agents include venlafaxine, nefazodone, mirtazapine. TCAs and MOIs are a third-line choice. Studies have shown buproprion to be ineffective in treating PTSD.

The use of anxiolytics for PTSD treatment is may be useful to diminish anxiety in situational contexts, however there is no evidence for use of benzodiazepines to effectively treat PTSD, and in fact this class of drugs may actually worsen PTSD. Given the comorbidity of PTSD and substance abuse use benzodiazepine use is not advised, especially for long-term treatment.

Key concepts in treatment of PTSD are similar to those for the treatment of depressive or anxiety disorders:

- Continue medication treatment for at least one year
- Augment if necessary and optimize dose
- Switch agents if response is not sufficient
- Consider drug-drug interactions in choice of agent

When and How to Say No:

Providing Medical Services to Patients with Addictions

Presented at Proyecto Salud by Dr. Joseph Mullen, D.O., Medical Director/ Psychiatrist at Avery Road Combined Care

"Saying NO"

"It takes 30 seconds to say yes and 30 minutes to say no"

Use Treatment Planning With Patient To Establish Boundaries

- Patient must be compliant with all of their medications
- Lost Rx will not be refilled
- Weekly Rx is an option to control access or titrate off a medication
- Refer for psychiatric evaluation if depression or anxiety are persistent or debilitating

Benzodiazepine Use Not Recommended

- Avoid use in patients with an addiction history
- Avoid alprazolam (Xanax) use—rapid acting produces a 'high'
- If using alprazolam in non-addicted patient Rx for 7-14 days, and avoid long-term use because of concerns of long-term dependence
- For acute anxiety consider clonazepam (Klonopin) 0.5 mg bid, oxazepam (Serax) 10-15 mg tid or lorazepam (Ativan) .5 mg

The gold standard for treating anxiety is combinational treatment with an SSRI and psychotherapy.

FOCUS: BHP Outreach and Provider Education

DOMESTIC VIOLENCE

Statistics Tell The Story

- 25 percent of women and 8 percent of men have been physically and/or sexually abused by an intimate partner at some point in their lives
- 3.4 – 5.5 percent of patients experienced violence within the past year
- 21 percent - 34.7 percent of patients had a lifetime prevalence of exposure

Source: Family Violence Prevention Fund

One study showed that the "Average healthcare costs for a woman who disclosed a history of physical, sexual or emotional abuse were $1,700 higher than never-abused women over a three-year period." -- Maryland Network Against Domestic

PATIENT EDUCATION RESOURCES

Family Violence Prevention Fund
http://endabuse.org/

Free posters, brochures, cards, videos, manuals for health care Information and Resources available in many different languages

The Texas Council on Family Violence
http://www.tcfv.org/resources/

POWER AND CONTROL WHEELS

- **Power and Control Wheel—English and Spanish**
- **Immigrant Power and Control Wheel**
- **LGBT Power and Control Wheel**
- **Equality Wheel**

INTERVENTION WITH VICTIMS IN THE PRIMARY CARE SETTING

Listen to the patient and provide validating messages.

The most important messages to deliver are:

- You are not alone.
- You are not to blame. It is not your fault.
- There is help available.
- You do not deserve to be treated this way.

Listen and respond to safety issues.

- Encourage victims to make their own safety plan for when a batterer is present in the medical setting, when a victim fears leaving the medical setting, or when a victim is returning to the batterer.

Provide information and education about domestic violence to the patient. (orally, handouts, cards, phone numbers)

- Domestic violence is health issue for patient (and children). Violence can escalate; damage from the abuse escalates over time.
- Stopping domestic violence is the responsibility of the perpetrator, not victim.
- Victims, with assistance and support from others, can increase their own safety (and their children's).

Make referrals to local resources.

- Within the health system; legal options; community advocacy services, shelters, crisis services

Follow-up.

- Schedule future appointments. Ensure the patient will have a connection to a primary care provider. Ask what happened after the last visit.
- Ask about past episodes of domestic violence in order to communicate a concern for patient and a willingness to address this health issue.

Guiding Principals for An Improved Healthcare Response to Domestic Violence

- Increase the safety of the domestic violence victim and her children.
- Respect the integrity and authority of the victim for making her own life choices.
- Hold perpetrators, not victims, responsible for both the abuse and for stopping it.
- Advocate on behalf of domestic violence victims and their children.
- Be willing to make changes in both individual practice and in the health care system in order to improve the

Behavioral Health Program Goal

To establish an evidence-based collaborative care model in community-based primary health care settings serving Montgomery Cares patients to:

- *Identify patients with mental health needs;*
- *Evaluate the patients to determine diagnoses and appropriate levels of care; and*
- *Collaborate with primary care providers to provide appropriate treatment including medication, support, social service intervention, and/or referral to primary psychiatric or substance abuse services.*

PROGRAM STAFF

Proyecto Salud
Talia Benami-Rosas, LGSW, Care Manager
Wendy Barillas, Family Support Worker

Mercy Health Clinic:
Marta Baker, LGSW, Care Manager
Priya D'Souza, Family Support Worker

Holy Cross Clinic
Pat DeLeon, RN, Nurse Care Manager
Alicia Beltran, Family Support Worker

Project Director
Jennifer Pauk, LCSW-C, MPH

For more information please contact:
jennifer_pauk@primarycarecoalition.org
301 628-3407

IMPACT MODEL OF COLLABORATIVE CARE

http://impact-uw.org/

The Montgomery Cares Behavioral Health Program is modeled after the IMPACT model of collaborative care. IMPACT followed 1,801 depressed, older adults from 18 diverse primary care clinics across the United States for two years. Study findings that clearly demonstrate the effectiveness of the model for treating depression in the primary care setting.

The IMPACT website offers resources and information, including:

- Program manuals
- Patient assessment forms, tracking systems, patient education, program evaluation tools
- Free on-line CME training program on the components of collaborative care

PRIMARY CARE COALITION OF MONTGOMERY COUNTY