Training Handout for the Online Training for Behavioral Health Care Managers

Thank you for taking the time to learn about Collaborative Care (CoCM) through our online training.

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This handout is a supplement to the AIMS Center's Online Training for Behavioral Health Care Managers. It should not be used as a standalone training tool. We recommend using this handout to take notes during the training as well as to reference after training access concludes.

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About the AIMS Center

The purpose of the AIMS Center is to inspire providers, researchers, and decision-makers to transform healthcare and improve patient outcomes. We accomplish this by translating and researching evidence-based approaches to behavioral health integration. To learn more about the AIMS Center and our work, you can visit our website: https://aims.uw.edu/

Questions About the Online Training?

- Website: https://aims.uw.edu/online-bhcm-modules
- Email: aimstrng@uw.edu

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How and When to Refer to Specialty Care

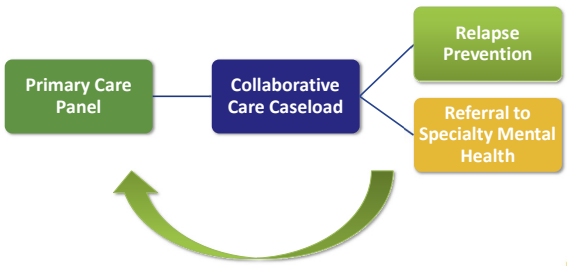
1

In This Module

- ✓Understanding when referral is necessary
- ✓Making a successful referral
- ✓Finding referral sources

2

Typical Course of Care Management



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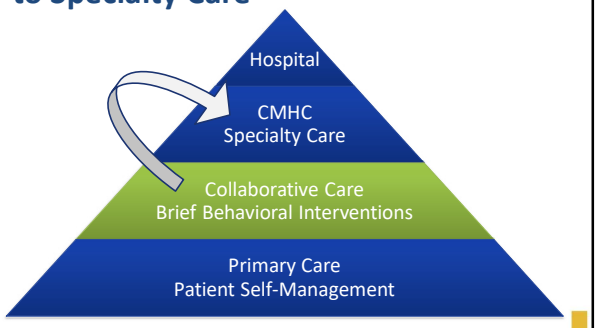
Intensifying Treatment with a Referral to Specialty Care



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Reasons to Refer

- **Patient not getting better**
- **Conditions requiring specialty behavioral health**
  - **Conditions needing special expertise**
  - **Conditions requiring longer-term care**
  - **Need for recovery-based services; people with serious and persistent mental illness**
- **Patient request**

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Patients Who Just Aren't Getting Better

- **Not all patients will respond to treatment in collaborative care**
- **Know when to refer the patient to specialty care**
- **Lack of improvement is normal in all treatment settings**

Source: NIMH

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Conditions That May Require Specialty Behavioral Health Care

- Treatment-resistant trauma disorders
- Substance use rehabilitation
- Major pediatric disorders; developmental disorders
- Severe obsessive-compulsive disorder
- Severe mood and severe bipolar disorders
- Serious and persistent mental illness

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Patient Request

- Model not a good fit
- Desire in-person psychiatric prescriber visits
- Interested in long-term therapy

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How to Make a Successful Referral

- More than a phone number
  - Use relationship with known provider
  - Call ahead to help set up connection
  - Talk about what your ongoing role will be
- Follow up with the patient after the referral
- Be realistic about payment/cost/insurance
  - Sometimes treatment is worth it!

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Develop a List of Referral Resources

- How do you find them?
  - Word of mouth
  - Colleagues
  - Professional listings, associations, etc.
- The phone is your friend
  - Call potential sources of care and talk to them about how you could work together
- Create a clinic list
  - Make sure to develop a formal list that can be shared in the clinic to anticipate turnover

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PRACTICE

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Activity 1: Case Study

A 16 year old girl is brought in by her parents for behavioral problems. She has suddenly become more defiant and refuses to do most school work. She has been caught sneaking out at night to be with friends, and her mom found marijuana in her room. She is moody and not sleeping regularly. She has a family history of a cousin that has been diagnosed with bipolar disorder.

You have had six visits with just her, and have also met with the family. No one feels that much progress has been made, including you and the patient, who says she just wants to get her parents off her back. Her parents have heard that bipolar illness is more common in children than people used to think and ask you if there is a chance their daughter could have bipolar disorder.

What are your next steps for this patient?

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Possible Approaches to Case Study

- Discuss this patient in weekly case review with your psychiatric consultant - you might ask:
  - Does this patient have bipolar disorder?
  - What other interventions might be helpful?
- Refer the family to an outside provider who specializes in adolescents
  - Discuss who might be available in your community
  - Go over possible costs
  - Discuss timing of the referral

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Activity 2: Resources in Your Community

- Consider the following list and identify at least one resource for each situation in your community:
  - Treatment-resistant trauma disorders
  - Substance use rehabilitation
  - Major pediatric disorders; developmental disorders
  - Severe obsessive-compulsive disorder
  - Severe mood and bipolar disorders; serious and persistent mental illness

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Identifying Resources in Your Community

- Use identified community resources to start building a community referral list
- Resources for referrals
  - Word of mouth
  - Colleagues
  - Professional listings and associations
- Call or even visit potential contacts

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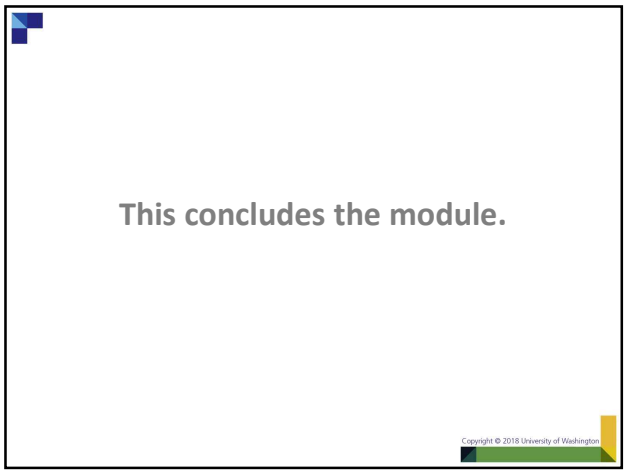
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Suicide Prevention in Collaborative Care

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In This Module

- ✓ Impact of suicide
- ✓ Role of the primary care team in suicide prevention
- ✓ Skills for working with patients at risk for suicide

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PARTNERS IN COURSE DEVELOPMENT

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Advancing Integrated Mental Health Solutions

FOREFRONT
SUICIDE PREVENTION

Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

UW Medicine
UW SCHOOL OF MEDICINE
DEPARTMENT OF FAMILY MEDICINE

WASHINGTON STATE DEPARTMENT OF VETERANS AFFAIRS
"Serving Those Who Served"

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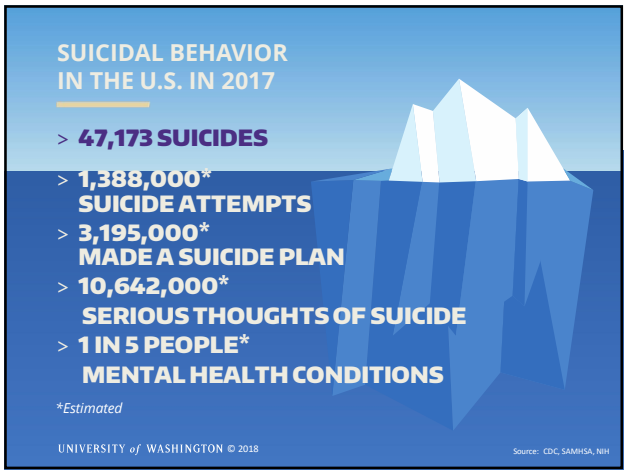
SUICIDAL BEHAVIOR
IN THE U.S. IN 2017
> 47,173 SUICIDES
> 1,388,000* SUICIDE ATTEMPTS
> 3,195,000* MADE A SUICIDE PLAN
> 10,642,000* SERIOUS THOUGHTS OF SUICIDE
> 1 IN 5 PEOPLE* MENTAL HEALTH CONDITIONS
*Estimated
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Source: CDC, SAMHSA, NIH

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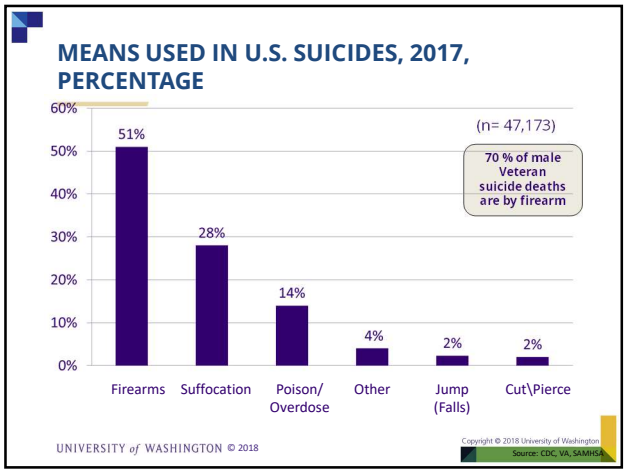
MEANS USED IN U.S. SUICIDES, 2017, PERCENTAGE
60%
50%
40%
30%
20%
10%
0%
51%
28%
14%
4%
2%
2%
(n= 47,173)
70 % of male Veteran suicide deaths are by firearm
Firearms
Suffocation
Poison/ Overdose
Other
Jump (Falls)
Cut\Pierce
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Source: CDC, VA, SAMHSA

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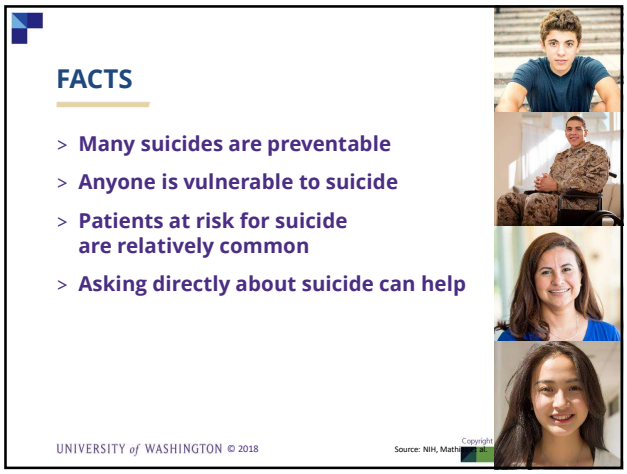
FACTS
> Many suicides are preventable
> Anyone is vulnerable to suicide
> Patients at risk for suicide are relatively common
> Asking directly about suicide can help
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SUICIDAL INDIVIDUALS AND BEHAVIORAL HEALTHCARE

90–95%

of those who die by suicide live with a mental health disorder.

- Only about 1/4 receive mental health care in the last month of life.

Source: Nock et al., Ahmedani et al.

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SUICIDAL INDIVIDUALS AND HEALTH CARE

Nearly 50% of those who die by suicide saw a primary care provider in the month before they

83%

of those who die by suicide visit a medical provider within the past year.

Source: Ahmedani et al.

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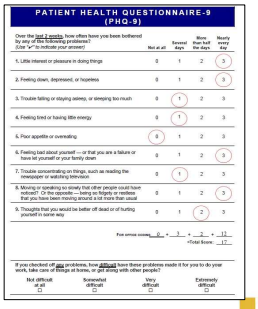
DEPRESSION SCREENING IN PRIMARY CARE SETTINGS: PHQ-9

- **Brief - 9 questions**
- **Question 9: "Thoughts that you would be better off dead or that you want to hurt yourself in some way"**
- **If patient screens positive for depression or suicidal thoughts, then evaluate further.**



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 figety 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 service screening 0 + 3 + 2 + 12 =Total Score: 17

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
☐	☐	☐	☐

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RISK FACTORS FOR SUICIDE

HEALTH FACTORS	ENVIRONMENTAL FACTORS	PERSONAL FACTORS
• Mental health conditions • Alcohol and substance use disorder • Serious or chronic health condition and/or pain • Impulsive or aggressive behaviors	• Stressful life events especially loss (relational, financial, social) • Prolonged stress • Access to lethal means • Local suicide cluster • Barriers to accessing mental health treatment	• Past suicide attempt • Family history of suicide • Family history of child maltreatment • Intergenerational trauma • Cultural and religious beliefs • LGBT status • Veteran status

Source: AFSP

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WARNING SIGNS

> **Feelings**
- Depression, anxiety
- Anger, irritability
- Hopelessness, helplessness
- Shame, humiliation

> **Situations**
- Loss of relationship, job or social standing
- Death of loved one
- Sudden, unexplainable joy after period of depressions

> **Behaviors**
- Social isolation
- Increasing drugs and alcohol
- Losing interest in activities
- Changed in sleep, weight, eating patterns

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DISTRESS IS NOT ALWAYS VOCALIZED

> Tearful, anxious, or overly tired

> Not refilling or seems desperate to get medications

> Appears intoxicated

> Disoriented, accompanied by caregiver

> Change from usual behavior

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SUICIDE PREVENTION

Ask & assess:
WHEN DO I ASK

- Notice multiple warning signs together
- Notice concerning changes of behavior
- Your gut tells you something is wrong

Remember: There is never harm in asking about suicide

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SUICIDE PREVENTION

Ask & assess:
HOW TO ASK

- Be DIRECT:
  - "Are you thinking about suicide?"
  - "Are you planning to kill yourself?"
- Add context
  - "Sometimes when people are overwhelmed by life, when they can't find solutions to their problems, they think about suicide. Are YOU thinking about suicide?"

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SUICIDE PREVENTION

Ask & assess:
IF YOUR PATIENT SAYS YES

- Thank them for honesty, courage
- Ask follow-up questions:
  - Have you thought about how you might end your life?
  - Do you have access to those means?
  - Are you thinking of when you might end your life?

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SUICIDE PREVENTION

Ask & assess:
IF YOUR PATIENT SAYS NO

Sometimes patients will not tell you they are thinking about suicide

- If your gut tells you to be concerned, ask open-ended questions, empathize, listen
- Be alert to discrepancies between self-report and screening tool
- Consider connecting patient to additional care and support

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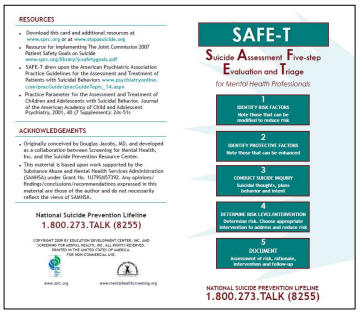
SAFE-T ASSESSMENT



Source: SAMHSA

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SAFE-T STEP 1: RISK FACTORS

HEALTH FACTORS	ENVIRONMENTAL FACTORS	PERSONAL FACTORS
• Mental health conditions • Alcohol and substance use disorder • Serious or chronic health condition and/or pain • Impulsive or aggressive behaviors	• Stressful life events especially loss (relational, financial, social) • Prolonged stress • Access to lethal means • Local suicide cluster • Barriers to accessing mental health treatment	• Past suicide attempt • Family history of suicide • Family history of child maltreatment • Intergenerational trauma • Cultural and religious beliefs • LGBT status • Veteran status

Source: CDC, AFSP

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SAFE-T STEP 2: PROTECTIVE FACTORS

INTERNAL

- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

EXTERNAL

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family, community support and pets (connectedness)
- Support from ongoing medical and mental health care relationships

Source: CDC

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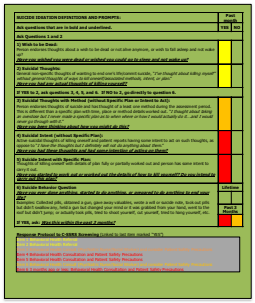
SAFE-T STEP 3: WHAT IS C-SSRS

Columbia-Suicide Severity Rating Scale (C-SSRS) – Primary Care Version

What is it?

- Validated instrument to assess suicide
- Six key questions about core elements of a suicide assessment



Source: C-SSRS

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SAFE-T STEP 4: DETERMINING LEVEL OF RISK

Risk Level	Risk/Protective Factor	Suicidality	Possible Interventions
High	Psychiatric diagnoses 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 is 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 SAFE-T Risk/Intervention Chart was created by SAMHSA and is intended to represent a range of risk levels and interventions, not actual determinations.

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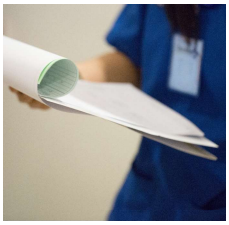
SAFE-T STEP 5: DOCUMENT

- Document level of risk and information used to make that assessment
  - Document data from assessment tools
  - Document safety plan
  - Remove any potential means identified by patient
- Plan to share documentation with other care providers



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HELP PATIENT PLAN TO REMOVE ANY POTENTIAL MEANS

ASK THE PATIENT: WHO CAN HELP LOCK OR LIMIT ACCESS TO THESE ITEMS IN HOME?

- Firearms
- Alcohol and drugs
- Prescription medications
- Over the counter medications
- Belts, rope, cords, plastic bags
- Knives
- Chemicals
- Cars / car keys
- Pesticides and poisons

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BREAKING CONFIDENTIALITY AND HIPAA

No release of information is needed to share patient information to provide continuity of care between medical providers.

Source: HHS

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BREAKING CONFIDENTIALITY AND HIPAA

Does HIPAA permit a provider to contact a patient's family or law enforcement if the provider believes that the patient might hurt herself or someone else?

- **YES.**
  The Privacy Rule permits a health care provider to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when the provider believes the patient presents a serious and imminent threat to self or others.

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Source: HHS

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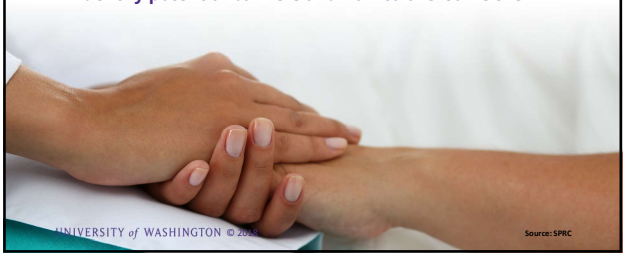
PLAN FOR SAFETY

- Use a standard safety plan format
- Develop plan jointly with patient
- Share with supports with permission
- Identify potential barriers and how to overcome them



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Source: SPRC

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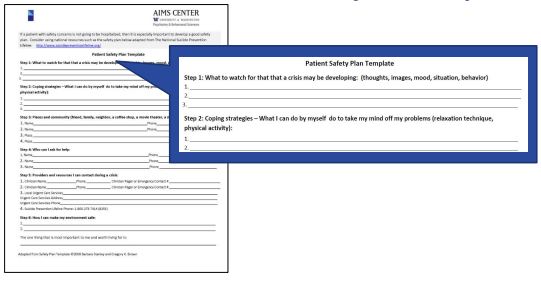
PLAN FOR SAFETY

- UW AIMS Center Patient Safety Plan Template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Patient Safety Plan Template

Step 1: What to watch for that that a crisis may be developing: (thoughts, images, mood, situation, behavior)

1. _____
2. _____
3. _____

Step 2: Coping strategies – What I can do by myself do to take my mind off my problems (relaxation technique, physical activity):

1. _____
2. _____

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Source: SPRC

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SAFETY PLANNING: 6 STEPS

1 Step 1 What to watch for

2 Step 2 Coping strategies (What I can do myself)

3 Step 3 Places & community that provide distraction

4 Step 4 Who I can ask for help

5 Step 5 Providers & resources I can contact during a crisis

6 Step 6 How can I make my environment safe

What is the one thing that is most important to me and worth living for?

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STEP 1: WHAT TO WATCH FOR

Signs that a crisis may be developing:

> _____
> _____
> _____

thoughts

images

mood

situation

behavior

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STEP 2: COPING STRATEGIES

What I can do by myself to take my mind off my problems:

> _____
> _____
> _____

relaxation technique

physical activity

working a puzzle or other hobby

taking a bath or

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STEP 3: PLACES & COMMUNITY

Places and community that provide distraction:

> _____
> _____
> _____

friend, family, neighbor, coffee shop, movie theater, store

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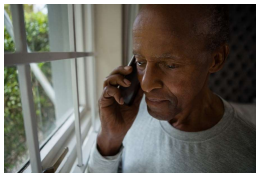
STEP 4: WHO I CAN ASK FOR HELP

1. **Name & phone:** _____
2. **Name & phone:** _____
3. **Name & phone:** _____



friend, physician, therapist, pastor,

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STEP 5: PROVIDERS & RESOURCES I CAN CONTACT DURING A CRISIS

Clinician name: _____
> **Phone:**
> **Pager or emergency contact #:**

Clinician name: _____
> **Phone:**
> **Pager or emergency contact #:**

Local Urgent Care _____
> **Urgent Care address:**
> **Urgent Care phone:**

Suicide Prevention Lifeline Phone 1-800-273-TALK (8255)

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CRISIS LINES & OTHER SUPPORTS

Call the Lifeline anytime, 24/7
1-800-273-8255

1. **CALL**
   - Press 1 for Veterans support
   - Non-emergency calls accepted
   - Assessment & recommendations of local resources
2. **TEXT**
   - "HOME" 741-741
3. **CHAT**
   - CrisisChat.org
4. **APPS** (iPhone, Android)
   - Virtual Hope Box
   - My 3

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STEP 6: HOW I CAN MAKE MY ENVIRONMENT SAFE?

1. _____
2. _____
3. _____

lock up firearms

lock up medications

remove other lethal means

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What is the one thing that is most important to me and worth living for:

_____

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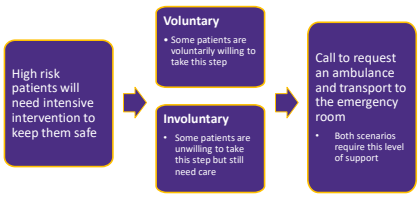
MAKING A REFERRAL FOR HOSPITALIZATION

State protocols will vary for involuntary detention

- **Washington Specific: Involuntary determination is made by a Designated Mental Health Professional**



Source: SPRC, WA DSHS, King County

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CARE TRANSITION AFTER HOSPITALIZATION

- **Immediately after inpatient hospitalization and emergency patients are at high-risk**
- **Contact after emergency intervention for suicide is critical**
- **Additional resources to structure your first follow-up visit**

Source: Zero Suicide, Brown & Green

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CONTINUITY OF CARE FOR ALL PATIENTS AT RISK FOR SUICIDE

- **Plan for close follow up in your practice**
  - **Continue to check in with the patient about safety plan and assess for suicidality**
- **Plan for referral**
  - **Know resources in your community and practice setting**
  - **Support patient to complete referral**
  - **Coordination of care with referral providers**
- **Long-term monitoring for suicide risk**
  - **Patient will always need a check in; may be brief**

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TREATMENT OF MENTAL HEALTH DISORDERS

- Help patients get connected to evidence based treatment
  - Keep supporting patients until they have treatment that relieves suffering
- Common disorders often treated in primary care
  - Depression
  - Anxiety
- Complex disorders need care coordination
  - Substance Use Disorders
  - Bipolar
  - Schizophrenia
  - Personality Disorders

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SUICIDE-SPECIFIC PSYCHOSOCIAL INTERVENTIONS

- Treatments that prevent suicide attempts or self-directed violence in adults
  - Cognitive therapy for suicide prevention (CT-SP)
  - Cognitive–behavioral therapy (CBT)
  - Dialectical behavior therapy (DBT)
  - Problem Solving treatment (PST)
  - Mentalization-based treatment (MBT)
  - Psychodynamic interpersonal therapy (PIT)
- Approaches that reduce suicidal ideation
  - Collaborative Assessment & Management of Suicidality (CAMS)
  - Cognitive–behavioral therapy (CBT)
  - Problem Solving treatment (PST)
  - Psychodynamic interpersonal therapy (PIT)
  - IMPACT/Collaborative Care Model (CoCM)

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SPECIFIC ANTI-SUICIDE MEDICATIONS

- Lithium
  - Mood disorders: 30-fold greater risk of suicide
  - Suicide protective effect over the long-term course in patients with mood disorders
- Clozapine
  - Only medication approved by the US FDA for preventing suicide in patients with schizophrenia

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MINIMAL ELEMENTS OF PROTOCOL

At a minimum a clinic protocol will address the following:

- **Look:**
  - How will you screen and identify those at risk for suicide?
- **Empathy:**
  - How will providers be trained and empowered to support patients at risk?
- **Ask & assess:**
  - What will your practice use to gather further information once a patient has screened positive for thoughts of suicide?
  - Do you have a triage plan for determining who needs to be sent to an emergency room immediately versus being followed in outpatient care.
- **Remove danger and plan for safety:**
  - What are the strategies in your community to remove means?
  - How will safety plans be generated and documented?
  - How will you make voluntary and involuntary treatment referrals?
- **Next steps to continuous care:**
  - How will you make sure to track any commitments?
  - How will you provide continuity of care and referrals?

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This concludes the module.

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