Improving Wellness by Reducing Stigma: The Case for Primary Care and Behavioral Health Integration

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Population with Serious Mental Illness

The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions.

More than 1 in 5 adults with mental illness have a co-occurring substance use disorder.
Issue is larger than SMI

- Primary care is the sole source of MH treatment for 1/3 of patients receiving care for a MH condition.
- 70% of all health care visits are generated by psychosocial factors. *(Fries et al., 1993; Shapiro et al. 1985).*
- Depressed patients are 3 times more likely than non-depressed patient to be non-compliant with treatment recommendations.
- Monthly costs for a patient with chronic condition and depression were $560 more than a patient with chronic condition w/o depression *(Melek & Norris, 2008).*
Behavioral Health Problems are Rarely the Only Health Problem

- Chronic Physical Pain: 25-50%
- Smoking, Obesity, Physical Inactivity: 40-70%
- Heart Disease: 10-30%
- Cancer: 10-20%
- Diabetes: 10-30%
- Neurologic Disorders: 10-20%
- Chronic Physical Pain
- Mental Health / Substance Abuse

Patient-centered care?

J.Unutzer, MD, AIMS Center
Behavioral Health is a Key Concern for Health Care

• Affects low-income populations
  – In the US, nearly half (49%) of all Medicaid beneficiaries with disabilities have a psychiatric diagnosis
  – Among Dual eligibles (Medicare/Medicaid), 44 percent have at least one mental health diagnosis

• Cost driver
  – Behavioral health disorders are among the five most costly conditions in the U.S. with expenditures of $57 billion
  – Mood disorders such as depression are the third most common cause of hospitalization in the U.S. for both youth and adults
The Solution: Integrated, Collaborative, Person-Centered Care

Primary Care
Integrated, Coordinated Care: Key Strategies for Improving Access and Reducing Stigma & Discrimination

- Research shows that integrating mental health and substance use care with primary care is an effective strategy to reduce stigma and improve access to behavioral health services, especially for vulnerable populations.

- A 2005 IOM report concluded that the only way to achieve true *quality and equality* in the health care system is to integrated primary care with mental health and substance use services.

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*Kautz C, Mauch D, and Smith S. Reimbursement of Mental health services in primary care settings. Rockville: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2008.*
Resources

- Integrated Behavioral Health Project (IBHP) [http://www.ibhp.org](http://www.ibhp.org)
- Partners in Health: Mental Health, Primary Care, and Substance Use Inter-Agency Collaboration Tool Kit, [http://www.ibhp.org](http://www.ibhp.org)
- University of Washington AIMS Center, WA State Mental Health Integration Program [http://uwaims.org/](http://uwaims.org/)
- SAMHSA-HRSA Center for Integrated Health Solutions [www.thenationalcouncil.org/cscscenter_for_integrated_health_solutions](http://www.thenationalcouncil.org/cscscenter_for_integrated_health_solutions)
- Wayne Katon, MD et. al., UofWA & Group Health--Treat to target [Teamcarehealth.org](http://www.teamcarehealth.org)
- CIMH [http://www.cimh.org/Initiatives/Primary-Care-BH-Integration](http://www.cimh.org/Initiatives/Primary-Care-BH-Integration) Business Case for Integration
Suicide Prevention in Primary Care Settings:
A new resource guide

Stan Collins

Pain Isn’t Always Obvious

KNOW THE SIGNS

Suicide Is Preventable.org
International stats and perspective

Age-standardized suicide rates (per 100 000 population), both sexes, 2012

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.
Why focus on primary care?

- Affordable Care Act
- It is where people come
- Antidepressants
- American College of Preventive Medicine
Why focus on suicide prevention in primary care settings?

“Key gatekeepers, those people who regularly come into contact with individuals or families in distress, must be trained to recognize behavioral patterns and other factors that place individuals at risk for suicide and be equipped with effective strategies to intervene before the behaviors and early signs of risk evolve further.”

U.S. National Strategy for Suicide Prevention
Why focus on suicide prevention in the primary care setting?

- **Warning signs / physical symptoms**
- **Less stigma**
- **Ongoing relationships**

- Approximately 45% of people who died by suicide were seen by a primary care provider within a month before their death
About the Guide

The Training Resource Guide is based on information found in:

• *Suicide Prevention Toolkit for Rural Primary Care Practices* by the Suicide Prevention Resource Center (SPRC) and the Western Interstate Commission for Higher Education (WICHE)

• A training for primary care settings created by the San Diego Health and Human Services Agency and Suicide Prevention Council
About the Guide

The Training Resource Guide is intended for:

- advocates
- behavioral health organizations
- suicide prevention trainers, and others

To use to educate primary care clinicians and staff about suicide prevention
Topics covered

1. Key principles
2. Why focus on primary care settings?
3. Epidemiology of suicide
4. Warning signs and risk factors
5. Suicide risk assessment
6. Safety Planning
7. Office plan of action
8. Resources
Warning Signs and Risk Factors

- **Warning signs**: Specific behavioral or emotional clues that may indicate suicidal intent (“red flags”)
- **Risk Factors**: Conditions or circumstances which may elevate a person’s risk for suicide
- **Protective Factors**: Conditions or circumstances which may reduce a person’s risk for suicide—and may “balance” risk factors
John Jones is a 74-year-old African American male with high blood pressure. He was successfully treated for prostate cancer ten years ago. Currently, he is being treated for severe chronic back pain associated with degenerative changes in the lumbar spine. He takes medication daily for blood pressure, pain, cholesterol, and arthritis. He was recently widowed. He says that he has little hope that his back pain will improve.
Key Components of a Suicide Risk Assessment

1. Assess risk factors
2. Ask about suicidal thoughts, plan, and intent
3. Assess protective factors
4. Apply clinical judgment
5. Document
Assessing Suicide Intent

Guiding questions:

• Are you thinking about suicide? Are you thinking about killing yourself?
• When did you begin thinking about suicide?
• Did any event cause these thoughts?
• How often do you think about suicide?
• How long do these thoughts last?
Safety Planning and Support

1. Recognizing the signs of crisis
2. Identifying coping strategies
3. Having social contacts who may distract from the crisis
4. Contacting friends and family for crisis support
5. Contacting health professionals, including 911 or crisis hotlines
6. Reducing access to lethal means
My3 Mobile Application

Target audience: Those at-risk for suicide

Purpose: Getting them connected to their primary support network when they are in crisis; also provides safety planning and other helpful resources
My3 Mobile Application

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. 
2. 
3. 

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1. 
2. 
3. 
4. 

Step 3: People and social settings that provide distraction:
1. Name: __________________________ Phone: __________________________
2. Name: __________________________ Phone: __________________________
3. Place: __________________________ 4. Place: __________________________

Step 4: People whom I can ask for help:
1. Name: __________________________ Phone: __________________________
2. Name: __________________________ Phone: __________________________
3. Name: __________________________ Phone: __________________________

Know the Signs >> Find the Words >> Reach Out
Tools clinicians can use

Office Protocol Development Guide for Suicidal Patients

The purpose of an Office Protocol for Suicidal Patients is to anticipate and have an appropriate plan in a “crisis plan” for the office allowing providers and office staff to be safe for a environment for a patient who is assessed to be at high risk for suicide. Patients can be contacted by a member of the clinical team or a posted office protocol will simplify the process of a high risk patient.

During the planning process:

1. Identify the patient’s needs and plan.
2. Communicate with the patient’s provider.
3. Establish a plan for suicide prevention.

-sample safety plan

Assessment and Interventions with Potentially Suicidal Patients

**High Risk**
- Patient has suicide ideation or past attempt(s) within the past two months. See right for risk factors and back for assessment questions.
- Patient has access to lethal means or a clear plan for suicide.
- Patient has history of suicide attempts.
- Patient has access to lethal means, or a clear plan for suicide.
- Patient has access to lethal means, or a clear plan for suicide.

**Moderate Risk**
- Patient has a past suicide attempt.
- Patient has a past suicide attempt.
- Patient has access to lethal means, or a clear plan for suicide.
- Patient has access to lethal means, or a clear plan for suicide.
- Patient has access to lethal means, or a clear plan for suicide.

**Low Risk**
- Patient has no history of suicidal ideation.
- Patient has no history of suicidal ideation.
- Patient has no history of suicidal ideation.
- Patient has no history of suicidal ideation.
- Patient has no history of suicidal ideation.

Safety Planning Guide

A Quick Guide for Clinicians

Safety Planning Guide

FAQs:

**What is a Safety Plan?**
- A prioritized written list of coping strategies and steps to take if a patient’s safety is at risk.

**Who can have a safety plan?**
- A patient who is at risk for suicide.

**Where can a Safety Plan be found?**
- Typically written by the clinician and given to the patient.

**What does the process of developing a Safety Plan look like?**

1. Identify the patient’s needs and plan.
2. Communicate with the patient’s provider.
3. Establish a plan for suicide prevention.

**End of the Safety Plan**

Know the Signs >> Find the Words >> Reach Out
Example of Use in the Field

• Lake County, California
  – Conducted “train the trainer” workshop
  – Utilized local suicide prevention trainers (QPR, ASIST)
  – During training, familiarized trainers with medical provider background and perspective
  – Introduced and rehearsed training in workshop
What you can do with the guide

• Download it and disseminate to local primary care clinicians
• Use it to provide trainings to primary care providers of all kinds in your community
• Find others who can train with it
Questions?

Thank you for your support of suicide prevention.

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