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Hello, welcome to the presentation today. I'm going to talk today about Handling Positive Screens: Managing Pandora's Box. My name's Ed Boudreaux, I'm a Behavioral Health Consultant.

- Today we're going to answer three really important questions. What secondary screening or assessments should you administer in response to a positive front line screen for depression or at risk alcohol use?
- What are the best practices for treating depression and/or at risk alcohol use?
- And what community resources and referrals are available to you to help manage depression and/or alcohol use in your patients?

Following this video our expectation is that you will be better prepared to handle a positive screen for depression or alcohol, including how to identify and use community based referral resources.

Let's talk about processes, protocols and the US Preventative Health Services Task Force. So we're really fortunate in that the US Preventative Health Services Task Force, which is an authoritative body that makes recommendations for screening in healthcare has already weighed in on this issue.

They grade their recommendations: an A that means that the recommended screening should be incorporated into routine clinical practice because there is a high certainty that the net benefit of the screening is substantial so this is the highest recommendation grade that they can provide.

A B level recommendation is a little bit lower. They still recommend the screening service because there's a high certainty that the net benefit is at least moderate or maybe a moderate to substantial benefit.

So depression screening in adults and adolescents receives a B recommendation from the US Preventative Health Services Task Force. And alcohol screening ranks a B for adults but an I for adolescents so an I means that there's simply insufficient information right now to advise whether or not screening should be done. So for adults both of these screenings are a B for adolescents for depression it's B but for adolescents and alcohol it's I.

Both of these recommendations come with an important proviso: universal screening should be done only if there are resources in place to adequately manage positive screens, in other words, to handle Pandora's Box when you open it.

That means that a site or a provider really should have written protocols that are put into place in order to drive how the positive screens are handled and all relevant personnel should be trained on the protocols and optimally they should be measured, monitored, reinforced and incentivized using continuous quality improvement methods. This is true because getting clinicians to change their normal routine practices is very difficult to do and without adequate attention to specific protocols training and CQI it's unlikely that the protocols would really be implemented in routine clinical practice.

I have here an example of a really good protocol from The Institute for Family Health. I really like this protocol as an example because I feel like it consolidates a lot of information in a very small space. And this particular clinical protocol is for managing suicidality in primary and behavioral healthcare, but as you can see it actually talks about screening for depression first. So in this protocol the depression screening is outlined as well as how to handle a positive suicide screen which is relevant any time a suicide item is imbedded in a depression screening. So I thought this was a really good example or a template for building a really good protocol.

Most people are going to use the PHQ-2 for a frontline depression screening as we've talked about before a positive screen on the PHQ-2 will usually lead to administration of the remaining items on the PHQ-9. There are accepted categories for severity ratings and proposed treatment actions for the PHQ-9 once a complete score is obtained and the protocol that is put into place at your site really should appeal to these commonly accepted thresholds.

Similar to depression alcohol can be done, screened, in a similar fashion with the AUDIT/ C or the USAUDIT, which is a new version of the three item screener that's available and that's been promoted by the CDC, can be administered first as a front line screening and then if there's a positive, the remaining items on the AUDIT can be administered and, once again, there are commonly accepted zones or a risk strata with recommended actions on the AUDIT. Any protocol that's put into place at your facility should make sure that the actions are linked to the recommended thresholds on the AUDIT.

Most places are going to want to put into place something after the standardized screening, or in some cases it's in place of the full PHQ-9 or AUDIT, in order to get a complete diagnostic evaluation performed. These usually align to DSM-5 or ICD categorizations for depressive disorders or substance use disorders. In many cases especially with patients who are in the severe range you're going to want to refer them to a mental health provider and, of course, the

protocol related to refer a mental health provider will be driven largely by whether there's co-located behavioral health on site or whether the community needs to be referred.

In addition to a more complete assessment following a screening, most facilities are going to want to follow some guidelines, accepted guidelines, for treating depression or alcohol and I've provided some links to some excellent depression and alcohol treatment guidelines from the Health Team Works. These are really exemplary, they really walk the provider through what to do based off of the different strata or severity levels of the patient. We're not going to go through all of these in detail right now because it's out of scope for this presentation.

So if you have no integrated behavior health or a behavior health clinician on board, or you don't feel comfortable treating the patient on your own, you can always refer them to the community so building your own referral resource list is going to be really important so you can have it handy so even areas that are low in resources have at least some mental health resources so those should be considered. And this doesn't have to be a Herculean task there are ways to do it relatively efficiently. I'm going to provide with some resources for building this.

The first question or first idea is where to send someone if immediate crisis is present when the person screens positive. So I think this is really important to have handy even in areas with limited mental health resources because usually some kind of crisis center or service is available by phone. These are often affiliated with community mental health centers or the state or county government so even if there's no local crisis resource, the National Suicide Prevention Lifeline is available 24/7 anywhere in the U.S. And this is particularly important to have handy because if one needs to manage acutely a positive screen for the suicide item on the PHQ-9.

Here are some suggestions for where to find the crisis resources for your area. Of course, the National Lifeline number is available anywhere in the United States but there's several websites that allow clinicians to identify more local hotlines or specialized hotlines that would be appropriate for different patient populations. I've provide those links here.

So one step further is to examine whether there are mental health Helplines or referral lines in your region. So these are not necessarily crisis lines but instead are lines that are directly used to identify referrals in the community or to identify providers for which a patient can seek help even when they're not in a crisis. Most states or counties will have a mental health helpline that's separate from a crisis line. Some of these simply provide information about mental health providers but others can provide more sophisticated referrals like direct patch into a center or to a clinic and information about state sponsored treatment initiatives. Because these Helplines are supported by central agencies they can often be much more accurate and up to date than anything that a specific clinician or specific practice can maintain.

If you don't know the number for your own mental health helpline you can usually find them by searching the internet or by perusing your respective state's Department Of Public Health or Department Of Mental Health website; these are the agencies that are usually sponsoring these so they often have them on their websites. Lacking that 211 is a nationwide access for people to find local mental health resources and this website can help you to find out more about the 211 system.

Specifically for substance abuse, SAMHSA has a national treatment locator primarily focused on alcohol and other illicit drug use so it's optimal for helping to find a location for care for a person who screens positive for alcohol use in the moderate to severe range. The number is listed her and the website is also listed here and it allows the user to be able to find treatment facilities within a zip code area.

Sometimes the best local resources consist of self-help and support groups. It's not actually clinicians or professionals and this is particularly true for alcohol use. The 12-step programs like Alcoholics Anonymous are often present in communities even when the professionals are not. So sometimes they're a real go-to resource. The most important thing to remember about this, though, is that some of these support groups are often geared towards managing a person who's of moderate to severe end, not on the really severe range and maybe not for acute patients but perhaps, after they've already been through treatment.

I've provided some resources here to help you find support groups within your region both for depression and for alcohol use. These websites will allow you to be able to find those resources, the self-help groups, that are registered with these agencies.

Finally, some regions, especially large healthcare systems will have telepsychiatry programs that can be accessed by individual clinicians so you should check with the insurance providers in your region because sometimes insurers will have lists of such programs and sometimes the health system itself with maintain a list of these programs or will have internal resources to help provide telepsychiatry consults for primary care so that the primary care clinician can continue to treat the patient but with the psychiatrist consulting remotely.

So in summary, opening Pandora's Box by screening for a depression and alcohol risk doesn't have to be as frightening if you can remember that you have to have a plan for managing the ills that escape when that person admits that they're depressed or having risky alcohol use. Remember in the great myth, hope was trapped when the black box was closed not when it was opened. So opening the box by asking a question and being prepared to respond to a positive will help you to be more confident in your screening.

You have to develop, monitor, reinforce and incentivize treatment protocols are pathways so that everyone in your practice is on the same page and if you do a little work ahead of time to identify the best community resources and have that resource sheet handy it'll make managing the positive screens a lot easier.

Thank you very much for joining us. If you want any more information feel free to contact me at the information below.