INTEGRATED CARE

Virna Little, PsyD, LCSW-R, SAP
Dorothy Muccio, LCSW-R

The Institute for Family Health
New York City

- Treat mental health disorders where the patient feels most comfortable receiving care
- Better coordination of care
- Mind and body connection
- More likely to keep appointments where multiple issues are being addressed
- The majority of mental health treatment will occur in community health settings- with focus on preventive care and integration.

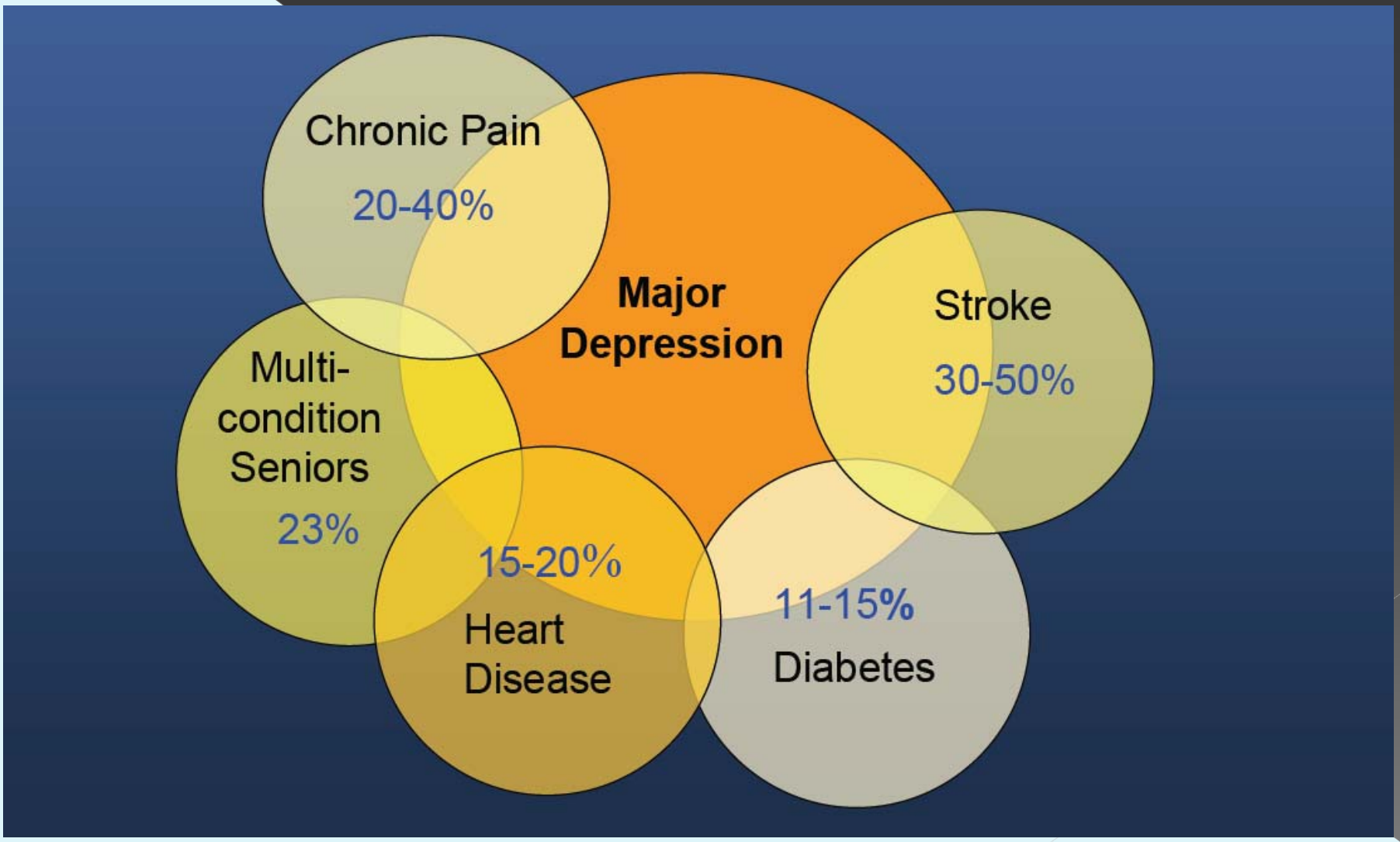
Unrecognized and untreated

- Mental health diagnosis often go unrecognized in primary care
- Primary care providers often under treat mental health diagnosis
- Screening alone does not improve outcomes for primary care nor is it considered integrated care

Less Stigma

- Comfortability in discussing mental health issues
- Established relationship with primary care provider
- “I am not crazy”
- Less stigma walking into primary care setting then mental health setting

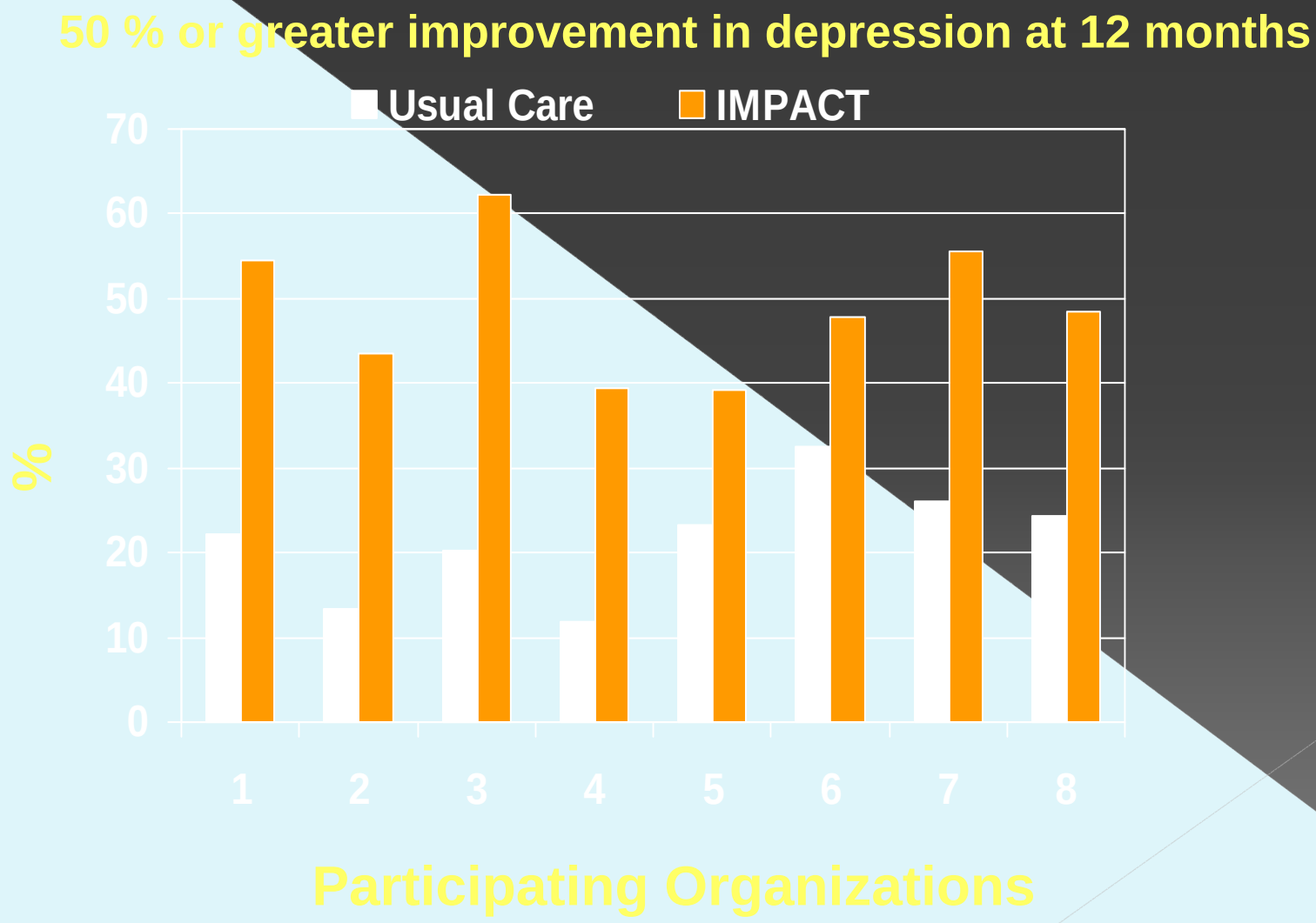
Comorbidity



Usual Care vs. Integrated Care

- Usual Care
  - Rarely treated effectively
  - Only 1 in 5 receive treatment
  - Rarely treated by MH professionals
  - Fewer than 10 report see a MH worker
  - Increasing use of antidepressants in PC but treatment often not effective
- Integrated Care
  - Most effective approach to treat mental health in PC settings
  - Comprehensive
  - Multidisciplinary approach
  - Fully integrated with information available to all practitioners
  - Cost-effective

IMPACT Findings Robust Across Diverse Organizations



Why Integrate?

(Source:www.impact-wu.edu)

Why Integrate Mental Health In Primary Care?

- People seek mental health care in primary care settings
- Many completed suicides were seen by PCP
  - 20% on the same day
  - 40% within 1 week
  - 70% within 1 month
- White men ages 85 and older highest risk
- PCP referrals to mental health providers may be necessary but not sufficient to improve outcomes

Why Integrate Mental Health In Primary Care?

- Strong evidence has emerged for collaborative/integrated care for treatment of common mental disorders
  - The IMPACT (Improving Mood Promoting Access to Collaborative Treatment Model)
  - The Three Component Model (3CM)
- Insurance does not provide adequate coverage for mental health services

Abstract Dollars

- Can help support integration work
- Will vary by organization/setting/payor mix
- Time spent with PCP
- No show rates for PCP, specialty care
- Medication adherence
- Emergency room visits/utilization
- Productivity for behavioral health

Outcome Measures

- What do you want to achieve?
- Are there diagnosis or measures your organization/department is already tracking/monitoring?
- Are there measures that will help us subsidize the integration work?
- Can this be a CQI or research project?
- What is realistic?
- Are there outcome measures that will increase organization buy-in for integration work

Integrated Care	Co-location	Collaborative Care
- Systematically combining physical and mental health services	- Most common model of integrated care	- Integrated health care model
- Term care approach to mental health based in community health primary care setting	- PCPs develop agreement with mental health providers to whom they refer their patients with mental health needs to on-site mental health services	-Partnership between the physical health and mental health providers to manage the treatment of mild to moderate and stable severe psychiatric disorders in primary care settings
- Integration of mental health treatment in primary care	- PCPs typically do not follow up on their referral once it has been made	- May include brief psychotherapy or simply medication management and patient education

Function	*Minimal Collabo-ration*	*Basic Collabo-ration from a Distance*	*Basic Collabo-ration on-Site*	*Close Collabo-ration Partly Integrated*	*Fully Integrated*
Doherty, McDaniel & Baird (1995)	▪Separate Systems ▪Separate facilities ▪Communication is rare ▪Little Appreciation	▪Separate Systems ▪Separate facilities ▪Periodic focused communication; mostly written ▪View each other as outside resources ▪Little understanding of each other's culture or influence	▪Separate systems ▪Same facilities ▪Regular communication; occasionally face-to-face ▪Some appreciation of each others role & general sense of large picture ▪Mental health usually has more influence	▪Some shared systems ▪Same facilities ▪Face-to-face consultation; coordinated tx plans ▪Basic appreciation of each others role and cultures ▪Collaborative routines difficult; time & operation barriers ▪Influence sharing	▪Shared systems & facilities in seamless biopsychosocial web ▪Consumers & providers have same expectations of system(s) ▪In-depth appreciation of roles & culture ▪Collaborative routines are regular & smooth ▪Conscious influence

Models of Care

Model 1: Mental health staff co-located in FQHC Community Health Centers	*Model 2: Article 31 Mental Health Center co-located in FQHC Community Health Center*	*Model 3: Cooperative Agreement with County Mental Health Service*	*Model 4: Part-time Primary Care Services in Mental Health Day Treatment Program*
- A full-time Licensed Social Worker Family Practice Psychiatry	- Staff includes primary care providers, adult and child psychiatrists and licensed mental health clinicians	- FQHC Community Health Center partnered with County Mental Health provider to provide comprehensive specialized care	- Primary care provider in day treatment program approximately 6 hours per week
- Model improved with EHR facilitates special populations receiving care at multiple Institute locations.	- Provides excellent ability to care for most populations with coordinated, comprehensive care	- Utilizes existing services to expand access, continuity and comprehensive care, and ensure all have access to appropriate level of service	- Primary care provider ongoing primary care as well as urgent care to patients who attend day treatment program
- Encourages psychiatrist to be a primary consultant	- Both services operate full time	- All patients will be connected to primary care	

Who to hire for integrated care?

- Able to use behavioral activation techniques with patients as an adjunct to other treatments
- Able to provide optional evidence-based, brief structured psychotherapy
- Able to establish quick rapports to a wide range of individuals
- Ability to make patients feel that they are being listened to and supported

Workflows

- Screening
- Referral
- Assessment
- Education
- Discuss Treatment options with patient
- Coordinate care with PCP
- Referral to psychiatrist
- Start Initial Treatment Plan
- Arrange follow-up Contact
- Documentation
- Referral to outside resources (if necessary)

Financing Collaborative Care

- Public insurers
  - Medicare, Medicare Advantage
  - States: variation among Medicaid plans/financing for mental health services in primary care

Barriers to Integrated Care

- Clinical Barriers
  - Traditional separation of mental health issues from general medical issues
  - Lack of awareness of mental health screening tools in the primary care setting
  - Physicians' limited training in psychiatric disorders and their treatment
- Financial Barriers
  - Lack of insurance parity for psychiatric disorders
  - Medicaid's low payment rates
  - Billing restrictions

Barriers to Integrated Care

- Policy Barriers
  - Physical health and Mental health funding streams
  - Difficulty of sharing information due to HIPAA regulations (progress notes)
- Organizational Barriers
  - Shortage of mental health professionals
  - Limited communication between medical and mental health providers
  - Lack of agreement between medical and mental health providers

Contact Information

Virna Little, PsyD., LCSW-R, SAP
Institute for Family Health
vlittle@institute2000.org
212-633-0800 ext 1337

Depression

- Depression is common in primary care settings
  - 60% of depression cases are treated in Primary Care Setting
  - Medication is usually the first line of treatment
  - Adherence to medication is an issue

Problem Solving Therapy

- Tenants of Problem Solving Treatment for Primary Care (PST-PC)
  - A problem is any situation in which an immediate and easily recognizable solution is not apparent
  - Problems and minor life events are strongly associated with psychological symptoms
  - Weak problem solving capability is linked to the creation and maintenance of psychological disorders
  - Regaining a sense of control over one's life problems is the most important factor for resolving depressive symptoms
  - The goal of PST is to teach the patient the problem solving skills so that they can use them in the future to avoid depression

Incorporating into Primary Care

- Ways to incorporate PST into Primary Care
  - By anyone trained in the method
  - Nurses, Social Workers, General Medical personnel
  - Case Manager
  - Behavioral Specialists

Structure of PST-PC

- 6-8 sessions
- First session is 1 hour, following sessions are 30 minutes
- Bi-weekly
- Focus for Practitioner: Teach Problem Solving
- Work on at least 1 problem a week
- Homework between session

Link between Problems, Depression and PST-PC

- Depression is caused by or worsened by problems in living
- Depression interferes with ability to problem solve, which affects depressive symptoms creating a downward spiral

Seven Stages of PST-PC

- Clarify and defining problems
- Establishing achievable goals
- Brainstorming
- Decision making: Pros/Cons
- Choosing a preferred solution
- Implementing the solution
- Evaluating the Outcome

Behavioral Activation

- Health outcomes improve when patients take an active role in managing their own health
- Better outcomes are achieved through techniques that emphasize patient empowerment, collaborative goal setting and problem solving skills

Role of Primary Care Provider in Behavioral Activation

- Collaboration vs. “Expert”
- Using questioning techniques vs. giving advice

4 Principles of Motivational Interviewing

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support for Self Efficacy

Self Management

- Any steps a patient can identify that they are willing to take to improve their health

Personal Action Plan

- Identifies a target for change
- Describes what, when, where, how often the change will occur
- Identifies barriers to the change
- Identifies and lists strategies to overcome barriers
- Assesses client confidence in accomplishing change
- Documents a follow up plan

- Physical Activity
  - What → Where → When
- Relaxation
  - What → Where → When
- Pleasurable Activity
  - What → Where → When
- What might get in the way of you accomplishing your goal
- How confident do you feel that you can reach your goal (0-10 scale)
- How do you think you did? (0-10)

Change tool

Benefits of Status Quo	Benefits of Change
Costs of Status Quo	Costs of Change

Contact Information

Dorothy Muccio, LCSW
Institute for Family Health
dmuccio@institute2000.org
212-633-0800 ext 1319

Behavioral Health Integration

Southcentral Foundation Primary Care Center
Anchorage, Alaska

◆

Meg Loomis, LMSW

Southcentral Foundation:

Organizational Profile

- An Alaska Native non-profit tribal health care corporation founded in 1982.
- Provides direct health and related services to over 50,000 Alaska Native and American Indian customers in Anchorage, the Mat-Su Valley, and 55 villages.
- Revenue sources:

Health Concerns for Alaska Native Population

- ***Depression and Anxiety****:* Rates nearly 2x that of non-Native Alaskans but lower rates of diagnosis.
- ***Alcohol and Substance Abuse****:* High rate of consumption and related violence.
- ***Fetal Alcohol Syndrome/Fetal Alcohol Spectrum Disorders***: 7x than U.S. rates; 12.3% mothers report drinking during pregnancy.
- ***Chronic Disease***: Colorectal cancer; diabetes.

Reasons for Integration at SCF Primary Care

- Behavioral and psychosocial factors in etiology and treatment of physical disease
- Primary care as the locus of treatment for mental health disorders
- Reduce stigma
- Financial advantages
- Improved quality of care
- Patient & provider satisfaction

Integration began in 2005 through SAMHSA funding

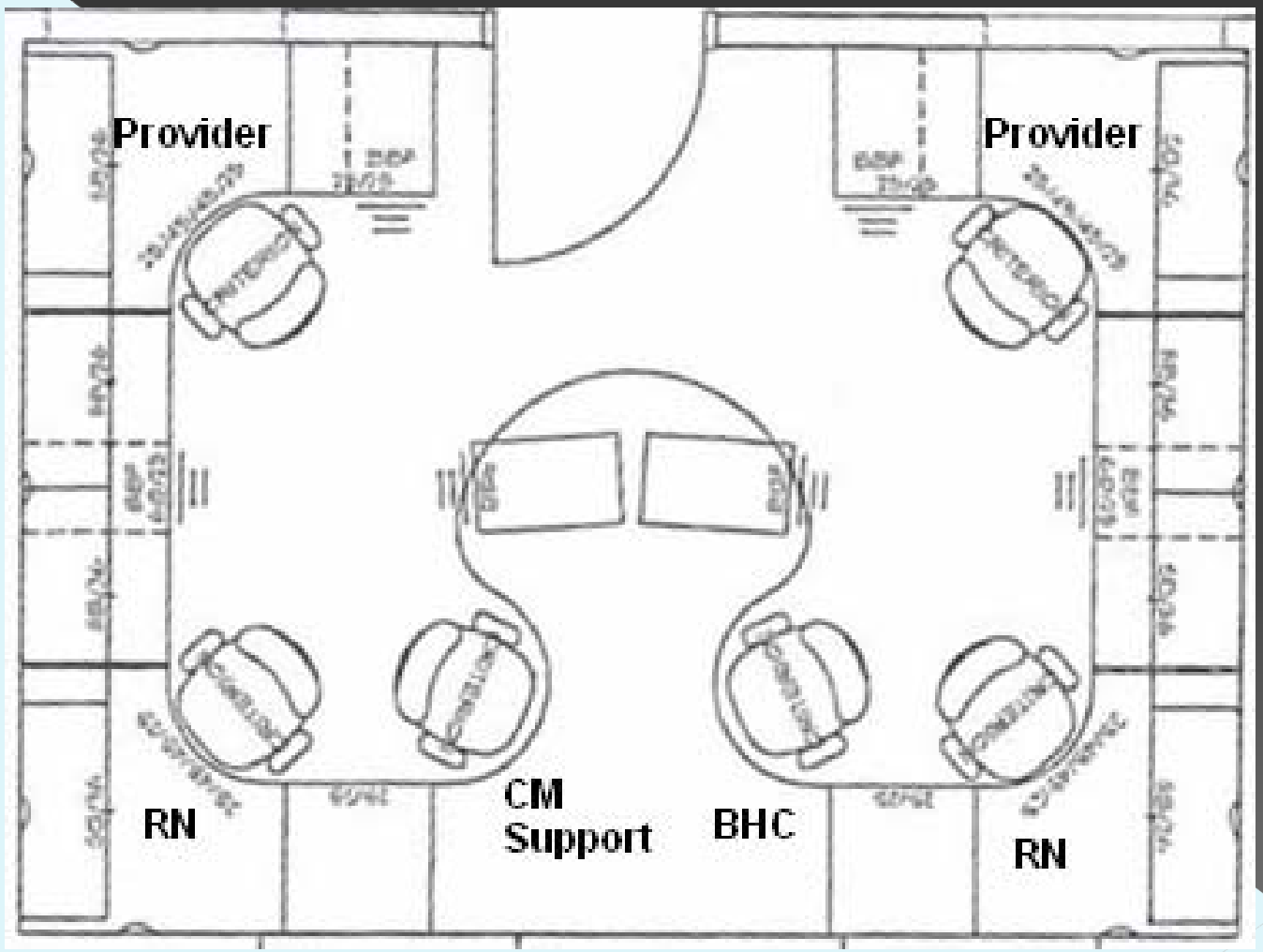
Southcentral Foundation's Integrated Framework

- Behavioral Health is ROUTINE component of medical care: 13 clinicians in family medicine, pediatric and women's clinics
- Annual depression & alcohol/drug screenings for all patients (SBIRT; BDI-PC).
- Integrated chart system
- Formal treatment team/case conferences
- BHC presence on all specialty workgroups (i.eopiod eligibility, chronic

Levels of Integrated Care

- *Level 1* – Consultation, brief targeted interventions, and management in primary care setting
- *Level 2* – Time-limited, focused interventions in primary care setting
- *Level 3* – Referral for longer-

Group Office Floor Plan



Behavioral Health Consultant Background & Skills

- Masters Level, ANP, or Ph.D/Psy.D
- Working Knowledge of Integrated Care Model
- Strong "Traditional" Clinical Skills
- Team Performance
- Understanding of Common Medications and Pharmacology
- Documentation Skills
- Evidence-based Treatment

Behavioral Health Consultant Role

- Consultation and education to providers and case managers on behavioral health issues.
- Psycho-educational materials and workbooks to aid in treatment and understanding.
- Assessment, brief intervention, education and follow-up for patients experiencing mental health issues and/or life stresses

Initial Challenges

- Slow Acceptance of Model
- Paradigm Shift for Medical Providers, Mental Health Providers, and Patients
- Lack of Consultation Space
- Recruitment

Successful Outcomes

- # Pts with ≥ 6 visit utilization in 6 months has decreased since BHC Integration
- 77% Primary Care Clinic staff reported increased efficiency
- 88% Primary Care Clinic staff more satisfied with their job since BHC Integration
- 91% increase in access to Behavioral Health Service
- Frees providers' time and resources to allow for more efficient use of limited appointment time.
- Provides patients with a more comprehensive evaluation of symptoms and issues.
- Offers providers and in-clinic specialty

Future Goals

- Refine Model based on Clinical Needs
- Prevention and Health Promotion
- Training
- Expand Tele-health Consultation
- Group Visits
- Recruitment

Questions?

Using a Patient's Own Methods

in the treatment of depression and anxiety

Aaron Spector MSN, APN
Formerly of Mission Healthcare
AtlantiCare Health Services
Atlantic City, New Jersey
Phone 856-316-2937 **SpectorPsychiatry@gmail.com**

****Any information concerning medication is not authorized by the manufacturer and solely reflects this clinician's professional experiences****

What is Depression?

- At least 5 of the following symptoms including one of the italicized
  - ***Depressed Mood***
  - ***Lack of interest in previously pleasurable activities "anhedonia"***
  - Increase or loss in weight/appetite
  - Insomnia/hypersomnia
  - Fatigue/loss of energy
    - "Tired" can be a depression buzz word
  - Psychomotor retardation/agitation
  - Feelings of guilt/regret/low self-worth
  - Diminished concentration/attention
  - Recurrent thoughts of death or suicide
    - Increased irritability (not in current DSM-IV)
- Standard 1st Line Treatment
  - Initiation of SSRI (Selective Serotonin Reuptake Inhibitor)
    - MOA – Blocks the reuptake of serotonin allowing for a more profound effect upon the brain

Depression: Epidemiology

- Prevalence
  - Lifetime
    - 10-25% females
    - 5-12% for males
  - Population - 6%
- Under treated
- Prevalence reacts to social climate

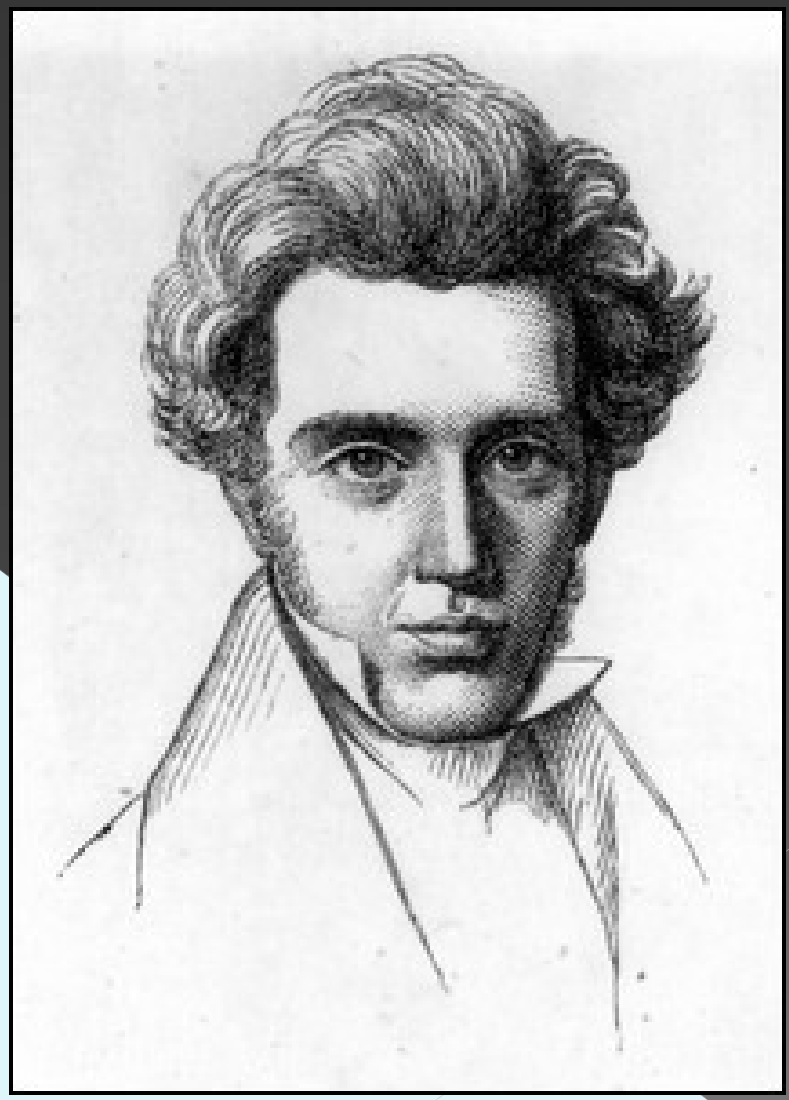
Depression: Recurrence

- 80% will have the disease more than once
  - Average is one episode every five years
- Two factors predict recurrence
  - Age
  - Severity
- In one study 25% had a second episode within 12 weeks of remission
- Once a month therapy and daily medication prevented 80% of reoccurrence

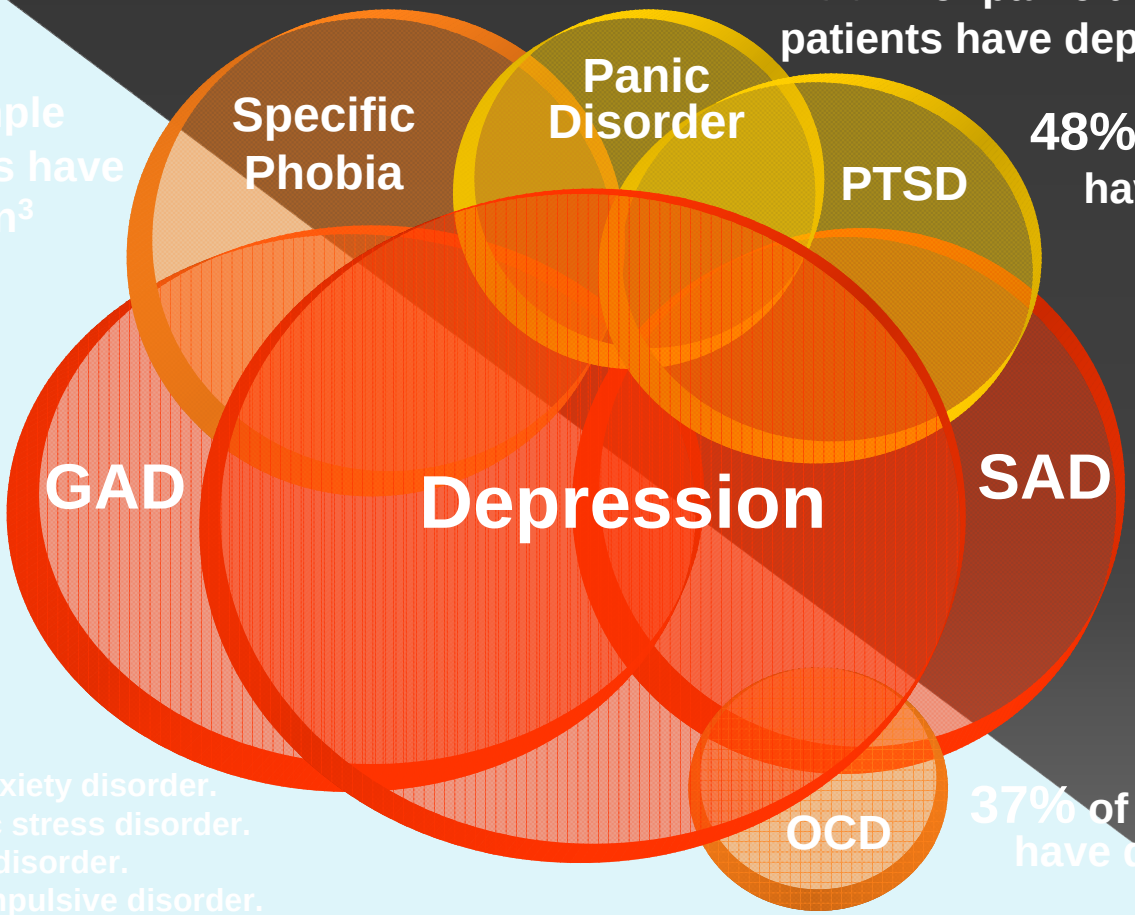
Søren Kierkegaard (1813-1855)

I do not care for anything. I do not care to ride, for the exercise is too violent. I do not care to walk, walking is too strenuous. I do not care to lie down, for I should either have to remain lying, and I do not care to do that, or I should have to get up again, and I do not care to do that either. Summa summarum: I do not care at all.

From: *Either/Or* (1843).



Depression and Anxiety



42% of simple phobia patients have depression[3]

56% of panic disorder patients have depression[4]

48% of PTSD patients have depression[1]

58% of GAD patients have depression[2]

37% of SAD patients have depression[3]

37% of OCD patients have depression[5]

GAD=generalized anxiety disorder.
PTSD=posttraumatic stress disorder.
SAD=social anxiety disorder.
OCD=obsessive-compulsive disorder.

1. Kessler RC, et al. *Arch Gen Psychiatry*. 1995;52:1048-1060.
2. Kessler RC, et al. *Am J Psychiatry*. 1999;V56:1915-1923.
3. Magee WJ, et al. *Arch Gen Psychiatry*. 1996;53:159-168.
4. Roy-Byrne PP, et al. *Br J Psychiatry*. 2000;176:229-235.
5. Overbeek T, et al. *J Clin Psychiatry*. 2002;63:1106-1112.

Clinical presentation of anxiety

- Agitation
- Psychomotor constriction with hypervigelence
- Possible hyperventilation
- Somatic complaints
- Information processing deteriorates as anxiety increases
- Depersonalization / derealization
- Pale
- Affect is worried, concerned, afraid.
- Speech may be rapid or constricted.
- Mood is irritable

Cognitive/Behavioral effects of anxiety

- Sense of doom or impending disaster
- Powerless, helpless
- Rumination
- Overgeneralization
- Distortion
- Hypervigilance
- Poor concentration
- Regression
- Reliance on structure and ritual
- Increased dependence and clinging
- Avoidance and withdrawal
- Accident prone, decreased coordination

Effects of chronic anxiety

- Insomnia (DFA, MNA, EMA)
- Sexual dysfunction
- Fatigue
- Low self confidence
- Diminished productivity
- Self consciousness
- Self medication with substances

Panic - Course

- Onset between 18 and 35
  - Maybe sudden or preceded by period of more generalized anxiety
- Most report onset during period of high stress
- First professional contact is often for medical work-up
- Recurrent - waxing and waning with stress
- Anticipatory anxiety is cause of dysfunction

Panic: Physical Symptoms

- **Palpitations - pounding heart**
- Sweating
- Trembling or shaking
- Feeling of choking
- Hyperventilating
- Dizzy, unsteady, lightheaded, or faint
- Numbness or tingling sensations
- Chest pain or discomfort
- Nausea or abdominal distress
- Chills or hot flushes

Comorbidity and Significance

- When people have more than one disorder, which do they say “troubles them the most”
  - Anxiety disorders 77%
  - Psychosis 61%
  - Affective disorders 54%
  - Substance use disorders 40%
  - Personality disorders 28%
  - Somatoform disorder 27%

From a survey done by the Rural Health Foundation, Australia: <http://www.rhef.com.au/videolts/Viddtls/000229.htm>

AtlantiCare Mission HealthCare

- Two delivery sites with a total of 17 staff members
  - ***2-3 Medical Providers***
  - ***1 Psychiatric Provider***
- Population Served
  - ***Homeless and Under-insured***
- Visits per year = ***24,791***

AtlantiCare

AtlantiCare Mission HealthCare

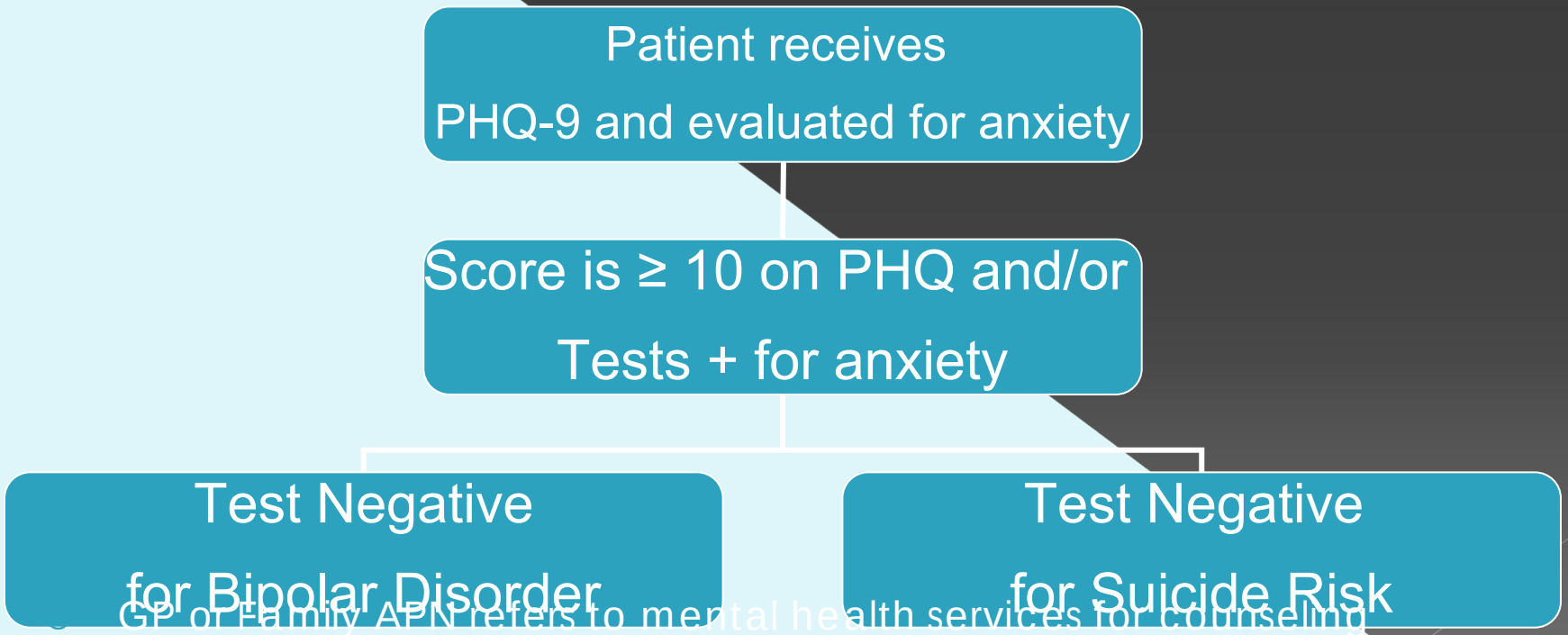
- Programs Offered:
  - ***Primary Healthcare***
  - ***Diabetic Education***
  - ***Pain Management***
  - ***Mental Health***
  - ***Withdrawal Management and Maintenance***
  - ***Substance Abuse Counseling***
  - ***Intensive Outpatient Program***
  - ***Relapse Prevention***
  - ***Case Management***

AtlantiCare

Patient Health Questionnaire - 9

	Not at all	Several days	Most 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 asleep, 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, that you are a failure or you have let yourself down 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, other people have noticed or being so fidgety/restless, others have noticed	0	1	2	3
9. Thoughts that you would be better of dead or of hurting yourself in some way	0	1	2	3

Model for Treatment of Depression & Anxiety



- GP or Family APN refers to mental health services for counseling
- ***GP or Family APN provides pt. with one month of low dose SSRI and patient education about their possible condition***
-

Depression Scores

*Using the Patient Health Questionnaire as Tool

2008 Core Measures Patient registry size - 48	Mission	National Goal
Pts with 50% reduction in Total PHQ Score	50.0%	>40%
Pts. With 5 point reduction in PHQ score within 6 months	81.8%	>50%
2008 Additional Measures		
Pts. with depression on an antidepressant at last visit	97.7%	>70%
Pts. with documented self-management goal	93.8%	>70%

Medication for Depression

Starting	1st Line 2 failed trials of SSRI	2nd Line	3rd Line
Escitalopram (Lexapro) 10mg	Escitalopram 20-30mg	Duloxetine (Cymbalta) 30mg ➔ 60-90mg	Aripiprazole (Abilify) 2-15 mg
Sertraline (Zoloft) 50mg	Sertraline 100-200mg	Desvenlafaxine (Pristiq) 50-100mg	Quetiapine XR (Seroquel) 150mg ➔ 200-400mg
Fluoxetine (Prozac) 20mg	Fluoxetine 40-80mg	Venlafaxine XR (Effexor) 75mg ➔ 150-300mg	Ziprasidone (Geodon) 60 ➔ 120mg
Citalopram (Celexa) 20mg	Citalopram 20-40mg (better for dysthymia than straight depression)	Bupropion XL (Wellbutrin) 150-450mg	Symbyax (Zyprexa /Fluoxetine combo) 6/25mg ➔ 6/50-12/50mg

Medication for Anxiety

Starting	1st Line 2 failed trials of SSRI	2nd Line	3rd Line	PRN
Escitalopram (Lexapro) 10mg	Escitalopram 20-40mg	Duloxetine (Cymbalta) 30mg → 90-120mg	Pregabalin (Lyrica) 75 BID → 150-300mg BID	Hydroxyzine (Vistaril) 25-200mg
Sertraline (Zoloft) 50mg	Sertraline 100-200mg	Desvenlafaxine (Pristiq) 100mg	Quetiapine XR (Seroquel) 150mg → 200-400mg	Clonazepam (Klonopin) 0.25-2mg
Fluoxetine (Prozac) 20mg	Fluoxetine 40-80mg	Venlafaxine XR (Effexor) 75mg → 150-300mg	Ziprasidone (Geodon) 60 → 120mg	

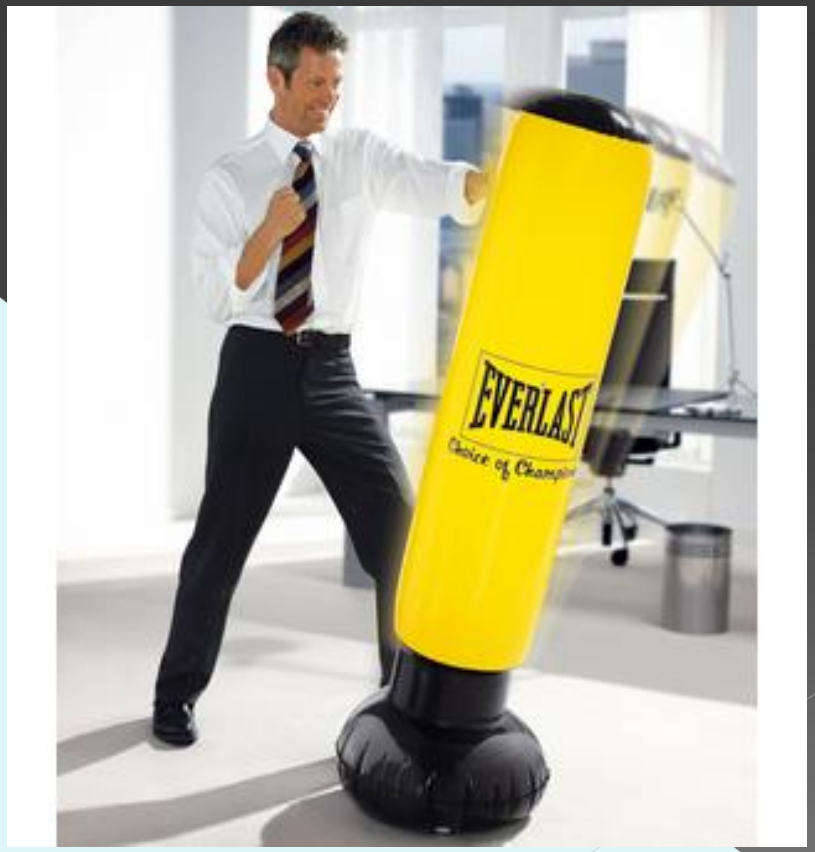
Easy & Quick Tools for Depression & Anxiety

- Evaluate lifestyle & interests
  - "What relaxes you?
  - "What have you done on a bad day that helped?"
  - "Who in your life helps you feel better?"
  - "What are favorite breaks, do you like a walk, a cup of coffee, tea etc..."
  - "What are you good at?"
- Promote *specific* changes or additions generally and an increase for "bad days"
  - Activities
  - Distraction
  - Sensory Stimulation

Easy & Quick Tools for Depression & Anxiety

Activities

- Physical activity
  - Basic exercise
    - Push-ups
    - Aerobics
    - Weights
    - Yard Work
  - Specific exercise based on patient
    - Kick Boxing
    - Punching bag
- Running Errands
  - Patient can feel productive
  - Socialization can be *both a pro and a con*



Easy & Quick Tools for Depression & Anxiety

Activities Actual Cases

- 48 year old Caucasian male suffering from severe chronic depression and PTSD from regular paternal physical abuse
  - Participates in yard work 3x a week
  - Uses punching bag on bad days when anger and flashbacks are high
  - Stable for 2-3 years
- 42 year old Caucasian female with schizo-affective disorder, bipolar subtype with high anxiety and anger rising to homicidal and violent levels. Multiple arrests for assault and hx of self-medication
  - Daily kick boxing helps control anger, longer sessions for bad days
  - Clean & Stable for 3 years

Easy & Quick Tools for Depression & Anxiety

Distraction

- Elementary procedure
  - Arranging ones clothes, possessions or food
  - Preparing food
  - Basic cleaning
- Playing with kids/pets
- Short television, movie, game or reading session
  - 20-30 minutes maximum
  - Otherwise it becomes an escape
- Conversation
  - Phone call
  - Visit
  - Going to social environment
    - Park
    - Book store
  - *Watch for rumination*

Easy & Quick Tools for Depression & Anxiety

Distraction Actual Cases

- 24 year old Caucasian male with chronic melancholic depression and hx of substance abuse
  - Uses time with his infant son for relaxation instead of obligation
    - Reworked thought process to see it as enjoyable
  - On days when stressed, attempts to have a 'special' time

Easy & Quick Tools for Depression & Anxiety

Sensory Stimulation

- Touch
  - Fresh air
    - Even better when windy, cold or hot
- Taste
  - Cold/Hot Beverage
  - Candy/Cough Drop/Gum
- Smell
  - Spices
  - Aromatherapy
- Sound
  - Music
  - A “relaxing voice”
- Sight
  - Fun/relaxing pictures
  - Moving object
    - Swaying tree
    - Fountain/moving water
    - Playground

Easy & Quick Tools for Depression & Anxiety

Sensory Stimulation Actual Cases

- 52 year old African-American male suffering from severe PTSD dating back to torture as an inmate in federal penitentiary with flashbacks, anger, psychosis and panic attacks
  - Carries a bottle of orange juice to self-treat panic attacks and flashbacks
  - "It's the opposite of jail"
  - Stable for 3 years
  - Volunteers at high schools speaking of the dangers of the drug world.

Easy & Quick Tools for Depression & Anxiety

Self Monitoring

- Mood log
- Journal
- Creative writing/Poetry
- Writing music
- Talking with counselor/sponsor
- Awareness of other people's perceptions
  - "How are people telling you, you been acting or feeling recently?"
- Usage of PRN medication

Easy & Quick Tools for Depression & Anxiety

Self Monitoring Actual Cases

- My Past
  - I made wrong decisions
  - Not knowing how they would
  - Adversely affect me
  - I forgot about me
  - Trying to be a good
  - Single working mom
  - When it came to thinking
  - About only me
  - I failed
- My Present
  - I wake up
  - I take a breath
  - A new day
  - I am thankful

Excerpts from a 45 year old Caucasian female with hx of chronic cocaine abuse, melancholic depression and frequent hospitalizations

Now stable for 4 years, Clean for 4 years with an isolated 2 day relapse

Integration is the Key

- Medical personnel see psychiatric illnesses prior to psychiatric clinician
- General health ***includes*** mental stability
- Follow-up on self-management is already done, questions and follow-through need to be added. Simple, Quick, Easy
- Diagnostic tools such as the PHQ-9 and the Beck Anxiety Inventory can help prior to diagnosis
- Early treatment leads to greater compliance, greater success and brighter future

Thank you….

Questions, Comments or Stories?

856-316-2937 or SpectorPsychiatry@gmail.com