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COLLABORATIVE MODELS OF MENTAL HEALTH CARE FOR OLDER IOWANS

CLINICAL RESOURCES





CLINICAL MATERIALS

Basic Model

The Mental Health Screen for Older Iowans

Mental Status Examination

Five Key Counseling Points

Diagnostic Testing

 Patient Health Questionnaire – 9

 Zung Anxiety Scale

 Modified Short Michigan Alcohol Screening Test

 Mini-Mental Status Examination

 Short Form 12 Health Survey

Diagnostic Interviewing

Treatment Plan

Evaluation Form

1. Screening

If patient screens positive for mental health problem, then proceed

2. Counseling & Referral

Counsel patient about benefits of mental health care and schedule diagnostic assessment

3. Diagnostic Assessment

Conduct formal assessment and start treatment within two weeks

4. Treatment

Initiate 24 week treatment plan





1. Screening

The Mental Health Screen
for Older Iowans

*If patient screens
positive for mental health
problem, then proceed*

2. Counseling & Referral

**Discuss the importance
of mental health care**
Schedule Diagnostic
Assessment

3. Diagnostic Assessment

↓
Testing

↓
Interview

↓
Begin Patient &
Family Education

4. Treatment

Treatment Plan Agreement

↓
Problem Solving
Therapy

Pharmacotherapy

Supportive
Services

↓
Evaluation

THE MENTAL HEALTH SCREEN FOR OLDER IOWANS

Provider Statement:

I am going to ask you some questions. Even if you are not sure, please just go ahead and provide your best answer.

I want to start by asking you to repeat and remember three words. Please wait until I say all three words, repeat them, and then try to remember what they are because I am going to ask you to name them again in a few minutes. OK?

Repeat these words after me:

- APPLE
- TABLE
- PENNY

Now I want to ask you some other questions:

No.	Question	Answer	
1	What year is this?	Wrong (1)	Right (0)
2	Have you ever had trouble remembering what you did or said after drinking or taking any of your prescription medication?	Yes (1)	No (0)
3	Who is the current President of the United States?	Wrong (1)	Right (0)
4	What day of the week is this?	Wrong (1)	Right (0)
5	In the past month, have you lost interest or found it difficult to enjoy activities?	Yes (1)	No (0)
6	Have you ever thought about cutting down on your drinking or prescription drug use?	Yes (1)	No (0)
7	In the past month, have you feared the worst happening?	Yes (1)	No (0)
8	Do you ever feel guilty about your drinking or prescription drug use?	Yes (1)	No (0)
9	In the past month, have you felt down or depressed?	Yes (1)	No (0)
10	Do you get annoyed when someone asks about your drinking or prescription drug use?	Yes (1)	No (0)
11	In the past month, have you been bothered by feelings of nervousness?	Yes (1)	No (0)
12	Do you ever drink as soon after you wake up?	Yes (1)	No (0)
	What were the three objects I asked you to remember?		
13	Apple	Wrong (1)	Right (0)
14	Table	Wrong (1)	Right (0)
15	Penny	Wrong (1)	Right (0)

TOTAL SCORE _____

A total score of 2 or more indicates a need for formal diagnostic assessment.

Source: University of Iowa, Center on Aging (2007)



MENTAL STATUS EXAMINATION



1. Speech
 - a. rate - volume _____
 - b. coherence _____

2. Thought process
 - a. content – logic _____
 - b. computation _____

3. Thought Association
 - a. loose-tangential _____
 - b. circumstantial _____

4. Abnormal, psychotic thoughts
 - a. hallucinations-delusion _____
 - b. obsessive thinking _____

5. Judgment
 - a. concerning social situations _____
 - b. insight into own condition _____

6. Orientation _____

7. Recent and remote memory _____

8. Attention span and concentration _____

9. Language
 - a. name objects _____
 - b. repeat list of words _____

10. Fund of knowledge
 - a. current events _____

11. Mood and affect _____

If patient screens positive for mental health problem, then proceed

2. Counseling & Referral

- A. Convey that mental illness among older adults is not so uncommon, and many types of mental illness do not appear until later in life.
- B. Discuss how many mental illnesses among older adults can co-occur with other health problems.
- C. Underscore the notion that mental illnesses are not normal aspects of getting older.
- D. Highlight the fact that treatment works.
- E. Tell them about the collaborative model.



PATIENT HEALTH QUESTIONNAIRE



PROVIDER: “Over the last two weeks, how often have you been bothered by the following...”
 “Please indicate if not at all, some days, more than half, or nearly every day.”

	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 fidgety 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
Total Score ____ = ____ + ____ + ____				

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Source: Developed the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ) by Drs. Robert L. Spitzer, Janet BW Williams, Kurt Kroenke, and colleagues. PRIME-MD PHQ is a trademark of Pfizer Inc. Copyright 1999

ZUNG ANXIETY SCALE

PROVIDER: "Over the last two weeks, how often have you been bothered by the following...."
 "Please indicate if not at all, some days, more than half, or nearly every day."

	Not at all	Several days	More than half the days	Nearly every day
1. Feel more nervous and anxious than usual	0	1	2	3
2. Bothered by dizzy spells	0	1	2	3
3. Feel afraid for no reason at all	0	1	2	3
4. Have fainted or feel like fainting	0	1	2	3
5. Get upset easily or feel panicky	0	1	2	3
6. Have trouble breathing in and out	0	1	2	3
7. Feel like falling apart or going to pieces	0	1	2	3
8. Feel numbness or tingling in fingers or toes	0	1	2	3
9. Feeling that everything is wrong and nothing good will happen	0	1	2	3
10. Bothered by stomach aches and indigestion	0	1	2	3
11. Arms and legs shake and tremble	0	1	2	3
12. Have to empty bladder often	0	1	2	3
13. Bothered by headaches, neck and backaches	0	1	2	3
14. Hands are usually warm and dry	0	1	2	3
15. Feel weak and tired	0	1	2	3
16. Face gets hot and blushes	0	1	2	3
17. Feel restless and cannot sit easily	0	1	2	3
18. Have trouble falling asleep and feeling rested	0	1	2	3
19. Feel heart beating fast	0	1	2	3
20. Have nightmares	0	1	2	3

Total Score _____ = _____ + _____ + _____

If score is 40 points or higher, then further interviewing should be conducted.

Source: Zung WWK. A rating instrument for anxiety disorders. *Psychosomatics*. 1971; 12: 371-379



SHORT MICHIGAN ALCOHOL SCREENING TEST -
GERIATRIC VERSION (MODIFIED)



	Yes	No
1. When talking with others do you ever underestimate how much you drink or how much medication you take?		
2. After a few drinks or pills, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
3. Does having a few drinks or pills help decrease your shakiness or tremors?		
4. Does alcohol or prescription drugs sometimes make it hard for you to remember parts of the day or night?		
5. Do you usually take a drink or a pill to relax or calm your nerves?		
6. Do you drink or take a pill to take your mind off your problems?		
7. Have you ever increased your drinking after experiencing a loss in your life?		
8. Has a doctor or nurse ever said they were worried or concerned about your drinking or prescription drug use?		
9. Have you ever made rules to manage your drinking or use of your prescriptions?		
10. When you feel lonely does having a drink or taking a pill help?		

TOTAL YES = _____

A total of 2 or more "YES" responses indicates a need for further assessment.

Copyright: The Regents of the University of Michigan

Source: Blow, F (1991). The short Michigan alcoholism screening test – geriatric version.

Ann Arbor, MI: University of Michigan Alcohol Research Center.

MINI MENTAL STATUS EXAMINATION (MMSE)

PLEASE ANSWER THE FOLLOWING QUESTIONS AS BEST AS YOU CAN

- _____ 1. What is today's date?
- _____ 2. What is the year?
- _____ 3. What is the month?
- _____ 4. What day is today?
- _____ 5. What season is it?
- _____ 6. What building are we in?
- _____ 7. What floor are we on?
- _____ 8. What town are we in?
- _____ 9. What state are we in?
- _____ 10. What country are we in?

PLEASE REPEAT THE FOLLOWING WORDS AFTER ME "ball", "flag", "tree"

- _____ 11. BALL
- _____ 12. FLAG
- _____ 13. TREE

STARTING AT 100, COUNT BACKWARDS BY 7 UNTIL I ASK YOU TO STOP

- _____ 14. 93
- _____ 15. 86
- _____ 16. 79
- _____ 17. 72
- _____ 18. 65

POINT TO THE FOLLOWING TWO OBJECTS AND ASK THE PATIENT TO NAME EACH "WHAT'S THIS?"

- _____ 19. Point to a watch or clock
- _____ 20. Point to a pen or pencil

ASK PATIENT TO REPEAT THE FOLLOWING "NO IFS, ANDS, OR BUTS"

- _____ 21. No ifs, ands, or buts

ASK THE PATIENT TO "take a piece of paper, fold it in half, and put it on the floor"

- _____ 22. take paper
- _____ 23. fold in half
- _____ 24. place on floor



MINI MENTAL STATUS EXAMINATION



ON A PIECE OF PAPER, WRITE 'CLOSE YOUR EYES" AND
ASK THE PATIENT TO READ THE SIGN AND DO WHAT IT SAYS

_____ 25. "CLOSE YOUR EYES" (1 point)

_____ 26. ASK THE PATIENT TO WRITE A SENTENCE WITH A NOUN AND
VERB

_____ 27. ASK THE PATIENT TO DRAW 2 INTERSECTING PENTAGONS (1
POINT)

PLEASE RECALL THE THREE WORDS I ASKED YOU TO REPEAT
EARLIER

_____ 28. BALL

_____ 29. FLAG

_____ 30. TREE

_____ TOTAL SCORE

Scoring

Because the MMSE is sensitive to age and education level, the following scoring system should be used to establish whether or not the patient may have a cognitive problem. A score that falls below these numbers indicates a need for more focused clinical examination.

Age/Education Level	4th Grade	8th Grade	High School	College
60-64	23	26	28	29
65-69	22	26	28	29
70-74	22	25	27	28
75-79	21	25	27	28
80-84	20	25	25	27
85+	19	23	25	27

Source: Folstein MF, Folstein, SE and McHugh PR (1975) Mini-Mental State: A practical method for grading the state of patients for the clinician, *Journal of Psychiatric Research*, 12: 189-198.

THE SHORT FORM-12 HEALTH SURVEY

- _____ 1. In general, would you say your health is excellent, very good, good, fair, or poor?
- _____ 2. Does your health limit you a lot, a little, or not at all when doing moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?
- _____ 3. Does your health limit you a lot, a little, or not at all when climbing several flights of stairs?
- _____ 4. During the past four weeks, have you accomplished less than you would like as a result of your physical health?
- _____ 5. During the past four weeks, were you limited in the kind of work or other regular activities you do as a result of your physical health?
- _____ 6. During the past four weeks, have you accomplished less than you would like to as a result of any emotional problems, such as feeling depressed or anxious?
- _____ 7. During the past four weeks, did you not do work or other regular activities as carefully as a result of any emotional problems such as feeling depressed?
- _____ 8. During the past four weeks, how much did pain interfere with your normal work, including both work outside the home and housework?
- _____ 9. How much time during the past month have you felt calm and peaceful?
All of the time
most of the time
some of the time
none of the time
- _____ 10. How much of the time during the past month did you have a lot of energy?
All of the time
most of the time
some of the time
none of the time
- _____ 11. How much time during the past month have you felt down?
All of the time
most of the time
some of the time
none of the time
- _____ 12. During the past month, how much of the time has your physical health or emotional problems interfered with your social activities like visiting with friends, relatives, etc?
All of the time
most of the time
some of the time
none of the time

Source: (SF-36.org, 2007)



MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE



BACKGROUND INFORMATION

CLIENT _____ DOB _____

ID _____ SOC SEC _____

CONTACT INFORMATION

St _____

City _____

Phone _____

COUNTY OF RESIDENCE _____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

NAME OF ASSESSOR _____

PLACE OF ASSESSMENT _____

REFERRAL SOURCE _____

REASON FOR REFERRAL _____

PRIMARY CARE SCREEN INDICATIONS

MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

HISTORY

DEVELOPMENTAL

ETHNIC-CULTURE _____

EDUCATION _____

SIGNIFICANT RELATIONSHIPS _____

MEDICAL - PHYSICAL

DISEASE _____

OTHER DIAGNOSES _____

HOSPITALIZATIONS _____

OTHER SERVICE USE _____

RELEVANT FAMILY Hx _____

PSYCHIATRIC

DISEASE _____

OTHER DIAGNOSES _____

HOSPITALIZATIONS _____

OTHER SERVICE USE _____

FAMILY HISTORY _____

FUNCTIONING

CHRONIC DISABILITY _____

PERIODS OF DIFFICULTY _____

OCCUPATIONAL



MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE



CURRENT STATUS

SIGNIFICANT OTHER _____

HOUSING SITUATION _____

MEDICAL - PHYSICAL STATUS

DISEASE _____

OTHER DIAGNOSES _____

SERVICE USE _____

PAIN - HEADACHES _____

APPETITE _____

SEXUAL RELATIONS _____

SLEEP _____

FUNCTIONING

ACTIVITIES OF DAILY LIVING _____

EXERCISE - LEISURE ACTIVITIES _____

SOCIAL ACTIVITIES _____

INDEPENDENT ACTIVITIES OF DAILY LIVING _____

RECENT LOSSES _____

OTHER _____

MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

PRESCRIPTION DRUG USE

Go through brown bag and fill out the chart and determine if any drugs are potentially high risk.

Brand Name	Generic-Class	Prescribing Physician	Reason for Rx	Dose	Daily Freq	How long
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

The following are considered to be potentially high risk drugs for older adults (generic name (brand name)):

amiodarone (Cordarone),
 amitriptyline (Elavil, Limbitrol, Triavil),
 amphetamines and anorexic agents,
 barbiturates (except phenobarbital for seizures),
 long-acting benzodiazepines (Dalmane, Librium,
 Limbitrol, Librax, Praxipam, Tranxene, Valium),
 chlorpropamide (Diabinese),
 disopyramide (Norpace),
 doxepin (Sinequan),
 gastrointestinal antispasmodics (Bentyl, Donnatal, Levsin,
 ProBanthine),
 guanethidine (Ismelin),
 guanadrel (Hylorel),
 indomethacin (Indocin),
 ketorolac (Toradol),
 meperidine (Demerol),

meprobamate (Equanil, Miltown),
 mesoridazine (Serentil),
 methyl dopa (Aldomet, Aldoril),
 methyltestosterone (Android, Testred, Virilon),
 muscle relaxants (Flexeril, Norflex, Robaxin, Soma,
 Skelaxin),
 NSAIDS (Daypro, Feldene, Naprosyn),
 pentazocine (Talwin),
 thioridazine (Mellaril),
 ticlopidine (Ticlid),
 trimethobenzamide (Tigan).

Consult with primary physician regarding current prescription use and treatment plan for mental health problem.

Source: <http://www.fda.gov/cder/drug/drugreactions>



MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE



MOTIVATION FOR TREATMENT

WHAT DO YOU WANT TO GET OUT OF YOUR TREATMENT?

WHAT DOES YOUR SIGNIFICANT OTHER WANT TO GET OUT OF YOUR TX?

ON A SCALE FROM 1-10, HOW SERIOUS ARE YOUR PROBLEMS? _____

HOW WOULD YOU LIKE TO DESCRIBE YOURSELF ONE YEAR FROM NOW?

HOW OFTEN WOULD YOU BE WILLING TO PARTICIPATE IN TREATMENT?

HOW LONG DO YOU THINK THE TREATMENT SHOULD LAST?

DO YOU THINK YOU MIGHT HAVE TROUBLE PAYING FOR TREATMENT?

DO YOU HAVE ANY CAREGIVING RESPONSIBILITIES?

WOULD YOU HAVE TROUBLE GOING TO THE OFFICE FOR TREATMENT?

OTHER FACTORS THAT MIGHT AFFECT YOUR PARTICIPATION IN TX?

MODIFIED DIAGNOSTIC INTERVIEW SCHEDULE

DIAGNOSTIC IMPRESSION

AXIS I: Clinical disorders; other conditions that may be focus of attention

AXIS II: Personality disorders

AXIS III: Medical conditions

AXIS IV: Psychosocial and environmental problems

AXIS V: Global assessment of functioning





TREATMENT PLAN

SITE: _____

PATIENT INITIALS: _____

PARTICIPATING STAFF:

Mental Health Specialist _____ p: _____

Primary Care Staff _____ p: _____

Consulting Psychiatrist _____ p: _____

Client Emergency Contact _____ p: _____

TREATMENT OVERVIEW:

Presenting Problem: _____

Diagnosis: _____

Other Diagnosis: _____

Goal of Treatment: _____

Date of Treatment Initiation: _____

Expected Date of Treatment Completion: _____

TREATMENT METHODS:

PRESCRIPTION MEDICATION:

Treatment target: _____

Type/Brand Name: _____

Dosage/Frequency: _____

Adjustment Dates: _____

PROBLEM SOLVING THERAPY:

Treatment Target(s): _____

Method of Focused Intervention:

Homework _____

Activity _____

SUPPORTIVE SERVICES

Treatment Target: _____

Recommended Services:

Contacts:





TREATMENT SCHEDULE:

		Dates	Place
Session 1:	Agree to Treatment Plan Prescribe medications Review PST - Supportive Services Educational Materials	_____	_____
Week 2-3:	Problem Solving Therapy Supportive Services	_____ _____	_____ _____
Week 4:	Medication Management Problem Solving Therapy Evaluation I Treatment Adjustments	_____	_____
Week 5-7:	Problem Solving Therapy Supportive Services	_____ _____	_____ _____
Week 8:	Medication Management Problem Solving Therapy Evaluation II Treatment Adjustments	_____	_____
Week 9-15:	Problem Solving Therapy Supportive Services	_____ _____ _____ _____	_____ _____ _____ _____
Week 16:	Medication Management Problem Solving Therapy Evaluation III Treatment Adjustments	_____	_____
Week 17-23:	Problem Solving Therapy Supportive Services	_____ _____ _____ _____	_____ _____ _____ _____
Week 24:	Medication Management Problem Solving Therapy Evaluation IV Treatment Plan Continuation	_____	_____

CLIENT EVALUATION

SITE: _____

PATIENT INITIALS: _____

PARTICIPATING STAFF:

Mental Health Specialist _____ p: _____

Primary Care Staff _____ p: _____

Initial Screening Date: _____

Initial Screening Score: _____

Initial Screening Impression: _____

Diagnostic Assessment Date: _____

Assessment Test Scores:

PHQ9 _____

ZUNG _____

SMAST-G _____

MMSE _____

SF-12 _____

Other: _____

Diagnosis: _____

Treatment Initiation date: _____

Treatment Plan Goals: _____



CLIENT EVALUATION



EVALUATION 1 (4 weeks)

PHQ9 _____ SMAST- G _____ SF-12 _____

ZUNG _____ MMSE _____

Other: _____

EVALUATION II (8 weeks)

PHQ9 _____ SMAST- G _____ SF-12 _____

ZUNG _____ MMSE _____

Other: _____

EVALUATION III (16 weeks)

PHQ9 _____ SMAST- G _____ SF-12 _____

ZUNG _____ MMSE _____

Other: _____

EVALUATION IV (24 weeks)

PHQ9 _____ SMAST- _____ SF-12 _____

ZUNG _____ MMSE _____

Other: _____