Behavioral Health Screening Programs

FHC of Puerto Rico (FHC) has been involved in the provision of behavioral and mental health services since 1996. We are committed to a system that promotes access to the highest standards of care. Our quality improvement philosophy encompasses prevention and early detection of health issues that could affect life functionalities and the progression of conditions of the populations we serve.

In order to implement this quality improvement philosophy, FHC has chosen two screening programs. These programs will advance the wellness of patients and aid in the reduction of negative effects of mental illness and substance use disorders, through the promotion of early screening and assessment. The first screening program addresses coexisting mental health and substance use disorder in patients diagnosed with bipolar disorder; the second one addresses the screening for metabolic syndrome in patients on second-generation antipsychotics (SGAs).

These two screening measures are based on scientific evidence, best practices, and industry standards. FHC will review available scientific evidence and update these programs every two years or more often when applicable. FHC obtained appropriate practitioner and providers input on the program design and implementation through the creation of the Behavioral Health Screening Task-Force. This Task-Force is composed of Psychiatrists, Psychologists, Social Workers and facilities who are part of our Providers Network. The overall program design, established by them, included: a) the selection of the screening measures; b) conditions were screening is indicated or required; c) identification of population screened; and d) recommended frequency of the screenings. Prior to its implementation, the Task-Force approved the final program design. These programs were initially implemented in 2016 and have been revised and updated ever since. Among the major changes implemented are the adoption of the AUDIT-C and DAST-10 for alcohol and substance use screening, respectively, and the addition of depression screening for patients with substance use disorder.

Both programs are publicized through FHC's website. The information is mailed to practitioners and providers who do not have fax, e-mail or Internet access. The screening programs are distributed to appropriate existing practitioners and providers at least every two years and when programs are added or revised. Screening programs are also distributed to new practitioners and providers as part of their credentialing process when they receive the Providers Handbook.

1. **Screening Programs to Address Coexisting Mental Health and Substance Use Disorders**

   According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the coexistence of both a mental health and a substance use disorder is referred to as co-occurring disorders. SAMHSA reports that for the 2019 in the United

States (US), approximately 9.5 million adults have co-occurring disorders, and only 7.8% of these individuals receive treatment for both conditions. These percentages in 2019 were similar to the percentages in 2015 to 2018. For Hispanics, similar needs were identified, for which approximately 1.4 million adults have co-occurring disorders and only 6% of these individuals receive treatment for both conditions.

The screening of coexisting mental health and substance use disorders is a fundamental performance within the quality of care spectrum and sound clinical practices. As explained, individuals with an alcohol misuse and alcohol use disorder (AUD) are more likely than the general population to have coexisting psychiatric disorders. According to Petrakis (2014), there are high rates of comorbid AUDs among psychiatric patients: highest prevalence is among those with bipolar disorder.

Co-occurring psychiatric and substance use disorders (SUD) are common in all treatment settings (e.g., centers for the treatment of substance use disorders, mental health clinics, primary care settings, emergency departments) and in the general community, according to the American Psychiatric Association. In community population samples studied in the National Comorbidity Survey, individuals with alcohol dependence had high rates of clinically significant depression during their lifetime (men: 24% depression and 11% dysthymia; women: 49% depression and 21% dysthymia) and individuals with bipolar disorder had high rates of alcohol (61%) and other substance (41%) dependence [VIII].

Therefore, FHC recommends screening for substance use disorders in patients with existing or newly diagnosed bipolar disorders and assess all patients with a substance use disorder for the presence of co-occurring depressive disorder.

For this initiative, our systematic approach is based on requiring our entire Network to perform screenings to patients they identify with the diagnosis or newly diagnose of Bipolar Disorder or SUD. Patients are eligible for screening if they present an already existing bipolar disorder or SUD diagnosis, or during the course of treatment, upon diagnosis of the condition and when they are first diagnosed. Follow up screens must not span longer than a year after last screening.

Screening for SUD in patients with Bipolar Disorder

FHC has chosen the utilization of the Alcohol Screening Questionnaire C (AUDIT-C) and the Drug Screening Questionnaire (DAST-10), which allows us to determine, in a fast and sensitive manner, if a patient diagnosed with bipolar disorder could have a problem with the use of alcohol or substances.

For alcohol use disorder screening, the practitioner must administer the Audit- C. The minimum score (for nondrinkers) is 0 and the maximum possible score is 12. Consider a screen positive for unhealthy alcohol use if AUDIT-C score is ≥4 points for men or ≥3 points for women. For substance use disorder screening, ask for lifetime use of

cannabis, solvents, tranquilizers, barbiturates, cocaine, stimulants or narcotics (do not include alcohol or tobacco). If patient has used any of the drugs mentioned in the established frequency, clinician must administer the Drug Screening Questionnaire (DAST-10). Affirmative responses counts as one point. No responses represents zero points. Clinician must add all responses to obtain a total. The total score correlates with a zone of use. The clinician must determine the risk zone depending on the total score.

Screening for a Depressive Disorder in patients with SUD

FHC requires practitioners to screen for Major Depressive Disorder using the PHQ-9 since it is the most prevalent diagnosis seen in the population served by FHC. Major depression is diagnosed if 5 or more of the 9 depressive symptom criteria have been present at least “more than half the days” in the past 2 weeks, and 1 of the symptoms is depressed mood or anhedonia. Other depression is diagnosed if 2, 3, or 4 depressive symptoms have been present at least “more than half the days” in the past 2 weeks, and 1 of the symptoms is depressed mood or anhedonia. One of the 9 symptom criteria (“thoughts that you would be better off dead or of hurting yourself in some way”) counts if present at all, regardless of duration. The practitioner is expected to rule out physical causes of depression, normal bereavement, and history of a manic episode. As a severity measure, the PHQ-9 score can range from 0 to 27, since each of the 9 items can be scored from 0 (not at all) to 3 (nearly every day) [IX].

2. Screening for Metabolic Syndrome in patients who are on Second Generation Antipsychotic

Second Generation Antipsychotics have been a key component for the pharmacological treatment of multiple psychiatric symptoms. Due to their minimal risk of extrapyramidal symptoms, they have become the first line of treatment for schizophrenia, other psychotic disorders and bipolar disorder. According to the American Diabetes Association, one of the downsides to the treatment with SGAs is the high risk of developing Metabolic Syndrome. Metabolic Syndrome, as defined by the National Institute of Health (NIH), is the name for a group of factors that raises the risk of heart disease and other health problems, such as diabetes and stroke. These factors include: a large waistline, high triglyceride levels, a low HDL cholesterol level, high blood pressure, and high fasting blood sugar. These adverse effects along with lifestyle and genetic components, contribute to the decreased lifespan of patients, including those with schizophrenia. As stated the Centers for Disease Control and Prevention (CDC), heart disease is the leading cause of mortality and morbidity in the general population.

Taking into account the possible health risks for patients treated with SGA’s and the impact to their wellbeing; FHC has chosen the screening for Metabolic Syndrome as our second program. This program focuses on the detection of the Metabolic

Syndrome identified by three (3) or more of the following: increased waist circumference, high blood pressure, elevated triglycerides levels, low HDL cholesterol levels or high fasting plasma glucose (see Table #1). Psychiatrists should screen patients for whom they are prescribing SGA's by ordering laboratory tests at least. Psychiatrists may perform the complete syndrome assessment, including physical examination, may refer the patient to their PCP to assess all the factors for the diagnosis of the syndrome, or may confirm assessments performed by PCPs by requesting evidence of recent tests performed. The non-physician providers will comply with our program by referring patient to their primary care physicians or psychiatrists for the detection of the condition. FHC recommends for patients to be screened as soon as SGA treatment is identified or prescribed. For screening frequency, refer to Table #2.

Large waistline	• Women ≥ 35 inches • Men ≥ 40 inches
High triglyceride level	≥ 150 mg/dL
Low HDL cholesterol level	• Women ≤ 50 mg/dL • Men ≤ 40 mg/dL
High blood pressure	≥ 130/85 mmHg
High fasting blood sugar	≥ 100 mg/dL

Table 1. Factors for the diagnosis of Metabolic Syndrome on patients who are on SGAs[V, VII].

Criteria	Baseline	4wk	8 wk	12 wk	Quarterly	Annually	Every 5 yr
Personal / Family history	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X			X			
Blood pressure	X			X		X	
Fasting plasma glucose	X			X		X	
Fasting lipid profile	X			X		X	X

Table 2. Monitoring recommendations for patients receiving antipsychotic treatment [IV].

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