DRAFT

Primary Care Consultation Psychiatry

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Primary Care Consultation Psychiatry

This series of five modules is designed to introduce a psychiatrist to the practice of primary care psychiatry. There is a special focus on the developing role of a psychiatrist functioning as part of a collaborative care team. Each module has stated objectives and a content slide set. The core topics are:

Module 1:	Introduction to Primary Care Consultation Psychiatry
Module 2	Building a collaborative Care Team
Module 3	Psychiatric Consulting in Primary Care
Module 4	Behavioral Interventions and Referrals in Primary Care
Module 5	Medical Patients with Psychiatric Illness

Module 4: Behavioral Interventions and Referrals in Primary Care

Learning Objectives: Module 4

By the end of this module, the participant will be able to:

- Integrate health behavior change recommendations into treatment plans for primary care settings.
- List the basic principles of common brief psychotherapeutic interventions including motivational interviewing, behavioral activation and problem solving therapy.
- Triage patients to appropriate referrals for common primary care behavioral health presentations.
- Support primary care providers in functional assessments including assessing disability for primary care patients.

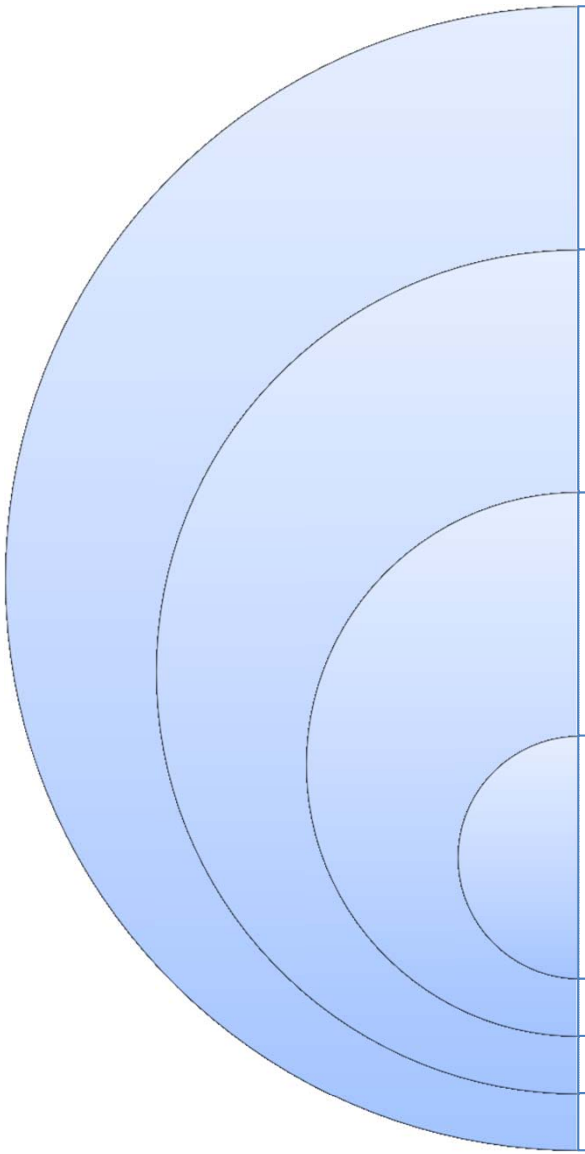
Think Beyond Medications!

Behavioral Medicine
&
Brief Psychotherapy

Referrals
&
Community Resources

Disability

Roles for Psychiatrists



Clinical Leader	• Shape behavioral healthcare for a defined population of patients in primary care
Caseload Consultant	• Consult indirectly through care team on a defined caseload of patients in primary care
Direct Consultant	• Consult directly by seeing selected patients
Clinical Educator	• Train BHPs and PCPs • Both directly and indirectly

Role for the Consulting Psychiatrist

- Support biopsychosocial assessment, case formulation and treatment planning
- Support training and coaching of primary care and behavioral health staff to provide
  - Behavioral health interventions
  - Brief psychotherapy
  - Referrals to community resources
- Support assessment for disability when appropriate

Role for the Consulting Psychiatrist

“This isn’t as easy as making a medication recommendation or writing a prescription!”

Think Beyond Medications!

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Brief Psychotherapy Skills

- **Evidence based psychotherapies can be adapted to primary care**
- **Brief psychotherapy requires specific skills**
  - Takes time and Practice
  - Systematic feedback on performance / skill coaching
- **Strategies to improve skills:**
  - Need basic training in specific skills
  - Network with other clinicians with experience for skills coaching
  - Bring in expert trainer to strengthen practice
  - Pay attention to patients → when you are effective you will see results; if patients are not improving, revisit skills used and need for additional training

Overview of Sample Skills

- Motivational Interviewing
- Distress Tolerance
- Behavioral Activation
- Problem Solving Therapy

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Motivational Interviewing for Health Behavior Change

Definition

- ***"client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence"*** **(Miller and Rollnick, 2002)**

Evidence

- **Demonstrated intervention for health behavior change:**
  - **Substance Use/Abuse**
  - **Dual Diagnosis**
  - **Eating Disorders/Obesity**
  - **Medical Co-morbidity (Cardiovascular health, Diabetes, Asthma, HIV treatment and more)**
  - **Health Promotion/Exercise Fitness**
  - **Medical Adherence**
  - **Depression and Anxiety**
  - **Smoking Cessation**
  - **Pain**

MI cowboy

"No one is making you do anything you don't want. I'm just saying we're all headed for Dodge City and we think you should come along."

"Of co *want*

and we'd like you to join us."

Spirit of MI

DO

Draw out Motivation

"What would you would like to change about your drinking?"

Honor Autonomy: Allow the freedom not to change

"How ready are you to change?"

Collaborate

"What do you think you'll do?"

AVOID

Implant the right ideas

"You really need to stop drinking."

Push for commitment

"If you delay getting sober, you could die."

Dictate

"I would urge you to quit drinking."

MI: Four Guiding Principles

Resist the Righting Reflex

Take up the argument NOT to change so the patient can argue FOR change

Understand Patient Motivation

Ask the patient why they would want to change and how they would do it

Listen to Your Patient

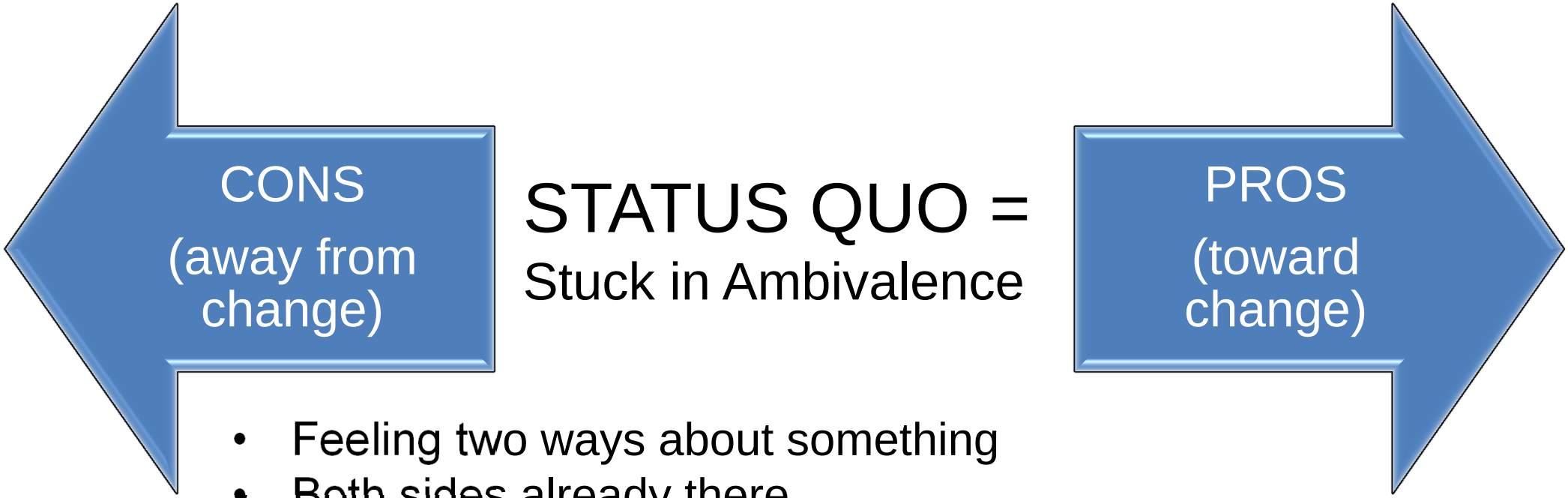
This is a COMPLEX SKILL that requires empathic interest and practice

Empower Your Patient

Help the patient explore how they can make a difference in their own health

MI Roadmap

Change Talk: Exploring Ambivalence



- Feeling two ways about something
- Both sides already there
- Common prior to habit change (common *during* habit change). Common with respect to alcohol.
- A communication trap! – Argue one side, person defends the other
- Defense of status quo makes *change less likely*

Assessment: Reflections Examples

MI Spirit

It sounds like you are feeling…

It sounds like you are not happy with…

It sounds like you are a bit uncomfortable about…

So you are saying that you are having trouble…

So you are saying that you are no so sure about …

You're not ready to…

You're having a problem with…

You're feeling that…

It's been difficult for you…

You're struggling with…

What a pisser!

Menu of Options: Drinking Example

MI Spirit

- Make no change whatsoever
- Cut down
- Don’t cut down but never drive after
- Quit entirely
- See a counselor
- (Others that the client thinks of?)

Overview of Sample Skills

- Motivational Interviewing
- Distress Tolerance
- Behavioral Activation
- Problem Solving Therapy

Distress tolerance skills are for getting through stress without making things WORSE!

Clients
face many stressors

- Housing
- Money
- Drugs and alcohol
- Dangerous neighborhoods or bus lines
- Trouble finding and keeping work
- Long waits for social services
- Medical problems and chronic pain

Clinicians
face many stressors

- Large caseloads
- Difficult clients
- Hearing many traumatic stories
- Inability to help their clients
- Lack of time or resources to help their clients
- Frustrating interactions with social services
- Unhelpful rules or regulations
- Paperwork

→ Evidence-informed crisis management skills
→ Adapted from Dialectical Behavior Therapy

Distress tolerance skills are for an unsolved crisis! Can you solve the problem?

If yes, **SOLVE IT**

- Stick with it, don't take your eye off the ball, and do what it takes.

If no (or not right now), **STOP** trying to solve it

- Trying to solve something you can't will often make it worse and send your emotions through the roof.
- Focus on distress tolerance skills during an unsolved crisis.

These skills taught just for an *unsolved* crisis.

Distress Tolerance skills

- Distract: ACCEPTS
- Self-Soothe
- IMPROVE the moment
- Pros and Cons

Distraction: deliberately turning your attention away from the crisis

Remember, wise mind ACCEPTS

Distracting with Sensations

This is ***THE BEST*** strategy to get unstuck when you are very distressed

Mobilize your body and it will bring your mind and emotions with it

- Put your face in ice water or hold ice
- Run up and down stairs
- Take cold shower
- If you are inside go outside or if you are outside go inside

Distress Tolerance skills

- Distract: ACCEPTS
- Self-Soothe
- IMPROVE the moment
- Pros and Cons

Self-Soothe with Five Senses

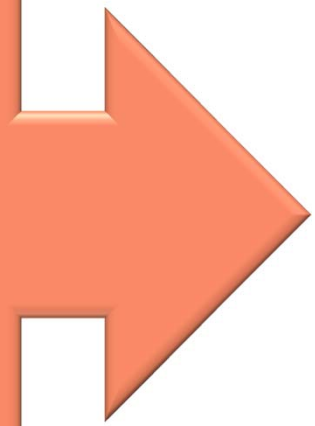
Vision	Decorate your space, go somewhere inspiring
Sound	Music, soothing voices, nature sounds
Smell	Cooking, lavender, the beach
Touch	Comfortable clothes, pet animal, foot massage
Taste	Favorite food, hard candy or mint, good cup of coffee

Distress Tolerance skills

- Distract: ACCEPTS
- Self-Soothe
- IMPROVE the moment
- Pros and Cons

IMPROVE the moment

Skills to accept pain and reduce suffering



- **I**magery
- **M**eaning
- **P**rayer
- **R**elaxation
- **O**ne thing in the moment
- **V**acation
- **E**ncouragement

Relaxation

The goal is to reduce suffering by removing physical stress from the body

Progressive relaxation

- Tighten each part of your body fully for 5 seconds and then completely relax it
- Start at toes and work through full body

Walk, yoga, other exercise that relaxes your muscles

Distress Tolerance skills

- Distract: ACCEPTS
- Self-Soothe
- IMPROVE the moment
- Pros and Cons

Pros and Cons

	Pros	Cons
Making it worse by: _____		
Tolerating distress by: _____		

Scenario: 10pm Sun night and you found an eviction notice on your door

	Pros	Cons
Making it worse by: *getting drunk*	-get to relax -won't have to think about it	-won't be able to function tomorrow when have to call guy back
Tolerating distress by: *self-soothing*	-get some relaxation -will be clear minded tomorrow	-will be worried all night -probably won't sleep

Overview of Sample Skills

- Motivational Interviewing
- Distress Tolerance
- Behavioral Activation
- Problem Solving Therapy

Behavioral Activation

Principles

•Structured, brief psychosocial approach

• Problems in vulnerable individuals' lives + behavioral responses = reduce ability to experience positive reward

• Three Goals:

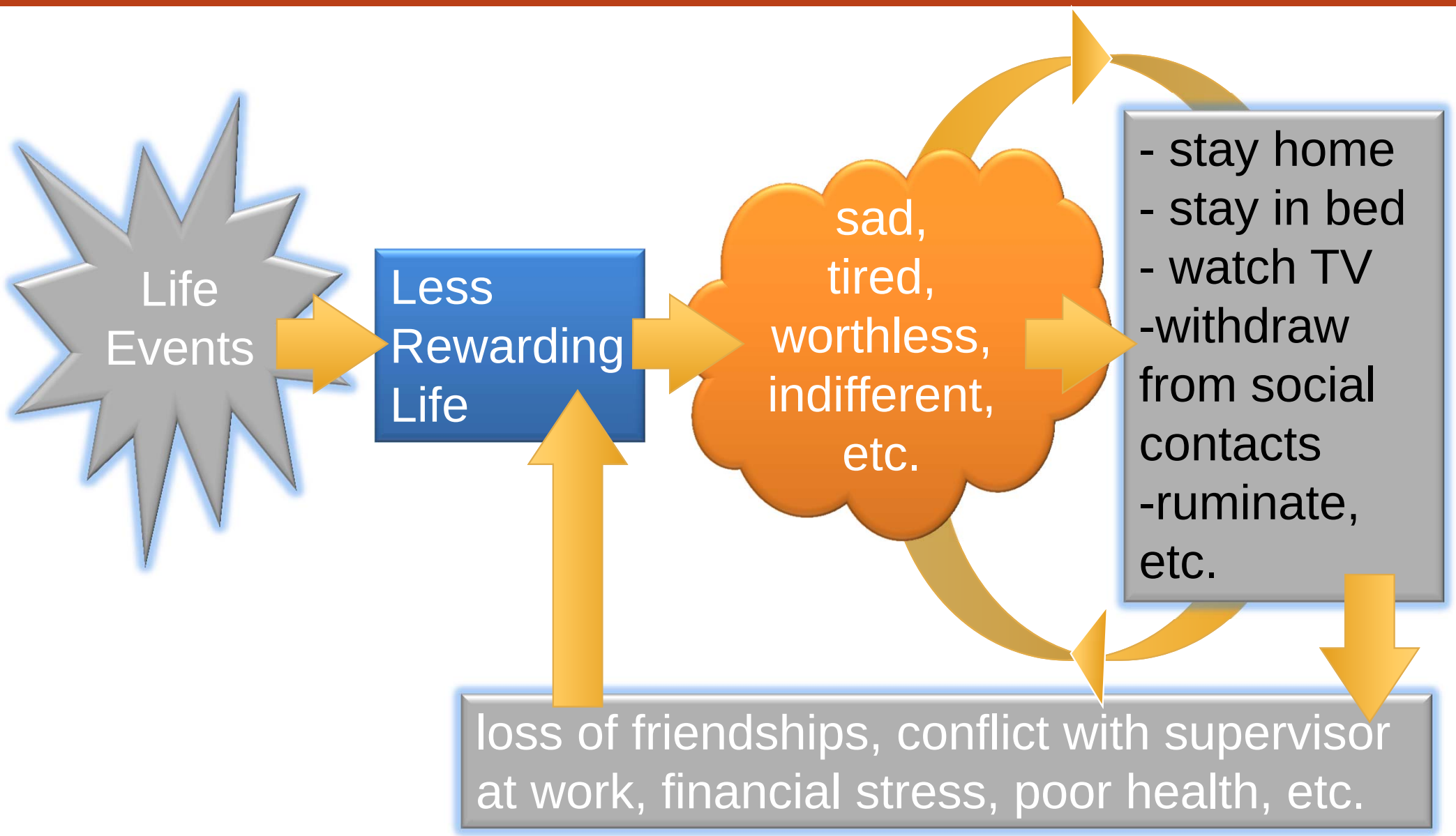
- •Increase adaptive activities
- •Reduce behaviors that maintain depression or make it worse
- •Problem solve around what is "getting in the way" of a rewarding life

Evidence

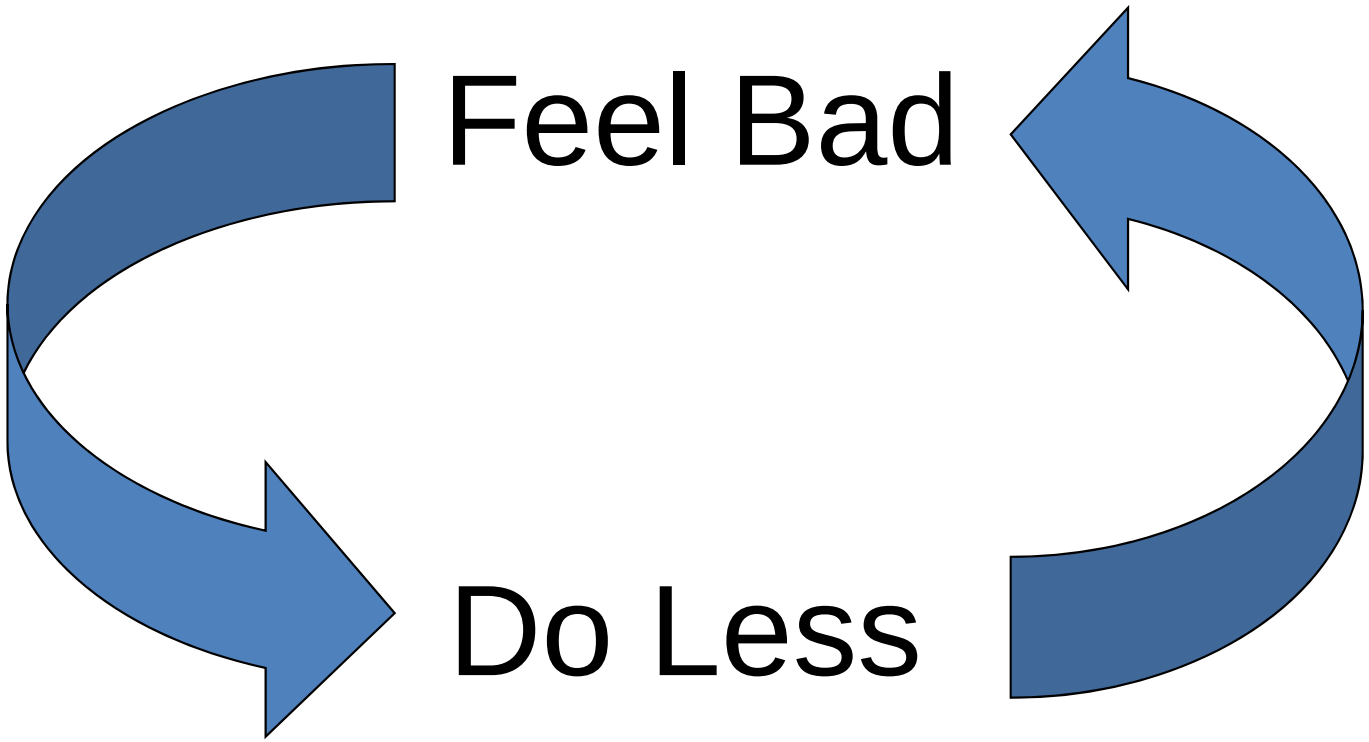
Reduces depression:

- Behavioral activation therapy for depression: Returning to contextual roots. Jacobson, N.S., Martell, C. R., & Dimidjian, S. (2001). Clinical Psychology: Science and Practice, 8 (3), 255-270.
- Behavioural activation delivered by the non-specialist: phase II randomised controlled trial. Ekers D, Richards D, McMillan D, Bland JM, Gilbody S. Br J Psychiatry. 2011 Jan;198(1):66-72.

BA Case Conceptualization

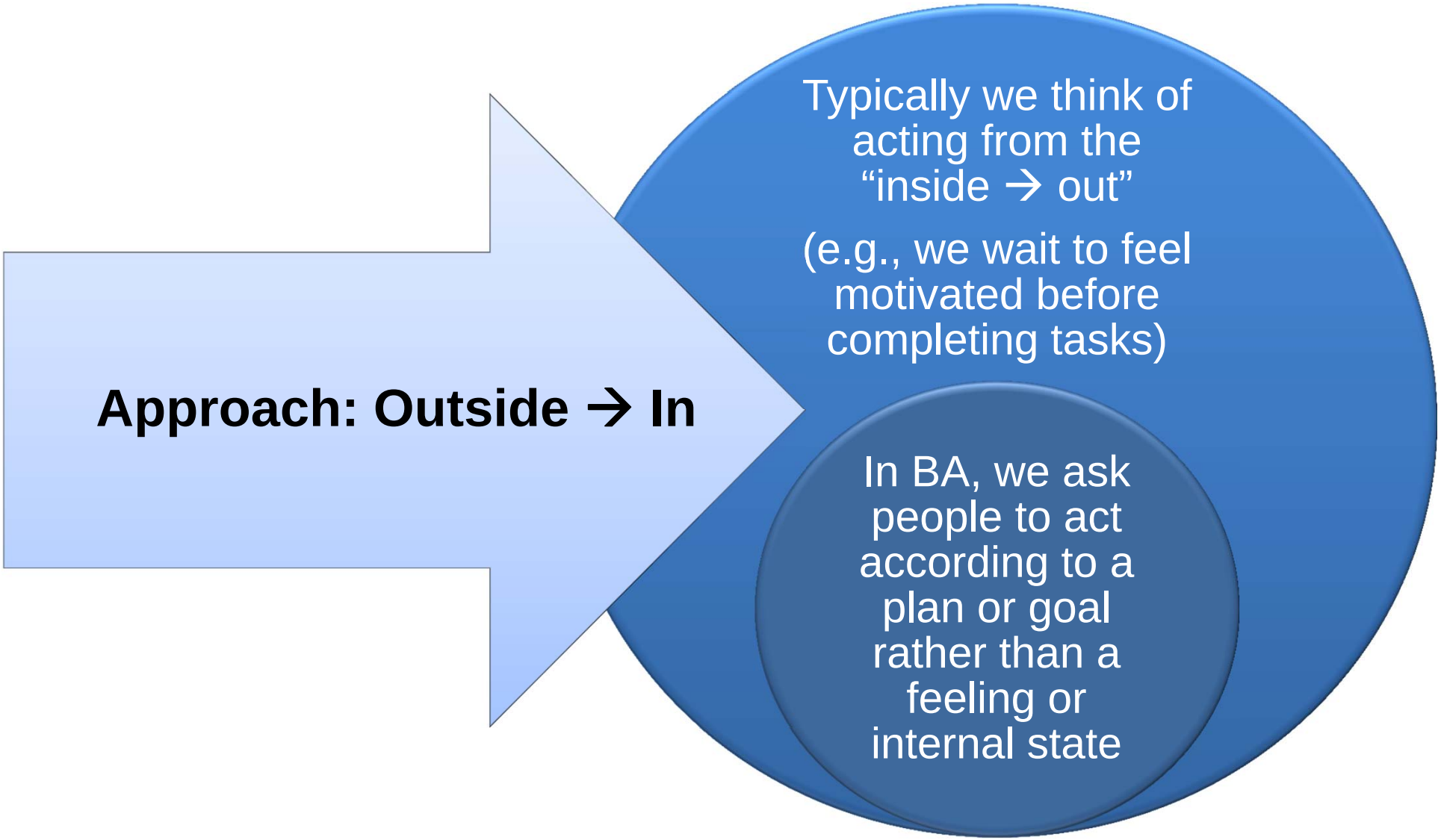


Activity Scheduling



- **Pick limited targets (1-3) and check on assigned homework**
- **Social / physical activities tend to be most potent mood boosters**
- **Treatment will also focus on increasing daily pleasant events**

Maximizing Activation



ACTION Strategy

Assess	• How will my behavior affect my depression? Am I avoiding? What are my goals in this situation?
Choose	• At times I may choose not to self-activate, I am choosing to take a break.
Try	• Try the behavior I have chosen.
Integrate	• Integrate any new activity into my daily routine.
Observe	• Observe the result. Do I feel better or worse??
Never	• Never give up.

Full Course of BA

- Establish good therapeutic relationship
- Present model of BA
- Goal setting
- Monitor relationship between situation/action and mood using activity logs and functional analysis
- Apply new coping strategies to “larger-life issues”
- Treatment review and relapse prevention

Overview of Sample Skills

- Motivational Interviewing
- Distress Tolerance
- Behavioral Activation
- Problem Solving Therapy

Problem Solving Therapy

Three Broad Goals

A. Help client understand the link between current life problems and current symptoms

B. Develop a systematic problem solving strategy

C. Engage in pleasant social and physical activities

Evidence

1991: UK researchers (Catalan, Gath et al.) design a Problem-Solving Therapy for use in Primary Care better than usual care

1995: Laurence Mynors-Wallis, Gath et al. apply PST in primary care for major depression versus amitriptyline and placebo control.

1997: Mynors-Wallis et al. test PST, provided by Community Health Nurses, for persons with persistent emotional distress.

2000: Mynors-Wallis et al. test PST for major depression in primary care with SRI and SRI + PST comparison.

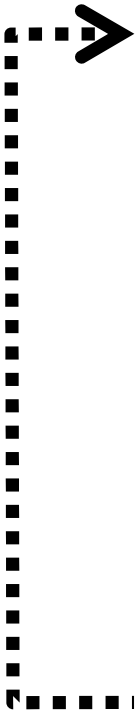
2001: Barrett, Williams et al. adapted PST for U.S. studies (PST-PC), comparing PST-PC with SRI and placebo control.

PST-PC Basics

Structure of PST-PC Treatment

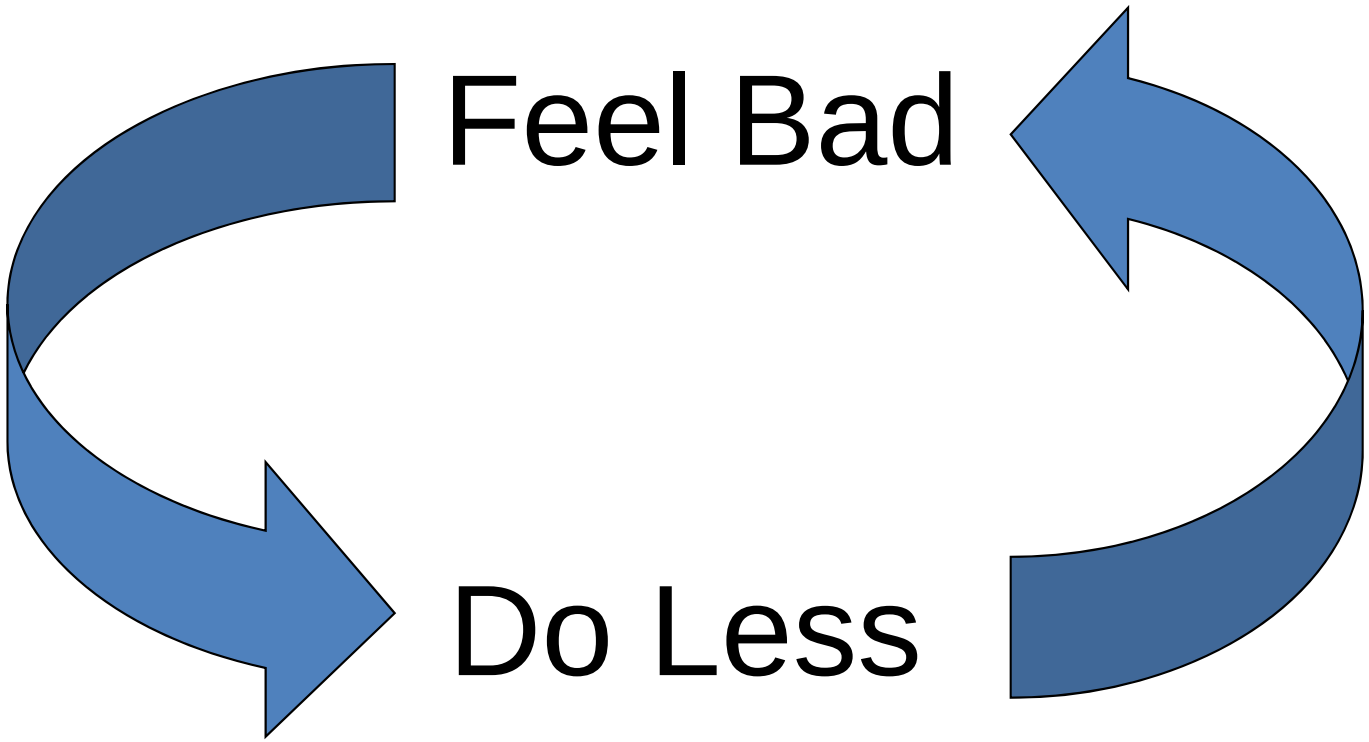
- Four to eight sessions: Weekly or biweekly
- Initial session: 1 Hour
- Subsequent sessions: 30 Minutes
- Work through at least one full problem per session
- Action between sessions

Seven Steps of PST-PC



1. Clarify and Define the Problem
2. Set Realistic / Achievable Goal
3. Generate Multiple Solutions
4. Evaluate and Compare Solutions
5. Select a Feasible Solution
6. Implement the Solution
7. Evaluate the Outcome

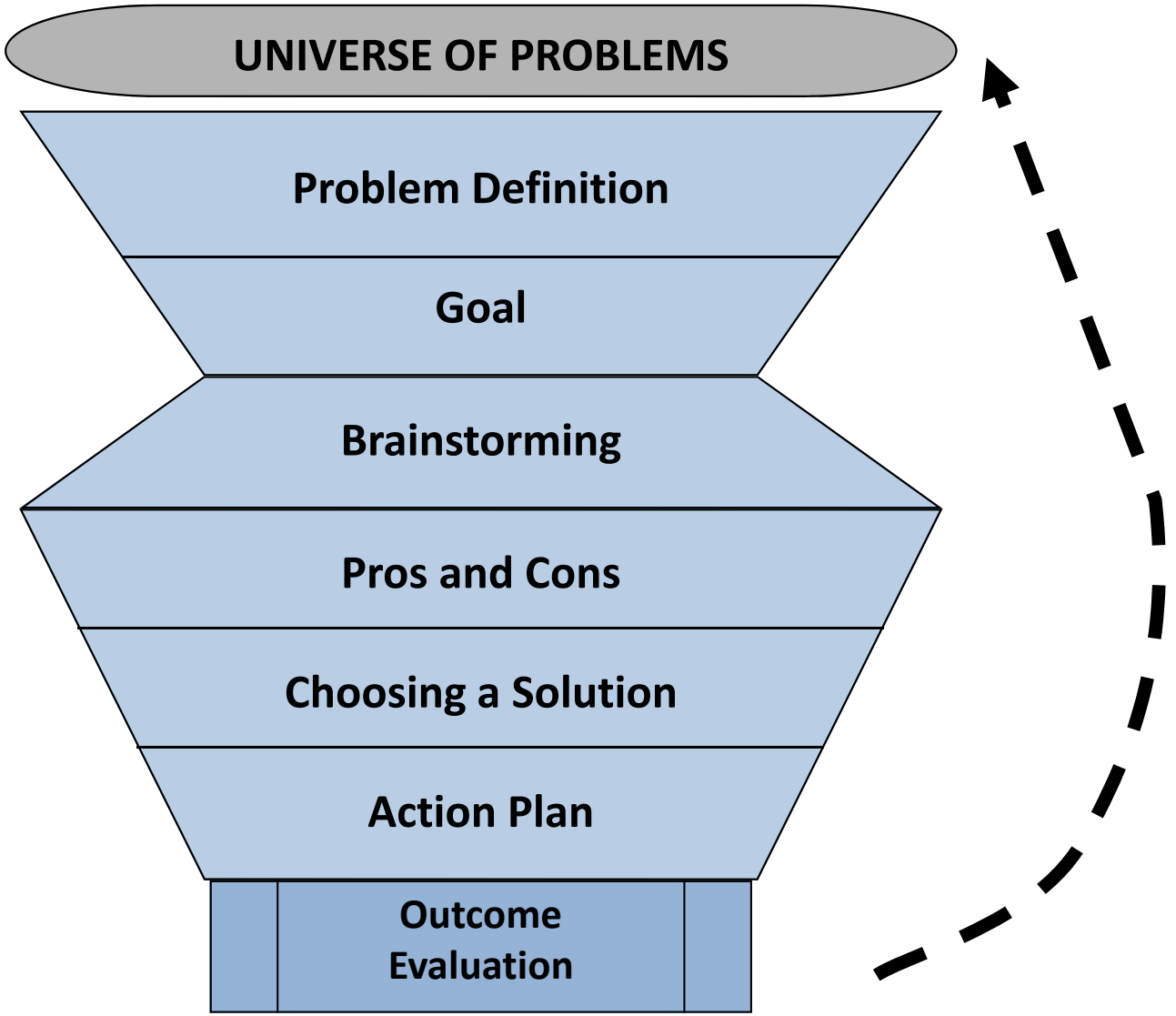
Activity Scheduling



Social / physical activities tend to be most potent mood boosters

Treatment will also focus on increasing daily pleasant events

Problem-Solving Process



Common Issues in PST-PC: Difficulty Keeping on Track

- **Starting the session on focus**
- **Redirecting sidetracks back on focus**
- **Maintaining engagement & motivation**
- **Ending the session**

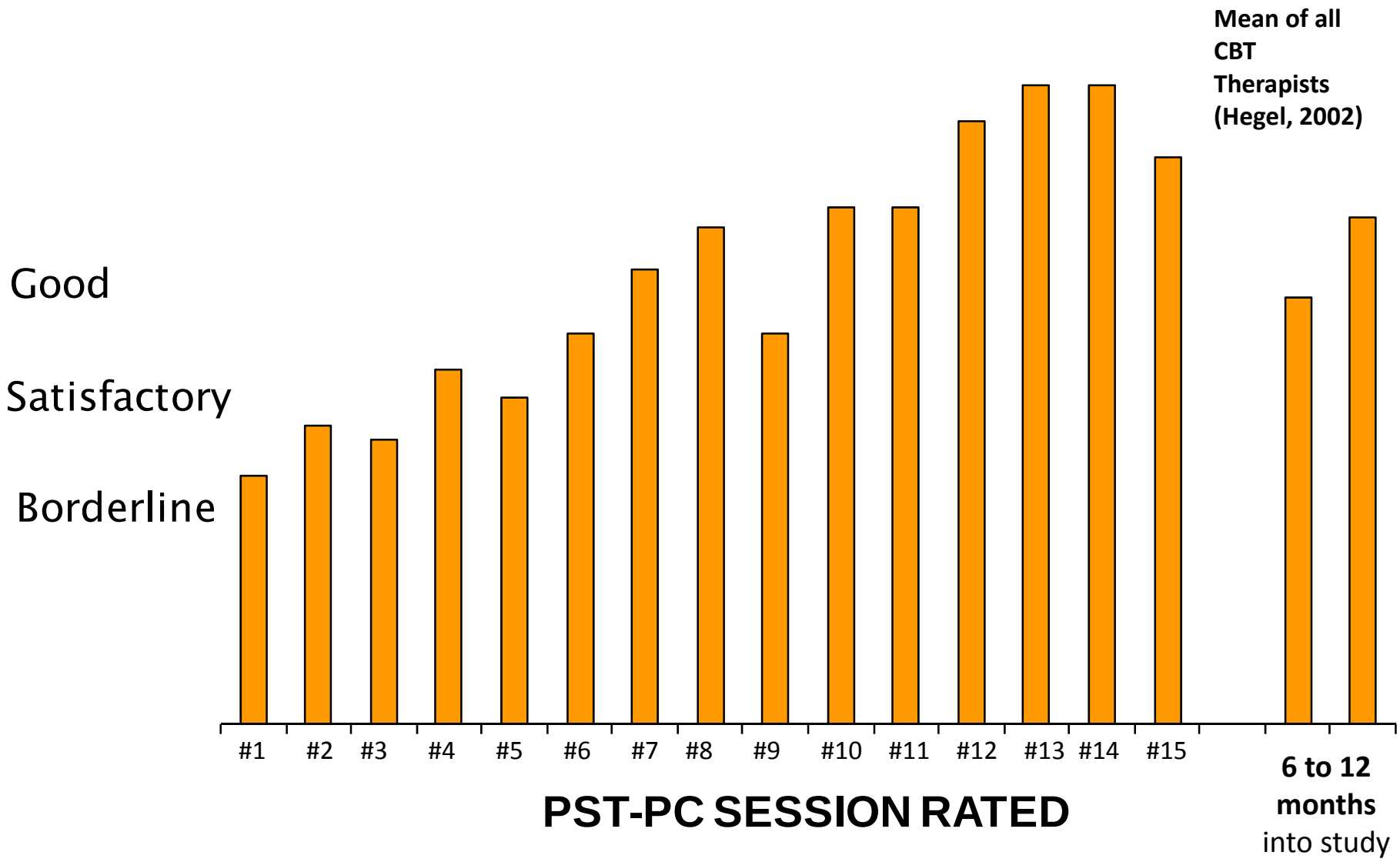
PST Case Supervision

Suggested Format:

- Tape record sessions / conference-call sessions
- Review and feedback before next session
- Case supervision with 1 – 3 patients, depending on prior experience with psychotherapy
- Known to be effective for honing skills

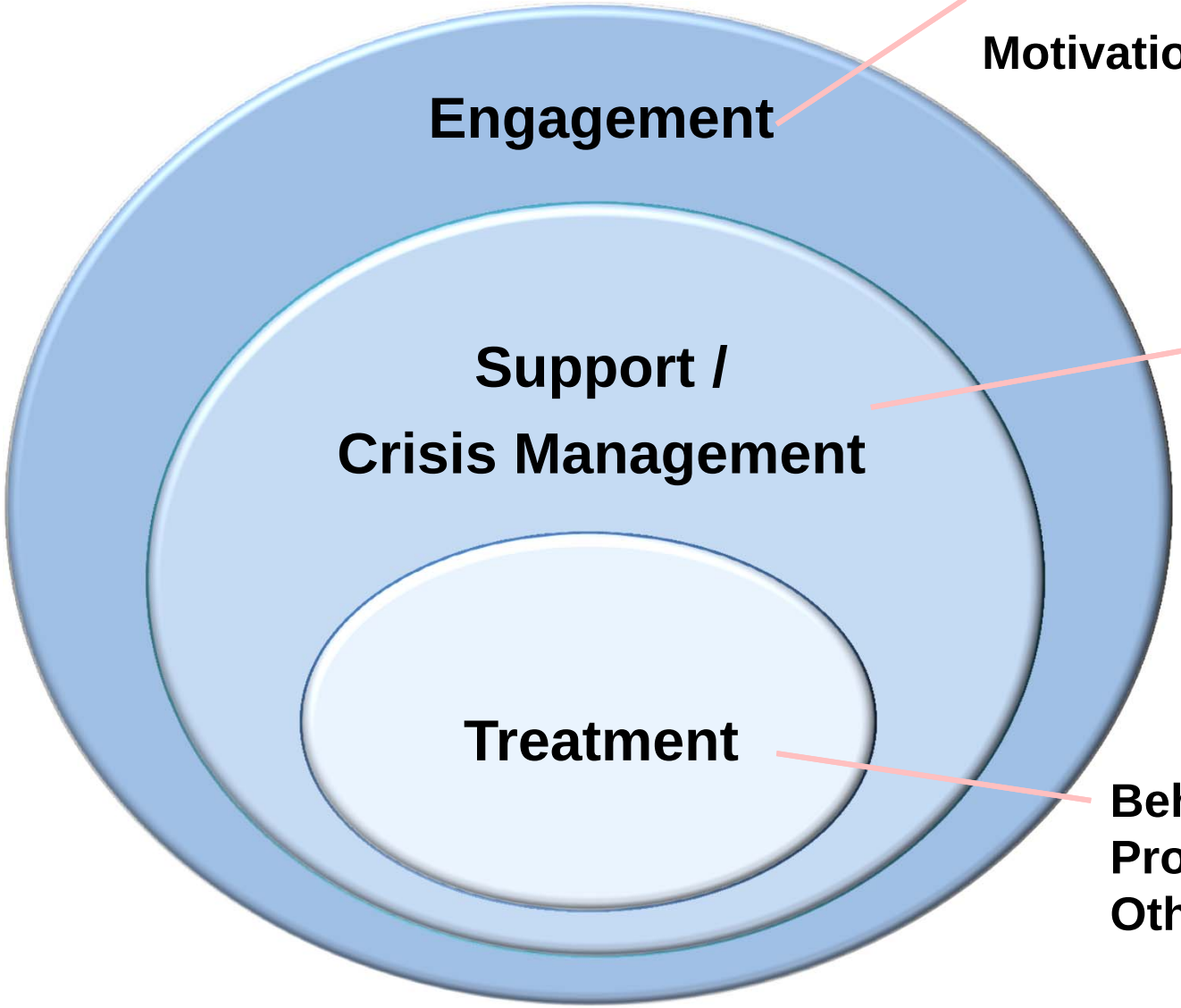
IMPACT Depression Care Managers

PST-PC Competency Rating on PST-PAC (range 0 to 50) Across Five Learning Cases (15 consecutively rated sessions)



“Toolbox” of Skills

Help BHP/CM Match Intervention with Patient Presentation



Health Behavior Change
Motivational Interviewing

Supportive Therapy
Distress Tolerance Skills

Behavioral Activation
Problem Solving therapy
Other Evidence-Based Therapy

Think Beyond Medications!

Behavioral Medicine
&
Brief Psychotherapy

Referrals
&
Community Resources

Disability

When to Suggest Referrals

Severe Mental Illness	• Patient needs case management • May need to have CM support getting higher level of support (SSDI)
Substance Use Disorders	• May need detox/inpatient treatment • May need other services; opiate replacement etc…
Social Services	• Housing, Food, Basic Needs • CM often is the best resource for these • Vary by community

Successful Referrals = Building community connections

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Assessing Disability

PCP Information: Assessing for Social Security Disability

Disability:

- A condition which results in a "marked and severe" functional limitation that will last 12 months or result in death

In other words

- The client's condition must cause such severe limitations that we can prove, with MD or PhD records, that this individual can't function in a workplace and/or the community.

PCP Information: Disability Considerations

Documented Medical Condition

- The condition must meet Social Security's definition of disability, as defined in the Blue Book listings
- What the condition prevents the client from doing
- Consider social and occupational functioning screener (SOFS)

Severe Functional Impairment

- Concentration, persistence, and pace
- Social functioning
- Activities of Daily Living (Personal Care)
- Periods of decompensation

Substance Use

- Is use a "contributing factor material to the determination of disability…"
- Would the client still be disabled if he/she stopped using drugs or alcohol

Treatment Compliance

- "Need to Follow Prescribed Treatment,"
- "If [the client] do[es] not follow the prescribed treatment …, [Social Security] will not find [the client] disabled or blind…"

Coaching PCPs to Document Disability: Example Handout

- **How can you help if you think that a patient needs disability?** You do not need to make this determination but your documentation of what you see and hear from the patient will likely determine the outcome.
- **Assess and document the functional impairment you see**
  - Document a MSE: " Pt presented with poor hygiene (clothes had food stains down the front and he smelled). Pt appeared to be responding to internal stimuli. Pt was agitated and unable to sit still with minimal eye contact. Pt speech was rapid. Pt thought process was loose and pt thought content was perseverating on government conspiracies. Denied overt AVH. Had IOR. Poor attention. Fair orientation. Limited insight and judgment."
  - Ask about ADLs and other functional impairments: Does the patient have trouble tracking? Are there transportation or other social issues? Are there hygiene issues? Is there a history of decompensation? (like missed appointments for severe agoraphobia etc…)
  - Social Occupational Functioning Scale (SOFS):
- **Carefully word treatment responses**
  - If pt has responded to a medication, document what changed and how functioning was affected.
    - " Pt reporting some improvement in his depression but continues to struggle to get out of bed for more than 2 hours at a time"
    - " Pt reporting some improvement in his psychosis as his AH is less intense but still cannot ride the bus due to paranoia"
    - Document treatment adherence: Pt must be trying to engage in treatment to qualify
- **Assess and document substance use/sobriety**

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Disability

Reflection Questions

Reflective Thinking

- How do I integrate behavioral recommendations into my treatment planning?
- How do I feel about assessing for disability as part of a treating team?

Adapt to Practice (including team building)

- Determine the skill level of team members to provide various behavioral interventions
- Develop a referral resource list
- Identify pathways for vocational rehabilitation in your community

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