Primary Care Consultation Psychiatry

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AIMS CENTER
Advancing Integrated Mental Health Solutions

Building on 25 years of Research and Practice in Integrated Mental Health Care
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

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td><strong>Clinical Leader</strong></td>
<td>• Shape behavioral healthcare for a defined population of patients in primary care</td>
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<tr>
<td><strong>Caseload Consultant</strong></td>
<td>• Consult indirectly through care team on a defined caseload of patients in primary care</td>
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<tr>
<td><strong>Direct Consultant</strong></td>
<td>• Consult directly by seeing selected patients</td>
</tr>
<tr>
<td><strong>Clinical Educator</strong></td>
<td>• Train BHPs and PCPs</td>
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<tr>
<td></td>
<td>• Both directly and indirectly</td>
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</table>
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
“This isn’t as easy as making a medication recommendation or writing a prescription!”
Think Beyond Medications!

- Behavioral Medicine & Brief Psychotherapy
- Referrals & Community Resources
- Disability
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
Overview of Sample Skills

- Motivational Interviewing
- Distress Tolerance
- Behavioral Activation
- Problem Solving Therapy
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
“Of course we can't make you do anything you don't want… But we’re all headed to Dodge City and we’d like you to join us.”

— MI cowboy

Cullum, L.
The New Yorker.
May 9, 2005.
Spirit of MI

**DO**

- **Draw out Motivation**
  “What would you 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

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**MI Roadmap**

1. Agree on a *target behavior* to talk about
2. Draw out client’s *story* about that target behavior
3. Ask for *change talk* and highlight it
4. Share *assessment results* relevant to target behavior
5. Explore *options* for changing target behavior
6. Try for a *commitment* to do something about target behavior
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

STATUS QUO = Stuck in Ambivalence

CONS (away from change)

PROS (toward change)
Assessment: Reflections Examples

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

- 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!

<table>
<thead>
<tr>
<th>Clients face many stressors</th>
<th>Clinicians face many stressors</th>
</tr>
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<tbody>
<tr>
<td>• Housing</td>
<td>• Large caseloads</td>
</tr>
<tr>
<td>• Money</td>
<td>• Difficult clients</td>
</tr>
<tr>
<td>• Drugs and alcohol</td>
<td>• Hearing many traumatic stories</td>
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<tr>
<td>• Dangerous neighborhoods or bus lines</td>
<td>• Inability to help their clients</td>
</tr>
<tr>
<td>• Trouble finding and keeping work</td>
<td>• Lack of time or resources to help their clients</td>
</tr>
<tr>
<td>• Long waits for social services</td>
<td>• Frustrating interactions with social services</td>
</tr>
<tr>
<td>• Medical problems and chronic pain</td>
<td>• Unhelpful rules or regulations</td>
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<td></td>
<td>• Paperwork</td>
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</table>

→ 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

Activities
Contributing
Comparisons
opposite Emotions
Pushing away
Thoughts
Sensations
Distracting with Sensations

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

This is **THE BEST** strategy to get unstuck when you are very distressed
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
Skills to accept pain and reduce suffering

- Imagery
- Meaning
- Prayer
- Relaxation
- One thing in the moment
- Vacation
- Encouragement

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Relaxation

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

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

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

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
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<tbody>
<tr>
<td><strong>Making it worse by:</strong></td>
<td></td>
</tr>
<tr>
<td>_______________</td>
<td></td>
</tr>
<tr>
<td><strong>Tolerating distress by:</strong></td>
<td></td>
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<tr>
<td>_______________</td>
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</tbody>
</table>
Scenario: 10pm Sun night and you found an eviction notice on your door

<table>
<thead>
<tr>
<th></th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making it worse by:</td>
<td>- get to relax</td>
<td>- won’t be able to function tomorrow when have to call guy back</td>
</tr>
<tr>
<td>getting drunk</td>
<td>- won’t have to think about it</td>
<td></td>
</tr>
<tr>
<td>Tolerating distress by:</td>
<td>- get some relaxation</td>
<td>- will be worried all night</td>
</tr>
<tr>
<td>self-soothing</td>
<td>- will be clear minded tomorrow</td>
<td>- probably won’t sleep</td>
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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:

Life Events

Less Rewarding Life

sad, tired, worthless, indifferent, etc.

- stay home
- stay in bed
- watch TV
- withdraw from social contacts
- ruminate, etc.

loss of friendships, conflict with supervisor at work, financial stress, poor health, etc.
Activity Scheduling

Feel Bad

Do Less

- 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
Typically we think of acting from the “inside → out” (e.g., we wait to feel motivated before completing tasks).

In BA, we ask people to act according to a plan or goal rather than a feeling or internal state.

Approach: Outside → In
**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.

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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

1. Problem Definition
2. Goal
3. Brainstorming
4. Pros and Cons
5. Choosing a Solution
6. Action Plan
7. Outcome Evaluation

UNIVERSE OF PROBLEMS
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
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)

PST-PC SESSION RATED

Mean of all CBT Therapists (Hegel, 2002)

6 to 12 months into study

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“Toolbox” of Skills

- Motivational Interviewing
- Distress Tolerance Skills
- Problem Solving Therapy
- Behavioral Activation
- Other Brief Therapies
Help BHP/CM Match Intervention with Patient Presentation

Engagement

Support / Crisis Management

Treatment

Health Behavior Change
Motivational Interviewing

Supportive Therapy
Distress Tolerance Skills

Behavioral Activation
Problem Solving therapy
Other Evidence-Based Therapy

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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

- Develop community resources list
- CM Contact & engage resources
- CM Follow-up with referrals
- Plan and support referrals
Think Beyond Medications!

- Behavioral Medicine & Brief Psychotherapy
- Referrals & Community Resources
- 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

1. **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)

2. **Severe Functional Impairment**
   - Concentration, persistence, and pace
   - Social functioning
   - Activities of Daily Living (Personal Care)
   - Periods of decompensation

3. **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

4. **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
Think Beyond Medications!

- Behavioral Medicine & Brief Psychotherapy
- Referrals & Community Resources
- 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
Motivational Interviewing:

Distress Tolerance:

Behavioral Activation:

Problem Solving Therapy:

Disability: