

Integrated Behavioral Health Care

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Learning Objectives

- By the end of this presentation, participants
 - Will know the meaning of the “Warm Handoff.”
 - Will be able to list the types of medical psychological conditions including substance abuse, that are the focus of attention by Behavioral Care Providers (BCPs).
 - Will be able to name several assessment tools useful in Primary Behavioral Health Care.
 - Will know the advantages of using outcome measures in primary behavioral care and be able to name one set of measures in the public domain.

Introduction

- A large number of people have psychological needs
- A disproportionate number of people present for services at a primary care medical offices and other medical services
- Many of these receive a prescription for antidepressants
 - Providers may have some training in the prescription of some psychotropic medications, but lack training in providing behavioral health services

Introduction (cont.)

- When a PCP decides to make a referral for specialty behavioral health care, only 30-40% of these follow through to see a professional in another office.
- On the other hand, if the referral is made to a Behavioral Care Provider (BCP) in the same office, the rate of follow-through increases to 70-80%
- Integrated behavioral health care is less costly. (Typical savings range between 20 and 40%, called the “medical cost offset.”)

What is Integrated Health Care?

- Integrated Health Care refers to the collaboration of health and behavioral health care professionals in the provision of health services.
 - A detailed treatment of this is beyond the scope of today's presentation.
 - Suffice it to say for now that there is a continuum of integration ranging from:
 - Two providers in different locations communicating about a mutual patient (coordinated care model). (Hunter et al. 2009)
 - In the middle there is on-site collaboration (co-located care model and care management model)
 - At the other end, there is a fully integrated team of people who share one medical record per patient, and who work together following a combined treatment plan (integrated care model)

Introduction to Integrated Health Care

- For purposes of this presentation, we will be discussing a fully integrated health care team that includes a primary care physician or provider (PCP) and a behavioral care provider (BCP), in what is becoming known as a “medical home.”
 - Other team members may include:
 - A nurse practitioner or physician’s assistant,
 - A dietician,
 - A pharmacist
 - Other allied health care providers.
- Also for purposes of this presentation, we are not going to discuss services to children and families.

The Warm Hand-Off

- When a PCP identifies a patient who could benefit from a referral to a BCP, he/she initiates the contact by bringing in and introducing the BCP.
 - The patients are referred to the BCP by the PCP in what is called a “hand-off.”
 - <http://www.youtube.com/user/sierrafamilymedical>
 - (Dr. Peter Van Houten and Ms. Jennifer Sayle, Sierra Family Health Center)
 - As you can see there are several components to this.
 - And you can see that the structure is similar across presenting issues.

BCP's Role

- After the “Warm Handoff,” the BCP initiates services
- He/she can follow a model that was developed by Hunter et al.(2009)
 - It's called the five A's:
 - Assess
 - Advise
 - Agree
 - Assist
 - Arrange

The Role of the BCP

- At that point, the BCP works with the patient for about 20-30 minutes, following the Five As
- The BCP then has a “Hallway Conversation” with the PCP about the results of the assessment and the proposed treatment plan.
- The BCP has several choices for disposition:
 - Re-schedule the patient for one or more 20-25 min. follow up visits.
 - Refer the patient out to a specialty care provider in the community.
 - Refer the patient to an in-house psycho-educational group.
 - And, of course, he/she can refer the patient back to the PCP for follow up with medical treatment.

The Hallway Conversation

- If you look at an initial session in an integrated health care setting you can see that there are two bookends, to use a metaphor.
 - One bookend is the Warm Hand-Off.
 - The other bookend is the Hallway Conversation.
- The Hallway Conversation, for lack of a better term (in fact it should not occur in the hallway, but often does), is when the BCP reconnects with the PCP or referring agent, communicates the result of the assessment and discusses a recommended treatment plan. (This meeting is crucial; leaving notes in a chart is not helpful)

Medical Culture

- It is important to learn about the culture of medical practice
 - Necessary to learn the language; hence, study medical pathophysiology
 - Necessary to learn values
 - In a medical setting, people take care of each other's health
 - So they may ask you to do the same
 - You can't refuse, but you also need to set good boundaries
 - Necessary to learn the style
 - Oral communication preferred over written communication
 - Prompt, timely communication
 - Time is of the essence; hence the 50 min. hour becomes the 25 min half-hour
 - Clear-cut, concrete suggestions or treatment plan

The Biodyne Model

As we will see later, the BCP's job during the initial session following the Biodyne Model, is more complex than would appear in this description.

- The Biodyne Model refers to both,
 - A model for integrated care, (O'Donahue, Cummings, Cucciare, Runyan & Cummings, 2006) and
 - A psychotherapy model

The Role of the BCP

- As a psychotherapy approach, the Biodyne Model refers to method of conducting therapy using techniques meant to facilitate a rapid connection with the client and the identification of issues that have implications for how to approach treatment.
 - This method is referred to as Focused Psychotherapy Throughout the Life Cycle
 - The basic information appears in the book *Focused Psychotherapy: A Casebook of Brief, Intermittent Psychotherapy Throughout the Life Cycle* by Nick Cummings, Ph.D., Sc.D. and Mike Sayama, Ph.D.

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The Biodyne Model: Introduction

- “Focused Psychotherapy” refers to the fact that the approach is designed to work on one issue or one set of related issues at a time.
- “Brief” refers to the fact that psychotherapy should be efficient as well as focused, and is generally brief.
- “Throughout the life cycle” is used to emphasize the similarity with primary health care. A patient comes in to see a PCP with a specific set of symptoms, receives the applicable treatment, returns for follow up one or more times, and is then discharged. The patient is likely to return again at a later date with a different presenting problem. The approach of the Biodyne Model is similar.

The Biodyne Model Introduction, cont.

- In this approach to psychotherapy, anxiety is considered “the fundamental psychological problem.”
 - When our defenses (or coping abilities) have been breached, we experience anxiety and feel threatened.
 - As we feel threatened, we regress to earlier methods of coping that were ingrained at a young age (the repetition compulsion).
 - That method of coping was a solution at that time, but at a later age, it becomes the problem instead of the solution.

Structuring the Initial Session

- Structuring the episode:
 - Who's presenting?
 - Why now?
 - What for?
 - How?
 - Answering these questions will allow the therapist to structure the episode of care,
 - Connect quickly with the client,
 - And avoid pitfalls that derail treatment.

The Biodyne Model, cont.

- 1) Who's presenting?
 - There are two broad categories that are very useful in distinguishing the type of person presenting for treatment. Defense mechanisms can be divided into two kinds:
 - Onion
 - Garlic
 - This is a metaphor based on what happens when a person eats foods containing a lot of one or the other of these ingredients.
 - The general therapeutic axiom: TREAT GARLIC BEFORE ONION.
 - Guilt is the salient characteristic of the onion person, while
 - Denial is at the core of the garlic dynamic
 - You cannot treat a person who is in denial by working on their guilt issues

Garlic vs. Onion, cont.

- Many well-intentioned therapists fall into the trap of treating a garlic person as if he/she were onion. This can go on for a long time, and very little change will take place.
 - Persons with a garlic presentation will often disguise themselves as onion. If the therapist is not astute, he or she will continue to follow the lead of the client and fall right into a trap.
 - For example, the addict who presents wanting to work on his depression.
 - Or the borderline who complains of extreme anxiety as well as depression.
- Many people have some of both, but if you get taken by the one, you're likely to miss the other.
- Empathizing with the person while identifying what is really going on, is often the key to connecting with the garlic person.

Why Now

- Why now? (or the Operational Diagnosis).
 - Identifying the Why Now along with the Implicit Contract, will permit a more accurate understanding of the problem and facilitate rapid progress.
 - The Operational Diagnosis tells you why the person is here now instead of last week, a month ago or even a year ago.
 - When you ask “What brings you in for treatment now?” people will give you many different answers; however, most of them will not be the Why Now.
 - The Operational Diagnosis is very helpful in assessing the degree of and the basis for the motivation of the patient.

Implicit Contract

- 3) Implicit Contract:
 - Just as helpful as knowing the Why Now in assessing the motivation of the client, is knowing the Implicit Contract.
 - In group dynamics, we would call this the Hidden Agenda.
 - It is important to deal with the Implicit Contract for the same reason it is important to deal with the Hidden Agenda: Nothing is going to get done, unless you take it into account.
 - Examples:
 - The person who says that he wants to stop drinking, but he doesn't really (he was told by his wife to get therapy or else...)
 - The woman who wants to bring her children for you to see them in order to reassure her that they are not being harmed by her divorce (when she is planning to try to get sole custody).

The Implicit Contract

- The Implicit Contract is often fantasy-laden or what Freud called “primary process” thinking.
- If the Implicit Contract is shared at all (or “implied” is another adjective), it is often shared in a very casual way.
 - By definition, it is not stated explicitly.
 - It often has the tone of a teaser in the form of a half-expressed thought.
 - Sometimes it’s mentioned casually, as an after-thought.
 - At other times it comes at the end of the session (“door knobbing”)
 - But it could just as easily be brought up at the beginning
 - If by the end of the session, you haven’t heard it, it is important that you try to figure it out and/or you take a guess at it.
 - Sometimes you get what Adler called “the recognition reflex:” a very slight non-verbal gesture indicating a reaction.

The Implicit Contract, cont.

- Sometimes you want to confront it directly, but at other times, especially when it signifies “resistance” you don’t want to confront it immediately.
 - With garlic people, confronting it is not very useful because it leads to denial.
 - Not taking account of the Implicit Contract almost always will result in prolonging therapy.
- The more that you can use the client’s own words in discussing the Implicit Contract, the greater the chance that you will get the “Recognition Reflex.”

The Ideal First Session

- The Ideal First Session:
 1. **Hit the ground running.** The first session has to be therapeutic. Believing that the first session has to be devoted to collecting data is to waste precious time. A skillful therapist elicits information and makes appropriate interventions in a smooth fashion.
 2. **Perform an operational diagnosis (Why Now).** The operational diagnosis is absolutely essential before formulating a treatment plan.
 3. **Elicit the implicit contract.** Know the difference between the explicit contract, the reason the client gives for being there; and the implicit contract which is the real reason for his/her being there.

The Ideal First Session, cont.

4. Formulate the therapeutic contract and incorporate the treatment plan.

- Without a mutually agreed upon plan, the therapy cannot progress. If by the end of the first session the therapist does not know the operational diagnosis or the implicit contract, then a treatment plan should not be formulated.
- If by the next session, the therapist realizes that the original operational diagnosis or implicit contract was wrong, then s/he has to revise the treatment plan.

5. Create a therapeutic contract. “I shall never abandon you as long as you need me...”

6. Create running hypotheses in your mind as to what the client is doing, saying or wanting, but always be ready to revise these as you obtain more information.

The Ideal First Session, cont.

- 7. Do something novel.** Find something novel or unexpected to do. This tends to dispel the notion that this is traditional long-term therapy if the person has had that experience before.
- 8. Give hope in the first session.** Reassurance has limited value; instead, aim to achieve a small therapeutic gain, or if not, share a successful story of a client with a similar problem. Maximize the probability that the person can identify with the example.

The Ideal First Session, cont.

9. **Be honest without being blaming.** Most often, clients have had difficult lives and made mistakes. They will often bring this up to test whether or not the therapist is going to be judgmental. Therapists often fall into the trap of not commenting on these in order to avoid being perceived as judgmental. But you have to be honest without being judgmental.
10. **Give homework in the first session and every session thereafter.** We have already covered the importance of homework and how to approach this task.

Additional Concepts

- Two more concepts are important:
 1. Change behavior first, not feelings or attitudes.
 2. Do not strong-arm the resistance

Specific Presenting Problems

- Introduction:
 - There are many behavioral problems that present in primary care.
 - Primary care physicians feel very comfortable treating some of them (depression and anxiety)
 - They don't feel very confident about treating others.
 - Highest among these are alcohol misuse
 - They often miss the diagnosis, and when they do recognize it, they don't know what to do (Friedman, McCullough, Chin & Saitz, 2000)
 - » More often than not, they refer to AA or another 12-step program
 - We will discuss intervention for alcohol misuse later.

Presenting Problems

- Depression
 - One of the most common presenting problem: 10-30% of patients seen in primary care have significant depressive symptoms
 - Unfortunately, PCPs do not recognize depression in roughly 67% of their patients
 - Assess:
 - PHQ-9 and PHQ-2
 - The PHQ-9 is available without cost and can be retrieved from:
 - www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9
 - This website is currently not available, but may be soon, as it has to do with the domain name

Depression, cont.

- The PHQ-2 has very good psychometric properties and is easily administered:
 - “Over the last 2 weeks, how often have you been bothered by any of the following:
 - » Little interest or pleasure in doing things?
 - Not at all (0)
 - Several days (1)
 - More than half the days (2)
 - Nearly every day (3)
 - » Feeling down, depressed or hopeless?”
 - » A cutoff of 3 points has reliability that is comparable to other longer instruments.

Depression, cont.

- You should conduct a functional assessment, to include a suicide risk assessment and rule out substance misuse disorders
- Advise: Review all of the information gathered and discuss a treatment plan
- Agree: Obtain agreement
- Assist: Most of the approaches developed for specialty care are applicable in primary care. These include CBT, Activation Therapy, Problem-Solving and Assertiveness training.

Anxiety

- An estimated 20% of patients in primary care clinics meet the criteria for one of the anxiety disorder diagnoses.
- Assess:
 - The Generalized Anxiety Disorder-7 (GAD-7), and the Generalized Anxiety Disorder-2 (GAD-2) both have excellent specificity and sensitivity with cut-off scores of 7 and 3 points, respectively

GAD-2

- GAD-2: “Over the last 2 weeks, how often have you been bothered by any of the following problems:
 - Feeling anxious, nervous or on-edge,
 - Not being able to stop or control worrying.”
 - Same rating scale as the PHQ-9 (Not at all, Several days, More than half the days, Nearly every day)
 - Website: <http://scopecme.org/resources/tools/GAD7.pdf>
 - R/O BPDs and addicts or substance abusers
 - If complaining of panic disorder, be sure to assess for agoraphobia

Anxiety, cont.

- Advise:
 - Explain that the recommended treatment requires learning skills, and committing to practicing them
 - The majority of the people who follow such a treatment plan show significant improvement
- Agree:
 - Goal is not to eliminate anxiety, but rather to learn methods for accepting and managing their feelings.

Assist

- Assist:
 - Methods adapted from specialty care are very successful. These include relaxation training, psychoeducation, worry logs, worry time. However, it is essential to learn to think differently about one's worries.
 - Therefore, CBT or REBT and especially Thought Disputation are very useful
 - Systematic desensitization essential in cases of agoraphobia or social phobia

Arrange

- Arrange:
 - Relief is usually prompt for people who follow the plan
 - Follow up appointments are usually necessary to cover all of the necessary skills and to make sure people are practicing
 - Medications are often helpful, but only in the beginning
 - SSRIs are often prescribed
 - Benzodiazepines less so
 - Antihistamines and antihypertensives are also good possibilities

Alcohol Misuse

- Approximately 30% of adults in the U.S. drink at elevated levels (Hunter et al, 2009)
 - 4-29% are risky drinkers
 - 0.3-10% are harmful drinkers
- Brief, multiple contact interventions, significantly reduced risky and harmful alcohol use (Whitlock, Polen, Green, Orleans and Klein, 2004)
 - 10-19% more of the intervention participants achieved recommended drinking levels in comparison with the control group
 - 13-34% also had greater reduction in comparison with the control group

The Five As:

- Assess
 - Screening: NIAAA (2005) recommends two questions:
 - “Do you sometimes drink beer, wine or other alcoholic beverages?”
 - If yes, then ask: “How many times in the past year have you had five or more drinks in a day (for men) four or more drinks in a day(for women)”
 - If once or more, then ask: “On average, how many days a week do you have alcoholic drinks? On a typical day, how many drinks do you have?” From here conduct further assessment:

Assess, cont.

- Alcohol Use Disorders Identification Test (AUDIT) or the shorter AUDIT-C (there are Spanish language versions of these)
 - » <http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/selfreport.htm>
- Other possibilities include the SOCRATES 7A, which has a Spanish language version (CASAA)
 - » <http://casaa.unm.edu/>
- or the MAST
 - » <http://www.ssw.umich.edu/public/currentProjects/icwtp/substanceAbuse/MAST.pdf>

Advise

- The goal of this step is to inform individuals that their level of drinking involves increased risk of medical problems, and to show them how their rate of drinking compares with other people in the U.S.
- Based on drinking limits: 4 per day for men, 3 for women and 14 per week for men and 7 per week for women:
 - Never exceed the daily limit: 72% (1/3 never drink or drink fewer than 12 drinks a year)
 - Exceed only the daily limit: 16% (More than 8/10 in this group exceed the daily limit less than once a week)
 - Exceed both daily and weekly limits: 10% (8/10 exceed the daily limit once a week or more)

Resource

- For a very complete clinician's guide:
 - <http://pubs.niaaa.nih.gov/publications/practitioner/cliniciansguide2005/guide.pdf>
 - Can be downloaded for free as a PDF
 - Or you can order it for a nominal fee

Advise and Assist

- Advise:
 - Those who are ready offer options:
 - Reduce the number of drinks consumed (following NIAAA guidelines)
 - Abstain from drinking for a particular period of time
- Agree: Obtain agreement for one of the goals
- Assist:
 - Reducing alcohol consumption:
 - Educate about standard drinks, concentrating on the drink the patient typically consumes
 - Determine goals (recommendation no more than 2 for men and no more than 1 for women)

Assist, cont.

- Keep track of number of drinks consumed
- Review ways to pace drinking
- Goal of abstinence
 - Make it temporary
 - Review ways to manage or avoid situations
 - Review assertive communication skills
 - Review stress and management techniques

Arrange

- For either group, drink reduction and total abstinence
 - Set up a follow up meeting
 - Adherence to plan?
 - Then assist in maintaining the plan
 - Discuss possible upcoming events or situations that the patient may have learned about since the last visit
 - Did not meet goal?
 - Then encourage them to learn from the experience
 - Explain that change can be difficult
 - Encourage and support any change that was made
 - Trouble shoot any past problems
 - Reassess and renegotiate

Arrange: Use of Medications

- Depending on the situation, you may want to refer back to the PCP for medications
- Possibilities include:
 - ReVia (naltrexone)
 - Camprol (acamprosate)
 - Antabuse (desulfiram)

Other Presenting Problems

- In addition to depression, anxiety, and alcohol misuse, we also intervene with:
 - Insomnia
 - Health behaviors (tobacco use, overeating, physical inactivity)
 - Diabetes
 - Irritable Bowel Syndrome (IBS)
 - Chronic Obstructive Pulmonary Disease (COPD) and Asthma
 - Cardiovascular Disease
 - Pain disorders
 - Prescription Medication Misuse
 - Sexual Dysfunction

Outcome Measures

- Our recommendation for outcome measures is the combination of Outcome Rating and Session Rating Scales
 - These consist of four items each with a continuous line as a rating scale, spanning from least (left) to most (right)
 - Available at no cost provided you agree not to sell them or use them for monetary gain:
 - <http://scottdmiller.com/?q=node/6>
 - it is especially powerful when used through the website: <https://myoutcomes.com>, which has a very low subscription fee
 - there is also an unlimited use program, which is Excel-based

Advantages

- As a program and as an individual, we have a strong commitment to data-driven therapy and client-centered evaluation methods
 - Decreases drop out rates
 - Increases successful terminations
 - Increases overall patient satisfaction
 - Increases effectiveness of therapy

Advantages, cont.

- The ORS/SRS combination:
 - Quick and easy to administer and score
 - Valid and reliable
 - Age-appropriate versions for adults and children
 - Available in Spanish for both adult and child versions
 - It's free!
 - There are ways to aggregate results
 - There is an increasing global community available for consultation
 - Join the International Center for Clinical Excellence:
<http://www.centerforclinicaexcellence.com/>
- It's free!

Outcome Rating Scale (ORS)

- ORS Subscales: “During the past week, including today...how well have you been doing in the following areas of your life:
 - Individually
 - Interpersonally
 - Socially
 - Overall”
- Cut off: 24 points

Session Rating Scale (SRS)

- Subscales: “Please rate today's session by placing a mark on the line nearest to the description that best fits your experience:
 - Relationship (heard, understood and respected)
 - Goals and Topics (worked and talked about what I wanted to work on and talk about)
 - Approach or Method (The therapist’s approach was a good fit for me)
 - Overall (There was something missing/Session was right for me)
- Cutoff: 36 pts.

Questions

- Other questions???
- Discussion???

Conclusion

- We showed how to do a “Warm Handoff.”
- We listed the types of medical psychological conditions including substance abuse, that are the focus of attention by Behavioral Care Providers (BCPs).
- We reviewed the Biodyne Model and its place in primary care services
- We reviewed several assessment tools useful in Primary Behavioral Health Care.
- We covered the advantages of using outcome measures in primary behavioral care and all of which are available in the public domain.

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