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DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
Michael Kennedy, MFT – Division Director

Mental Health Review For Primary Care Providers: Part II

May 17, 2016

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Thankyous!

- **Special Thanks to Redwood Community Health Coalition for hosting this training series and taking a leading role in helping to integrate mental health services in primary care programs throughout the North Bay.**
- Specific Thanks to **Mary Maddox-Gonzalez**, **Suzie Shupe**, **Teresa Tillman**, and **Colleen Petersen** from **RCHC**.
- Special Thanks to **Megan Burns**, **Carlos Mariscal**, **Melissa Ladrech, Rebecca Lankford, Dave Sheaves, Susan Castillo and Mike Kennedy** from **Sonoma County Behavioral Health**.
- Special thanks also to **Maryellen Curran** from **Santa Rosa Community Health Centers** for helping to design and prepare our training today.

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Introductions

- Maryellen Curran PhD, Director, Integrated Behavioral and Mental Health Services, Santa Rosa Community Health Centers.
  - Dr. Curran is a clinical psychologist and program director who has pioneered behavioral health integration at SRCHC. In her own clinical practice, she specializes in the treatment of anxiety and trauma-based conditions. Prior to joining SRCHC, she served as the Chief of Adult Psychiatry for Kaiser Permanente in Santa Rosa
- Megan Burns MD, Staff Psychiatrist, Youth and Family Program, Sonoma County Behavioral Health
  - Dr. Burns is a Board Certified Child Psychiatrist who has worked in the Youth and Family Program at Sonoma County Behavioral Health. In her clinical practice, she specializes in the care of foster youth, and has spearheaded an effort to oversee psychiatric services for all foster youth in the county.
- Michael Kozart MD PhD, Medical Director, Sonoma County Behavioral Health
  - Dr. Kozart is Board Certified general psychiatrist. Prior to becoming the Medical Director for SCBH, he worked as the medical director for the Brookwood Health Center, developing integrated primary care programs and outreach to the homeless.

Welcome

- This is the Second of a two-part training series aimed at Primary Care Providers. The purpose is to review and enhance basic clinical skills in the delivery of mental healthcare in community health centers.
- The first training (**April 7th**) generally focused on **Evaluation**, and today's training (**May 17th**) will be more focused on **Treatment**.
  - In truth, it is impossible to fully untangle evaluation from treatment. How we choose to 'evaluate' a mental health condition clearly relates to how we choose 'treat it,' and vice versa—as we shall soon see!

General Terminology

- Patients=Clients=Consumers=Individuals=Folks=People=Humans
- MH/BH Providers=MH/BHSpecialists
  - Psychiatric vs. Mental Health/Behavioral Health.
- Psychiatric Providers
  - Psychiatrist=PMHNP, Psychiatric PA
  - Therapist=Counselor=BH Clinician
- Psychotropic=Psychiatric Medication=Psychoactive Medication
- Adjectives
  - mental health=behavioral health
    - Psychiatric refers to the subset of MH services that involve medical intervention
- PES (Psychiatric Emergency Services) now is CSU (Crisis Stabilization Unit), Sonoma County Behavior Health Urgent Care Center at the Lakes

General Terminology

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Why are we doing this training?

- Mental Illness is an extremely important and yet complex area of Primary Care Medicine
  - Approximately **25%** of all primary care outpatients carry a psychiatric dx. (Katon, 2013)
  - Over **50%** of U.S. patients receive their MH care exclusively in the primary care setting (Tesar, 2010).
- Nationwide, PCPs are the **'de facto psychiatrist'**.
- Even in health centers with robust, specialized mental health programs, PCPs are often responsible for:
    - The initial psychiatric diagnosis
    - Initiating and managing ongoing psychotropic prescriptions
    - The decision when/if to refer to a mental health specialist
    - Front line crisis management

Why are we doing this training?

- “The battle for connecting the mind and the body is seen every day in the largest platform of health care delivery: primary care. More care for mental health, behavioral health, and substance use is provided in primary care than any other health care setting.” (Miller, 2011).

Please ask questions

We have a lot of material to cover, but don't let that stand in the way of asking questions as we go through topics. If we need to skip over sections because of time constraints, we'll *improvise*.

April 7th: Brief Recap

- We discussed the conceptual foundations of Modern Psychiatry. We reviewed two broad frameworks by which mental illness has come to be defined.

First

- The **Static Framework**: Offers a snap-shot view of mental illness. We get a read of a clinical condition at a point in time. Mental illness is targeted either as a named disorder (the **Categorical Approach**), or as a quantitative measurement on a rating scale (the **Dimensional Approach**).
  - Example--Depression: 'Major Depression' (Categorical), or 'Greater than 11 on the PHQ-9' (Dimensional).

April 7th: Brief Recap (cont.)

The Categorical Approach in detail:

- The naming of mental illness in the **Categorical Approach** involves **Diagnostic Categories** that include specifically defined symptoms (Whitney 2010). Diagnosis becomes a process of **checking-off** symptoms: as soon as you meet the criteria for a certain number of symptoms, you make a diagnosis.
- The **Categorical Approach** is the reigning paradigm in current-day Psychiatry. It constitutes the bulk of the **DSM (Section II).** It also forms the backbone of our current billing and diagnostic coding system under **CMS** (Center for Medicaid and Medicare). On an everyday basis, it is what we're most familiar with in **FQHCs**.
- It is comprehensively linked to the **ICD**.

April 7th: Brief Recap (cont.)

The Dimensional Approach in detail:

- Symptoms are **Measured**, and illness is defined when a certain numerical value is met. In this way, all symptoms are arrayed on a **Continuum with Normal** (Thompson 2001). The **PHQ-9** is one well-known example (Whitney 2009).
- It allows for the fact that similar symptoms can **cross-cut** multiple diagnoses. It also allows for the description of **sub-syndromal symptoms** —meaning symptoms that impact on general health, but which do not meet the **intensity-threshold** of a primary psychiatric disorder (Kupfer 2013).
- The Dimensional Approach is the up-and-coming paradigm in psychiatry. It is seen as more humanistic, less stigmatizing: it captures a broader swath of experience than the categorical approach
  - E.g. Personality can be sub-typed around **profiles** rather than **disorders**.
- It factors into the CMS, EHR Incentives Program for MU.
- It constitutes **Section III of the DSM 5** and is likely to play a much greater role in all future editions of the DSM.

April 7th: Brief Recap (cont.)

- **Categorical/Dimensional Approaches and the Medical Model**
  - Both the **categorical and dimensional** approaches deal with mental illness as a static thing that can be named and/or measured, differentiated from normal, correlated with biological findings, and targeted for specific treatment.
    - Highly complementary with the **Medical/Medication Oriented** approach to mental illness. (Shah 2007)
    - Highly expedient for communication, whether that be for consultation, QI/QA, or billing purposes.
    - Yet, these two approaches factor out much of what we might call the 'individual perspective,' i.e., the patient's own way of thinking, feeling and behaving. *Why is this **so** important?*

April 7th: Brief Recap (cont.)

Because:

- **Mental Illness is all about Life Experience**
  - Regardless of the diagnosis, or the symptoms, mental illness is fundamentally about consciousness and awareness, which is shaped by an individual's unique biography, and molded by that person's unique and evolving situation in the world.
- **In order to effectively treat mental illness, we need to grasp the person's unique state of mind, and engage him/her in meaningful talk that reflects personal life experience, including past trauma.**
  - In general, it is hardly enough to simply prescribe meds.
- **We need to be careful that we don't overly pathologize states of mental distress. These states lie on a continuum with normal.**
  - We need to find a way to talk about the issues of mental illness without always slipping into the terminology of 'pathology' or 'disorder', which is certainly a feature of the categorical approach, and often as well of the dimensional approach.

April 7th: Brief Recap (cont.)

This brings us to our **Second** Approach to Defining Mental Illness: **The Dynamic/Cognitive Approach**

- The **Dynamic Framework**: Offers a view of mental illness as a flow of experience. Mental Illness is not a **'thing'** but rather a **'process'** whose significance is played out in how we think, feel, and act each moment of the day. It involves an analysis of the interplay of thoughts, feelings, and actions in the context of memory/experience, environmental stressors, and medical health.
    - Example--Depression: 'Recent relationship breakup triggered memories of abandonment as a child, leading to social withdrawal.'
- The Dynamic Framework usually involves some sort of **Cognitive Model**: a roadmap to connect thoughts, feelings and actions, and to correlate all this with other psychological processes, like the unconscious, or past history (e.g. Trauma).

April 7th: Brief Recap (cont.)

The Dynamic/Cognitive Model Approach

Used to be the dominant paradigm in Psychiatry.

- Freudian dynamic psychology, for example, was the foundation for DSM I (1952).
- All disorders were hypothesized in the context of theories about how the mind works. The DSM was more a textbook of psychology than a list of symptoms and disorders.

April 7th: Brief Recap (cont.)

- Due to increasing rancor between competing schools of **dynamic/cognitive psychology**, the field of psychiatry was unable to converge around any unified theory of the mind, and thus the dynamic/cognitive approach was all but abandoned by the DSM III (1980), leaving in its wake the 'theoretically neutral' albeit static **Categorical Approach**. Not surprisingly, this has coincided with the rise of the medical model, and the use of medications, in psychiatry.
  - But medications often fall far short of the mark, especially for the most common MH conditions such as mood and anxiety disorders, personality disorders, and PTSD.
  - This has led to a renewed interest in how to revive a dynamic/cognitive approach in psychiatry.

April 7th: Brief Recap (cont.)

Current Status of Dynamic/Cognitive Approaches in Mainstream Psychiatry

- **DBT** (Dialectical Behavioral Therapy), **CT** (Cognitive Therapy), **CBT** (Cognitive Behavioral Therapy), **ACT** (Acceptance and Commitment Therapy)
  - We will be discussing DBT in depth later one today.
- None of these techniques preclude the use of meds—in fact, considerable literature demonstrates that the combination of counseling and meds is superior to the use of either modality alone
- Also, there is nothing contradictory about utilizing both medical and psychological formulations in diagnosis.
  - There is a biological basis to everything psychological

April 7th: Brief Recap (cont.)

Practice Implications for PCPs

- **One of our training objectives on April 7 was to discuss how PCPs can incorporate dynamic/cognitive approaches in their busy practice.**
- Many PCPs surveyed do not feel comfortable formulating psychological assessments or engaging in talk therapy, even though there are **evidence based modules** for PCP-based counseling psychology (e.g., the '15 Minute Hour').
- We discussed a simple, and universally applicable, dynamic/cognitive approach that can be conveniently incorporated into the PCP visit. This involves something called the **Cognitive Behavioral Model (CBM).**

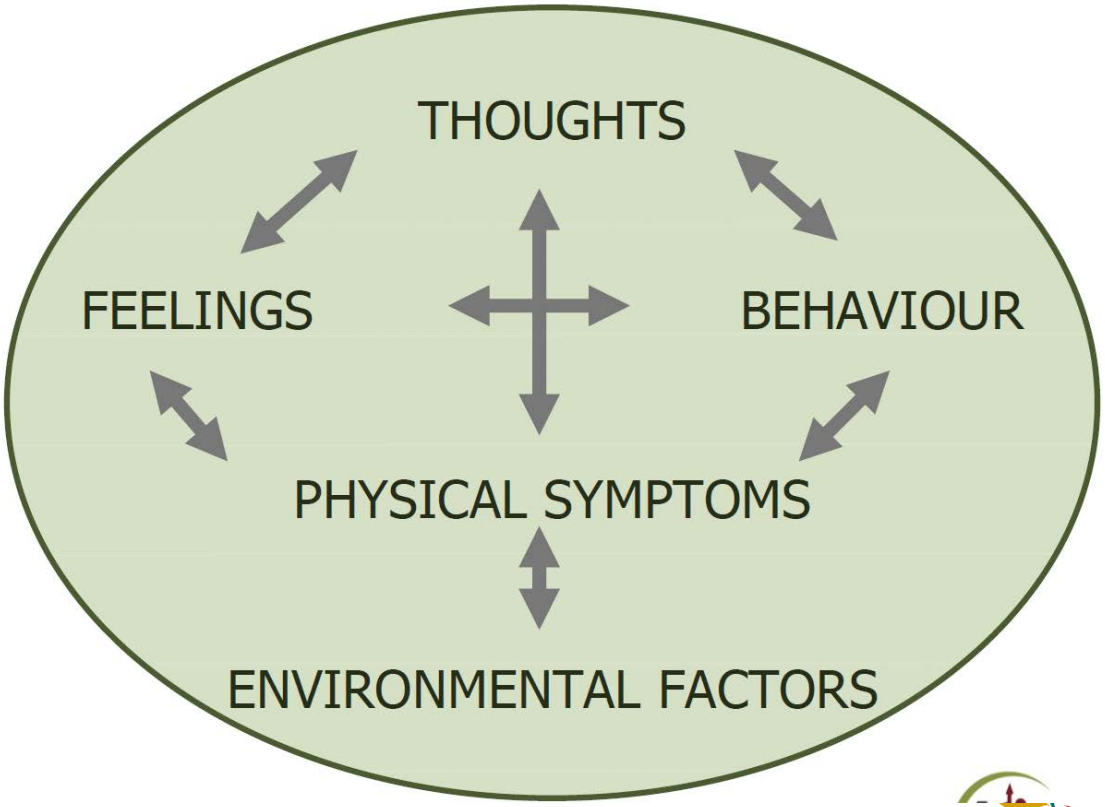
April 7th: Brief Recap (cont.)

Cognitive Behavioral Model (CBM)

- A primary action of one mental process leads to a reaction of the other
- All thoughts, feelings, physical symptoms and behaviors are interconnected, and all these interconnections have an impact on the environment, and vice versa.

April 7th: Brief Recap (cont.)

The Five Areas of the Cognitive Behavioral Model (CBM)



April 7th: Brief Recap (cont.)

CBM in Practice:

- **Starting with thoughts, let's consider those that have to do with our very own states of mind. We might call these thoughts, *self-reflections.***
  - Self reflections are ubiquitous, but they are particularly salient when we find ourselves in a state of mental distress. *Why?*
  - Because we're drawn to focus on, and in fact to be preoccupied with, personal distress, regardless of where it occurs (body or mind). There's probably an evolutionary/survival reason for this.
  - So when we are in a state of mental crisis, we are naturally drawn to think about ramifications: how serious is the crisis, and what does it bode for the future?
  - The point is that, depending on their nature, these self-reflections can either ameliorate or worsen the primary mental state. In fact these thoughts play a key role in the progression of all forms of mental illness.

April 7th: Brief Recap (cont.)

Consider Depression

What happens when I reflect on being depressed?

The 'Negative' option

Thought: "If I am this sad, hopeless, gloomy, lethargic, unmotivated, uninterested, unrested, then I will never:

- Be accepted by my peers
- Establish a relationship
- Enjoy my life
- Be promoted at work
- Be admired
- Live the life that I always wanted to live…

The consequence in the CBM model: Feelings, Behaviors, Physical Symptoms, which ultimately impacts on how we function in the world

April 7th: Brief Recap (cont.)

For example: how thoughts influence feelings, behaviors and physical symptoms, and these feelings, behaviors and physical symptoms influence thoughts:

Feeling:

- Ever more sad, hopeless, overwhelmed, fatigued
- These feelings intensify my thinking that I am utterly doomed, which further intensify the basic feeling of being depressed.

Behavior:

- Loss of drive, diminished motivation
- This behavior confirms my negative view that my plight is hopeless

Physical Symptoms:

- Corresponding physical symptoms include sedation, lack of energy, sluggishness
- Further confirmation

April 7th: Brief Recap (cont.)

The 'Positive' Option

Thought: "If I am this sad, hopeless, gloomy, lethargic, unmotivated, uninterested, unrested, then… **Wait a minute, who said that being depressed is so bad?"**

- There is no shame in being depressed.
- There is no rule that says we must be happy all the time.
- There is no rule that says if I'm depressed now that I can never be happy again.
- There are countless examples of absolutely amazing depressed people in the world.
- If I can **accept** my depression, I won't feel so depressed about being depressed. It is bad enough to be depressed, even worse to be depressed about being depressed, so let's just be depressed. The burden will be a let less to bear.

April 7th: Brief Recap (cont.)

The 'Positive' Option

The point is that given all the things we can do to modify the causes for mental distress like depression, our very thoughts about the state of being depressed is the most 'proximal' for enacting therapeutic change.

- We can't change genetics.
- We can't change what happened in the past.
- We can't always change the environment.
- We can't change other people, like partners, children, parents.
- We can't necessarily change who is going to be the next president of the United States (though we can certainly try)…
- But one thing we always can change is how we think. In the area of thoughts directed to our own mental state, we can offer options that are positive and empowering, thereby altering the future course of mental distress.

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April 7th: Brief Recap (cont.)

Caveat

- In order to 'reflect' on the process 'self-reflection,' we need patients to be able to focus and concentrate, and often emotion (stress) gets in the way. So a big part of this approach involves relaxation/meditation.
- We also have to frame things in words and ideas that are familiar and acceptable to each patient, which invokes cultural competency, among other things.
- It takes time to do all this—time that competes with the PCP's obligation to handle all the other issues on the problem list, time that is arguably greater than what it would take to simply prescribe a medication.

April 7th: Brief Recap (cont.)

Time-Management Techniques

- We talked about the Kaiser 4-Habit Model and the '15-Minute Hour' models to achieve optimal counseling outcomes.

Today's Lectures

- Our lectures today will pick up on where we left off on April 7th
- We will have two lectures by Maryellen Curran focusing on:
  - The PHQ-9 and the philosophical context of Dimensional Rating Scales
  - The theoretical foundation of DBT and its applicability to some of the most common MH conditions
- We will also have a slew of lectures on the use of medications, with an emphasis on the limits of efficacy to the use of all meds.
- Finally, we will conclude with a simulated patient-provider interview that will weave our general themes together.

Order of the Day

- Introduction: April 7th Recap (20 min)
- Use of Rating Scales: Maryellen Curran. (30 min)
- Antidepressants/Antipsychotics Michael Kozart (40 min)
- Break (10 min)
- Mood Stabilizers/Stimulants/Miscellaneous Megan Burns (40 min)
- Benzodiazepines Michael Kozart (20 min)
- Use of Lab Data in Psychiatric Practice: Michael Kozart (handout)
- Practical Tips on Use of DBT: Maryellen Curran (30 min)
- Break (10 min)
- Simulated Case and Discussion: Michael Kozart and Maryellen Curran (40 min)

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