BRIEF BEHAVIORAL INTERVENTIONS FOR THE PRIMARY CARE PROVIDER

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A NEW PERSPECTIVE

MAKING THE CASE FOR BH INTERVENTIONS DELIVERED IN PRIMARY CARE
THE CHALLENGE

- 75% of children with a mental health disorder were seen by a pediatrician within the last year\textsuperscript{1}
- Identification of mental health problems in children by primary care pediatricians continues to rise\textsuperscript{2}
- 50% of U.S. adults with a mental health disorder had symptoms by the age of 14 years\textsuperscript{3}

\textsuperscript{1}Tyler, Hulkower, & Kiminski, 2017
\textsuperscript{2}Horwitz et al., 2015
\textsuperscript{3}Kessler et al., 2005
BARRIERS TO CARE AND TREATMENT

- Only 15%-25% of children with psychiatric disorders receive specialty care\textsuperscript{4}
  - No follow through with referrals
  - Issues navigating the system
  - Lack of options
- Most individuals only attend 1-2 SMH visits\textsuperscript{5}.
- Limited collaboration and coordination of care between providers
- “Subthreshold syndromes”\textsuperscript{6,7}

\textsuperscript{4}Bitsko et al., 2016
\textsuperscript{5}University of Washington AIMS Center, 2019
\textsuperscript{6}Robinson & Reiter, 2016
\textsuperscript{7}Briggs-Gowan et al., 2000
THE CURRENT STATE

• AAP advocates for the development of behavioral health competencies in primary care pediatricians

• But...
  • 2/3 of pediatricians report lack of training in treatment of children’s behavioral health needs
  • There is limited time and resources within the typical PCP office visit
  • The body of research advocates for “task shifting”

AAP, 2009
Wissow et al., 2016
THE PCP AS A BEHAVIORAL HEALTH CARE PROVIDER

- Ongoing relationship with the child and family
- Established trust and rapport
- Expert knowledge in the relationship between the patient’s development, health history, and social history
- Patient is likely to return to care regularly
- Problems can be addressed before they become clinical
- Mental Wellness versus Mental Illness
- Key component of population-based health
EVIDENCE FOR BRIEF INTERVENTIONS

• Limited research on brief BH interventions conducted by the primary care provider – most studies in the adult population

• Modest improvements in rates of identification of new mental disorders, increased treatments, and some improvements in symptoms

• Interventions delivered by PCP may:
  • Enhance readiness to explore specialty MH options
  • More likely to follow through with referrals and stay engaged in care
  • Improve comfort with discussing MH topics, reduce stigma, and normalize
  • Expand emotional vocabulary and awareness of the problem
  • Build confidence and self-efficacy in management of BH problems

10Kelleher & Stevens, 2009
“COMMON FACTORS” IN CARE DELIVERY

• Robust “Common factors” literature
  • Provider-patient interaction predicts outcomes across conditions and treatments\textsuperscript{11}

• Studies of “single session” therapy demonstrate effectiveness
  • problem-rather than diagnostic-targeted treatment in brief pulses across extended periods, \textit{similar to patterns of medical care}\textsuperscript{12}

• “Stepped care” models suggest that generalists can provide first-contact mental health treatment based on brief, problem-oriented assessments\textsuperscript{13}

\textsuperscript{11}Karver et al., 2005
\textsuperscript{12}Perkins & Scarlett, 2008
\textsuperscript{13}Katon et al., 2010
### Presenting Problem

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Common Elements of EBPs</th>
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<tbody>
<tr>
<td>Anxiety</td>
<td>Graded Exposure, modeling</td>
</tr>
<tr>
<td>ADHD/Behavior Problems</td>
<td>Tangible rewards, labeled praise, help with monitoring, time out, effective commands and limit setting, response cost</td>
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<tr>
<td>Low Mood</td>
<td>Cognitive/coping methods, problem-solving strategies, activity scheduling, behavioral rehearsal, social skill building</td>
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OVERVIEW OF BH CARE DELIVERY
FEATURES OF EFFECTIVE BRIEF INTERVENTIONS

• Problem/Solution focused
• Clearly defined goals related to specific behavior change
• Incorporate patient values and beliefs
• Measurable outcomes
• Enhance self-efficacy
• Active and empathic therapeutic style
• Responsibility for change on the patient

Adapted from Khatri & Hays, 2011
KEY COMPONENTS OF BRIEF INTERVENTIONS

- Individualized assessment
- Collaborative goal-setting
- Skills enhancement
- Follow-up & support
- Promotion of self-efficacy
- Access to resources
- Continuity of coordinated quality clinical care as applicable

Adapted from Khatri & Hays, 2011
BASIC KNOWLEDGE AND SKILLS

• Overall attitude of understanding and acceptance
• Active listening skills
• Focus on immediate goals
• Working knowledge of motivational interviewing and stages of change
• Working knowledge of cognitive behavioral and solution-oriented approaches

Adapted from Khatri & Hays, 2011
FRAMEWORK FOR BRIEF INTERVENTIONS IN PRIMARY CARE

- Relationship
- Emphasis on self-management
- Assessment of the problem
- Structured advice
- Brief Counseling
- Brief episodes of care over time

Emphasis on self-management leads to Assessment of the problem, which then leads to Structured advice. Structured advice leads to Brief Counseling, which in turn leads to Brief episodes of care over time. These brief episodes then lead back to Relationship, completing the cycle.
USE THE 5A’S

1. **Assess**: Beliefs, Behavior & Knowledge
2. **Advise**: Information about health risks and benefits of change
3. **Agree**: Collaboratively set goals
4. **Assist**: Provide information, teach skills, problem solve barriers to reach goals
5. **Arrange**: Specify plan for follow-up

Whitlock et al., 2002
Personal Action Plan

Assess
Risk Factors, Behaviors, Symptoms, Attitudes, Preferences

Arrange
Specify plans for follow-up (visits, phone calls, mail reminders)

Assist
Provide information, teach skills, problem solve barriers to reach goals

Advise
Specific, personalized, options for tx, how sx can be decreased, functioning, quality of life/health improved

Agree
Collaboratively select goals based on patient interest and motivation to change

Glasgow & Nutting, 2004
USING THE 5A’S TO GUIDE YOUR VISIT: DEPRESSION & ANXIETY

Assess
• Use 50-75% of the time you have to gather information, including safety issues

Advise
• Brief psychoeducation, motivate change, instill hope

Agree
• Quick overview of the initial treatment plan

Assist
• Delivery of a brief intervention

Arrange
• Make a follow-up plan, including possible referral to specialty care
FOUNDATIONAL SKILLS

BEHAVIORAL ACTIVATION
RELAXATION STRATEGIES
DISTRESS TOLERANCE SKILLS
PROBLEM SOLVING THERAPY
BEHAVIORAL ACTIVATION

- Rationale for patient behavior change
  - Shift from inside→ out behavior to outside→ in behavior
- Select activities that increase pleasure and sense of accomplishment
- Reinforce positive behavior change
- Review progress on goals
- Reset goals as needed goals as needed
BASIC COPING SKILLS

• Create a list of relaxing and pleasurable activities
• Use ideas based on your knowledge of the patient’s interests
• Young children can create a “coping box” with parent help
• Help guide the patient and parent with identifying things that are realistic; and vary with time commitment, location, and available resources
• Instruct the patient to write down the coping skills
DIAPHRAGMATIC BREATHING

- “Smell the Flowers, Blow out the Candles”
- Bubble blowing
- Practice in the visit! Demo and try it together
- Just like building endurance in sports, breathing must be practiced
  - It is not effective to wait until anxiety/distress/upset arises
  - Plan a specific time each day (bedtime is great)
  - Set a brief time period (1-3 minutes)
  - Include visual imagery if patient is unsuccessful initially, or if desired
  - Encourage caregiver to practice with the child (if younger)
  - Older kids/teens may enjoy apps
  - Make a reward plan
PROGRESSIVE MUSCLE RELAXATION

• People with anxiety difficulties are often chronically tensing muscles
• PMR helps people learn to distinguish between the feelings of a tensed muscle and a completely relaxed muscle
  • Teaches the child to “cue” this relaxed state at the first sign of the muscle tension that accompanies anxiety
  • Helps build awareness about anxiety triggers through physical sensations
  • Teaches an association between relaxed muscles and a relaxed mental state
• “Robot & Ragdoll” exercise is one easy way illustrate
GROUNDING TECHNIQUES

• Useful for affect regulation, stress reduction, illustrating present moment focus, and helping kids learn to connect their thoughts to physical sensations

• Useful activities:
  • 5 senses
  • Alphabet Game and variations
  • Read a story (young children)
  • Sing a song together (young children)
DISTRESS TOLERANCE: TIPP SKILLS

T – Temperature
   Hold an ice cube, splash cold water on face, use an ice pack, blow AC
I – Intense Exercise
   Jumping jacks/rope, run around the block, YouTube aerobics videos
P – Paced Breathing (Diaphragmatic Breathing)
P – Paired muscle relaxation (PMR)
A CALM MIND ACCEPTS

A group of skills to help tolerate a negative emotions until patient is able to address and eventually resolve the situation.

A – Activities
C – Contributing
C – Comparisons
E – Emotions
P – Push Away
T – Thoughts
S - Sensation
Whether the circumstance is small or big there will be many times that an individual doesn’t have control over an unpleasant event. Intense emotions don't last forever, we teach patients to tolerate emotions until the intensity subsides.

I – Imagery
M – Meaning
P – Prayer
R – Relaxation
O – One thing in the moment
V – Vacation
E – Encouragement
PROBLEM SOLVING THERAPY

7 steps:
1. Define a problem
2. Select achievable goal
3. Generate multiple solutions
4. Pros and cons of each solution
5. Select a feasible solution
6. Implement solution
7. Evaluate the outcome
VIGNETTE 1: ELIZA

• At her 6 year WCC, parents mention that Eliza has been complaining of stomachaches, worry, and nervousness in different day-to-day situations.

• She is shying away from activities that she used to enjoy, such as birthday parties and dance lessons.

• She and her parents deny concerns about low mood, academic problems, social changes, or any big changes at home.

• She is sleeping and eating normally.
VIGNETTE 1: ELIZA

• **Assess:** Mild functional impairment at this time with no clear anxiety trigger; symptoms fairly generalized.

• **Advise:** Psychoeducation to Eliza and her parents about anxiety; connection between stomach pain and anxiety.

• **Agree:** Discuss use of parent-guided self-help resources and coping skills.

• **Assist:** Teach diaphragmatic breathing; give HW for parents to help Eliza make a coping plan.

• **Arrange:** Plan for 1-month follow-up with possible referral to SMH at that time (or sooner if parents desire).
VIGNETTE 2: ALEXANDER

• 14 yo Alexander presents for a visit regarding new onset of depression symptoms. PHQ9 = 13
• Parents complain that Alex is missing many days of school, grades are slipping, naps frequently, and has not seen his friends in weeks.
• Alex adds that he plans to quit his soccer team because it feels like “too much” right now and is no longer enjoyable.
• Parents wonder if spending a lot of time gaming is contributing to the problem.
• In the confidential portion of the visit, Alex denies any recent trauma or substance use. He has thoughts about “not being in the world” a few times/week with no intent or plan ever.
VIGNETTE 2: ALEXANDER

- **Assess**: Meets criteria for depression based off PHQ9 + brief interview
- **Advise**: Psychoeducation for low mood and how it connects specifically to Alexander’s current behavior.
- **Agree**: Discuss confidentiality with Alex and determine level of parental involvement. Referral to SMH/Discuss preference for continued care plan.
- **Assist**: Brief behavioral activation -> hold off on quitting soccer and planned HW time w support from school; allowances for structured gaming time as a compromise to the plan
- **Arrange**: Plan for 2-week follow-up to check on progress and build on interventions.
VIJNETTE 3: ANGELICA

• 16 yo Angelica is in for an ED follow up after an episode of shortness of breath, racing heart, and dizziness, which was thought to be anxiety related.

• Angelica states adamantly that she does not have anxiety.

• Angelica reviews that she is stressed out by various demands including all AP classes and several extracurricular activities. Angelica acknowledges that she is barely sleeping and often doesn’t have time to eat healthfully.

• Angelica and her parents are not interested in decreasing her commitments or academic expectations at this time.
VIGNETTE 3: ANGELICA

• **Assess**: anxiety, stress, and new onset of panic attacks. Possible mild depression
• **Advise**: discuss mind-body connection
• **Agree**: Follow up in PC for now (given ambivalence about tx) with school counseling component
• **Assist**: PST to set goal of 15 minutes of daily self-care, introduction of TIPP skills with handout provided
• **Arrange**: Plan for 2-week follow-up to check on progress and build on interventions
VIGNETTE 4: AARON

- Aaron is a 9yo coming in for “anxiety” and “sleep problems.” SCARED (Child) = 30
- Aaron cannot fall asleep at night due to worry thoughts. After a brief discussion, you find out that Aaron is feeling dread about school.
- Aaron has good friends, but does have some mild social anxiety.
- Aaron doesn’t like being called on by the teacher, and worries about giving the wrong answer, disappointing his teacher/parents; general poor performance
- Denies low mood, but appears to have low self-esteem and is “hard on himself” per his parents. No recent stressors/changes at home
- Aaron is not involved in any activities at this time
VIGNETTE 4: AARON

• **Assess**: Moderate functional impairment; performance/social anxiety + concerns for low self-esteem.

• **Advise**: Psychoeducation to Aaron and his parents about anxiety and how it comes in different forms. Briefly touch on cycle of anxiety and sleep disturbance.

• **Agree**: Discuss dual approach of anxiety management and sleep hygiene. Referral to SMH.

• **Assist**: Teach the 5 senses exercise with lollipop (practice nightly plus use at school for calming); Provide list of self-help books; Give sleep hygiene handout and highlight key takeaways.

• **Arrange**: Plan for 3-week follow-up to discuss increasing self-esteem (activities).
REFERENCES


REFERENCES CONT.


