Though practitioners follow different roads to get there, most clinicians and clients would probably agree that the ultimate goal of treatment is to have clients achieve their highest level of psychosocial functioning and to prevent a relapse of their mental health and health problems. While the Integrated Behavioral Health Project does not subscribe to nor promote any particular therapeutic approach, many successfully integrated clinics have found that short-term, targeted, behaviorally-oriented treatment works best in primary care settings. Whatever the approach, it is imperative that the client be a partner in his or her own recovery and emerge from behavioral care equipped with appropriate self-management and coping skills.

The following are a few examples of some commonly used approaches used by themselves or in combination with others in primary-care behavioral programs.

Recovery Model

The recovery model is not so much a specific clinical approach as it is a conceptual framework for delivery of service, promoting a person-centered rather than an illness-centered perspective. Its main message is that people can achieve stability and lead meaningful lives despite mental disabilities. The basic underpinnings are consumer collaboration, participation, peer-support and empowerment.

Dr. Mark Ragins, a leading proponent of the model, describes it as guiding clients “through the process of building hope, empowerment and self-responsibility and attaining meaningful roles in life….We intentionally use treatment and rehabilitation as tools to promote recovery. We choose techniques that emphasize growth, building skills and natural supports, learning from successes and failures, and internalizing recovery gains to enhance resilience and wellness, rather than emphasizing stability, caretaking, risk reduction and treatment compliance.”

This chart, developed by Dr. Ragins, delineates the differences between the person-centered and illness-centered approaches:

<table>
<thead>
<tr>
<th>PERSON CENTERED</th>
<th>ILLNESS CENTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>The relationship is the foundation</td>
<td>The diagnosis is the foundation</td>
</tr>
<tr>
<td>Begin with illness assessment</td>
<td>Begin with welcoming – outreach and engagement</td>
</tr>
<tr>
<td>Services are based on personal suffering and help needed</td>
<td>Services are based on diagnosis and treatment needed</td>
</tr>
<tr>
<td>Services work towards quality of life goals</td>
<td>Services work towards illness reduction goals</td>
</tr>
<tr>
<td>Treatment and rehabilitation are goal driven</td>
<td>Treatment is symptom driven and rehabilitation is disability driven</td>
</tr>
<tr>
<td>Personal recovery is central from beginning to end</td>
<td>Recovery from the illness sometimes results after the illness and then the disability are taken care of</td>
</tr>
<tr>
<td>Track personal progress towards recovery</td>
<td>Track illness progress towards symptom reduction and cure</td>
</tr>
<tr>
<td>Use techniques that promote personal growth and self responsibility</td>
<td>Use techniques that promote illness control and reduction of risk of damage from the illness</td>
</tr>
<tr>
<td>Services end when the person manages their own life and attains meaningful roles</td>
<td>Services end when the illness is cured</td>
</tr>
</tbody>
</table>
The relationship may change and grow throughout and continue even after services end.

The relationship only exists to treat the illness and must be carefully restricted throughout keeping it professional.

Though this model is more commonly embraced by free-standing mental health programs than those embedded in more medically-oriented primary care services, many of its tenets overlap with principles used by medical practitioners: helping the client with self-management and coping skills, encouraging responsibility, and providing information and educational material so clients can make more informed choices in their care and in their lives.

For more about the Recovery Model and other articles by Dr. Ragins, go to http://www.village-isas.org. To access Dr. Ragins' recovery model Powerpoint presentation made at a conference jointly sponsored by the Integrated Behavioral Health Project, the California Department of Mental Health and the California Primary Care Association, go to the Training Archives Section of this website. His handouts for this presentation synthesized many of his thoughts and papers.

An exploration of recovery-oriented programs that attempts to isolate factors correlated with reduced symptomatology and decreased hospitalization is presented in "Implementing Recovery-Oriented Evidenced-Based Programs" by Marianne Farkas et al., 2005.

In the US Department of Health and Human Services-issued National Consensus Statement on Mental Health Recovery, Recovery consensus statement.pdf ten fundamental components are listed: "self-direction; individualized and person-centered; empowerment; holistic; strengths-based; peer support; hope; respect; non-linear; and responsibility."

Stepped Care

Like the recovery model, stepped care is not so much a type of therapy as a general treatment approach. Because clients vary considerably in their condition, progress and circumstances, a one-size-fits-all therapeutic stance has definite limits. Stepped care simply involves a continual assessment of the clients’ response to the treatment offered and the initiation of another level or a different approach if the client hasn’t shown the expected improvement. In integrated behavioral care, stepped care often involves reassessment of medication and counseling effectiveness and, in some cases, replacement of one with the other.

Jurgen Unutzer, a leading research involved in the IMPACT model for treating depression, emphasizes aggressive medication tracking and switching or modifying medication regimens according to an established algorithm if improvement is not shown. In a September, 2007 presentation for the Hogg Foundation For Mental Health, he advised that improvement should be seen in six to eight weeks for most clients given an antidepressant medication. If there is none, re-evaluation of the treatment plan should take place within eight to ten weeks. The main drawback of usual care, he says, is that practitioners “sit on treatment plans too long”; clients receive one antidepressant and simply stay on it for years without any reassessment of effectiveness.

A federal study published in the New England Journal of Medicine validates Dr. Unutzer’s remarks. Only 37% of persons with depression went into remission when given an antidepressant medication. But about 25% of the nonresponders showed an improvement with a second medication, and 67% eventually responded with up to four rounds of treatment. At least with regard to depression, treatment success appears largely dependent on the practitioners willingness to try multiple treatment approaches.

Cognitive Behavioral Therapy

Because it is time-limited, structured and goal-directed, cognitive behavioral therapy meshes well with the problem-solving, fact-paced orientation of primary care settings. This approach concentrates on the clients’ patterns of thinking rather than their external situation, allowing the clients to dictate the specific issues to be addressed. Though the therapy is directive, the emphasis is not on dictating what goals the client should have, but how they go about achieving the ones they’ve set for themselves.

While therapeutic techniques can vary, the approach often involves questioning thoughts, assumptions and attitudes that may be counterproductive or unrealistic; trying out new perceptions, and behaviors; facing situations or activities that have previously been avoided; and maintaining diaries of events, thoughts and behaviors so they can be discussed and, if needed, restructured. Though cognitive behavioral therapy is not equally effective for all types of mental disorders, it has been shown to be an evidence-based, cost effective approach for many.

A few of the many websites that describe cognitive behavioral therapy are NAMI’s and the National Association of Cognitive-Behavioral Therapists.

Behavioral Activation

The IMPACT study, one of the largest treatment trials for depression to date, focused on depressed elderly clients in primary care facilities. Along with educating the clients about depression, and supporting antidepressant therapy prescribed by the client’s primary care provider, depression
managers assigned to clients coached them in behavioral activation and pleasant events scheduling. Behavioral activation concentrates on reducing depressive symptoms by “gradually increasing engagement in pleasant and enjoyable activities” and teaching the client new ways of dealing with distress. The goals, as delineated in presentations by IMPACT's Jergen Unitzer, are to re-establish the clients’ routines, distract them from problems or unpleasant events, increase positively reinforcing experiences and reduce avoidant patterns. Activities to achieve this are having the clients chose pleasurable activities, mentally rehearse carrying them out, and then gradually begin to take action to engage in them.

For more information, go to University of Wisconsin's Depression Treatment Specialty Clinic Behavioral Activation Studies or to "Contemporary Behavioral Activation Treatment for Depression: Procedures, Principles and Program" by Derek Hope et al., Clinical Psychology Review, 2003.

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Stress Management

In his book, Integrated Behavioral Health Care, William O’Donohue highlights five essential elements of a good stress-management program:

- **Cognitive restructuring** to help people recognize irrational thought patterns and replace them with more positive, rational ones;
- **Assertiveness** training to help clients express their wishes effectively while still respecting the rights and needs of others;
- **Education** to familiarize the clients on the nature of stress, the problems it can generate and its physical manifestations so they can immediate steps to deal with it once recognized;
- **Social support** and helping clients improve their emotional, physical and financial support network; and
- **Exercise** to control weight, improve muscle tone, increase energy, and decrease anxiety and depression.

A good source for articles and information about stress is Oklahoma State University's stress web site or the one offered by the National Institute of Health.

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Motivational Interviewing

Behavior Consultants may meet with primary clients individually or in groups to address lifestyle changes. Among the many motivational interviewing strategies is the ‘FRAMES’ approach, developed by Miller and Rollnick.

Though originally designed for substance abusers, this brief intervention technique is applicable a wide variety of medical conditions commonly encountered in primary care. The elements making up the acronym ‘FRAMES’ are:

- **Feedback** regarding personal risk or impairment is given to the client following assessment of problematic patterns.
- **Responsibility** for change is placed squarely and explicitly on the client (and with respect for the client's right to make choices for him/herself).
- **Advice** about changing—reducing or stopping—problematic behavioral is clearly given to the client by the clinician in a nonjudgmental manner.
- **Nurture** of self-directed change options and treatment alternatives are offered to the client.
- **Empathic** counseling—showing warmth, respect, and understanding—is emphasized.
- **Self-efficacy or optimistic empowerment is engendered in the client to encourage change.** (Summary provided by the National Library of Medicine)

The clinician must attempt to tailor the intervention to both the client’s risk level and his/her readiness to make the needed changes.

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Self-Management

Teaching self-management skills can take place in a one-to-one exchange, but this approach lends itself well to group settings. Dr. William O’Donohue espouses self-management groups as being effective in changing unhealthy or counterproductive lifestyle choices. The following is a passage from his book Integrated Behavioral Care: A Guide to Effective Intervention (2006):

One of the central tenets in these groups is that patients and their families are respected as the primary caregivers in chronic illness. The five core self-management skills that are targeted in these groups include (1) problem solving, (2) decision making, (3) resource utilization, (4) forming a patient/healthcare provider partnership and (5) taking action.

Evidence exists that self-management programs that focus on these core elements improve health status and decrease health-care utilization for several key chronic conditions, including arthritis, asthma, cardiovascular disease, depression, diabetes and chronic back pain (Center for Health Studies of Group Health Cooperative of Puget Sound 1996).

In general, these groups help patients reframe their role in their illness and the role of their medical care providers.
O’Donohue divides stress-management techniques into those that are emotion-focused and those problem-focused. Emotion-focused techniques - helping people relax and cope with feelings evoked by stressful situations - are used in dealing with unavoidable problems or situations that cannot be changed, while problem-focused techniques help people solve specific dilemmas. Important components of self-management are providing the clients with sufficient information about their condition so that they can make informed choices; having them monitor their own behaviors and pace themselves appropriately, and generally enlisting their participation in their own recovery.

The California HealthCare Foundation is a good resource for videos and tool kits designed to encourage self-management. “Coaching Patients for Successful Self-Management”; “Techniques for Effective Patient Self-Management: and “Helping Patients Manage Their Chronic Conditions” can be accessed through their home page.

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Relaxation Training

Progressive muscle relaxation, meditation and controlled breathing relaxation have been shown to help some clients deal with pain and with stress that accompanies many physical diseases.

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Biofeedback

Allowing clients to monitor their muscle tension and activity, blood pressure, heart rate, and skin temperature in real-time via biofeedback is thought to raise their awareness of, and give them more conscious control over these physical processes.

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Relapse Prevention

Given that some behavioral disorders are known to recur over time, relapse prevention is an important component of treatment. Simply addressing the problem at hand has proven insufficient in some instances; the client needs to be given the skills and strategies for coping in the future. For example, with regard to depression, clients should be asked to identify and record warning signs that precede a depressive episode so they will be in a better position to recognize these harbingers in the future. They should also record what, if anything made them feel better.

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Clinical Goals

Clinical goals can vary, depending on clinic orientation, objectives and target population. The Washington Association of Migrant and Community Health Centers put forth the following in their “Providing Behavioral Health Services in a Community Health Center Setting (2002), offered here as an example:

- To assist primary care providers in the recognition and treatment of mental disorders and psychosocial problems.
- To assist in the early detection of "at risk" patients, with the aim of preventing further psychological or physical deterioration.
- To assist the primary care provider in preventing relapse or morbidity in conditions that tend to recur over time.
- To assist in preventing and managing addiction to pain medicine or tranquilizers.
- To assist in the prevention and management of work and/or functional disability.
- To help primary care providers obtain quality clinical outcomes with high prevalence mental disorders.
- To help primary care providers treat and manage clients with chronic emotional and/or health problems efficiently and effectively.
- To help providers manage clients who use medical visits to obtain needed social support.
- To more efficiently move clients into appropriate mental health specialty care when indicated.

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