Practical Approaches to Integrated Behavioral Health: Insomnia and Posttraumatic Stress

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Disclosure

• The presenter has no financial arrangement related to the content of this continuing education activity.
Objectives

At the completion of this activity, participants will be able to:

• Describe models and approaches used to integrate behavioral health and primary care.

• Identify practical, evidence-based methods for improving insomnia and treating symptoms of posttraumatic stress.

• Identify specific considerations in planning, implementing or evaluating integrated behavioral health and primary care in community settings.
Definition of Integrated Care

The care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

(SAMHSA-HRSA Center for Integrated Health Solutions, 2016)

www.integration.samhsa.gov
COORDINATION
   Discuss patients, exchange info if needed; collaboration from a distance
CO-LOCATION
   In the same facility, may share some functions/staffing, discuss patients
INTEGRATION
   System-wide transformation, merged practice, frequent communication as a team
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<thead>
<tr>
<th>COORDINATED</th>
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</thead>
<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
</tr>
<tr>
<td>LEVEL 1</td>
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<td>LEVEL 3</td>
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<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
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**Behavioral health, primary care and other healthcare providers work:**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Level 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>In separate facilities, where they:</td>
<td>In separate facilities, where they:</td>
<td>In same facility not necessarily same offices, where they:</td>
<td>In same space within the same facility, where they:</td>
<td>In same space within the same facility (some shared space), where they:</td>
<td>In same space within the same facility, sharing all practice space, where they:</td>
</tr>
<tr>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Have separate systems</td>
<td>Share some systems, like scheduling or medical records</td>
<td>Actively seek system solutions together or develop work-a-rounds</td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
</tr>
<tr>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td>Communicate periodically about shared patients</td>
<td>Communicate regularly about shared patients, by phone or e-mail</td>
<td>Communicate in person as needed</td>
<td>Communicate consistently at the system, team and individual levels</td>
<td>Communicate frequently in person</td>
</tr>
<tr>
<td>Communicate, driven by provider need</td>
<td>Communicate, driven by specific patient issues</td>
<td>Collaborate, driven by need for each other’s services and more reliable referral</td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
<td>Collaborate, driven by desire to be a member of the care team</td>
<td>Collaborate, driven by shared concept of team care</td>
</tr>
<tr>
<td>May never meet in person</td>
<td>May meet as part of larger community</td>
<td>May meet as part of larger community</td>
<td>Have regular face-to-face interactions about some patients</td>
<td>Have regular team meetings to discuss overall patient care and specific patient issues</td>
<td>Have formal and informal meetings to support integrated model of care</td>
</tr>
<tr>
<td>Have limited understanding of each other’s roles</td>
<td>Appreciate each other’s roles as resources</td>
<td>Feel part of a larger yet ill-defined team</td>
<td>Have a basic understanding of roles and culture</td>
<td>Have an in-depth understanding of roles and culture</td>
<td>Have roles and cultures that blur or blend</td>
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<td>Approaching an Integrated Practice</td>
</tr>
<tr>
<td>LEVEL 4</td>
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<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
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### Key Differentiator: Clinical Delivery

- **LEVEL 1**
  - Screening and assessment done according to separate practice models
  - Separate treatment plans
  - Evidenced-based practices (EBP) implemented separately

- **LEVEL 2**
  - Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges
  - Separate service plans shared based on established relationships between specific providers
  - Separate responsibility for care/EBPs

- **LEVEL 3**
  - May agree on a specific screening or other criteria for more effective in-house referral
  - Separate service plans with some shared information that informs them
  - Some shared knowledge of each other’s EBPs, especially for high utilizers

- **LEVEL 4**
  - Agree on specific screening, based on ability to respond to results
  - Collaborative treatment planning for specific patients
  - Some EBPs and some training shared, focused on interest or specific population needs

- **LEVEL 5**
  - Consistent set of agreed upon screenings across disciplines, which guide treatment interventions
  - Collaborative treatment planning for all shared patients
  - EBPs shared across system with some joint monitoring of health conditions for some patients

- **LEVEL 6**
  - Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place
  - One treatment plan for all patients
  - EBPs are team selected, trained and implemented across disciplines as standard practice

### Key Differentiator: Patient Experience

- **LEVEL 1**
  - Population-based physical and behavioral health needs are treated as separate issues
  - Patient must negotiate separate practices and sites on their own with varying degrees of success

- **LEVEL 2**
  - Patient health needs are treated separately, but records are shared, promoting better provider knowledge
  - Patients may be referred, but a variety of barriers prevent many patients from accessing care

- **LEVEL 3**
  - Patient health needs are treated separately at the same location
  - Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider

- **LEVEL 4**
  - Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers
  - Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services

- **LEVEL 5**
  - Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others
  - Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop

- **LEVEL 6**
  - All patient health needs are treated for all patients by a team, who function effectively together
  - Patients experience a seamless response to all healthcare needs as they present, in a unified practice
### Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

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<td>In a Transformed/Merged Integrated Practice</td>
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**Key Differentiator: Practice/Organization**

- Minimal Collaboration:
  - No coordination or management of collaborative efforts
  - Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow
- Basic Collaboration:
  - Some practice leadership in more systematic information sharing
  - Some provider buy-in to collaboration and value placed on having needed information
- Close Collaboration:
  - Organization leaders supportive but often colocation viewed as a project or program
  - Provider buy-in to making referrals work and appreciation of onsite availability
- Close Collaboration, Onsite with Some System Integration:
  - Organization leaders support integration through mutual problem-solving of some system barriers
  - More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components
- Close Collaboration, Approaching an Integrated Practice:
  - Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced
  - Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers
- Full Collaboration in a Transformed/Merged Integrated Practice:
  - Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
  - Integrated care and all components embraced by all providers and active involvement in practice change

**Key Differentiator: Business Model**

- Minimal Collaboration:
  - Separate funding
  - No sharing of resources
  - Separate billing practices
- Basic Collaboration:
  - Separate funding
  - May share resources for single projects
  - Separate billing practices
- Close Collaboration:
  - Separate funding, but may share grants
  - May share facility expenses
  - Separate billing practices
- Close Collaboration, Onsite with Some System Integration:
  - Separate funding based on contracts, grants or agreements
  - May share office expenses, staffing costs, or infrastructure
  - Separate billing due to system barriers
- Close Collaboration, Approaching an Integrated Practice:
  - Blended funding based on contracts, grants or agreements
  - Variety of ways to structure the sharing of all expenses
  - Billing function combined or agreed upon process
- Full Collaboration in a Transformed/Merged Integrated Practice:
  - Integrated funding, based on multiple sources of revenue
  - Resources shared and allocated across whole practice
  - Billing maximized for integrated model and single billing structure

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Population Model for Integrated Care

Behavioral health needs of the primary care population: What is your range of services?

- High severity or specialty mental health
- Multi-morbid mental and physical health problems
- Mental health and substance use – moderate severity
- Medical health problems requiring behavioral or psychological intervention
- Psychosocial barriers to care
Designing workflows that support treatment to target: Care planning, team functions, clinical systems

Level of Complexity

**Straightforward** situations: Typical protocols apply – usual care & decision-making, usual team functions & processes

**Complex** situations: challenges to usual processes requiring unusual attention, non-standard care processes or team functions

Clinical Presenting Problems

- **Behavioral Health** (MH or SUD) conditions commonly presenting in primary care, e.g. depression, anxiety, PTSD, or other depending on scope of services offered

- **Medical** conditions with strong behavioral health component, even if patient doesn’t see self as having MH or SUD problem, e.g. diabetes, IBS, asthma, chronic pain

When planning and implementing integrated behavioral health in primary care, it is useful to consider:

A. Capacity to provide a range of services for a given population.
B. Workflows for straightforward vs. complex clinical situations.
C. Your organization’s current characteristics with respect to levels of integration.
D. All of the above.
Insomnia

- **50%** of primary care patients report **occasional** insomnia; **19%** of primary care patients report **chronic** insomnia (Schochat et al., 1999).

- Compared to prescription medications, cognitive and behavioral treatment is equally as effective short-term, and more effective long-term.

- Insomnia may occur as part of a diagnosable mental disorder, or independently (functional impairment and >1 mo. duration).

- Behavioral treatment typically yields **initial improvement in 2-3 weeks**, substantial improvement after 4 weeks.
Assessment

Functional assessment must consider:

- History, frequency
- Environment: noise, light, disruptions
- Pre-sleep behaviors
- Caffeine, tobacco, alcohol, medications
- Sleep/wake schedule, napping
- Insomnia duration, timing
- Behavior in bed while awake (doing, thinking, feeling)
- Consequences/impairment
- Exclusions: sleep apnea, periodic limb movements; restless leg syndrome
Treating Insomnia – Sleep Hygiene

• Avoid caffeine 6-8 hours before bedtime.
• Avoid nicotine and alcohol 2 hours before bedtime.
• Reduce use of sleep medication.
• Exercise regularly, but not within 2 hours of bedtime.
• Maintain regular sleep schedule and avoid naps.
• Make the bedtime environment conducive for sleep.
• Create a routine to begin winding down at least 60 minutes before bedtime, and **minimize use of electronic screens** during this time.
• A light bedtime snack can help, but avoid snacks when wakeful in the night.
Treating Insomnia – Stimulus Control

• Stimulus control is based on the behavioral principle that conditioned antecedents increase likelihood of conditioned behavior.

• Stimulus control procedures to treat insomnia help ensure the bed and bedroom are conditioned triggers for sleep, **not** wakefulness.
  1. Go to bed only when sleepy (but get up at the scheduled time).
  2. If awake in bed for more than 15-20 minutes, get up, leave the room and do not return until feeling drowsy. Engage in calm, soothing activity until signs of drowsiness/reduced concentration.
  3. Use bed for sleep and sex only. No TV, phone/tablet, reading or eating in bed.
Treating Insomnia – Sleep Restriction

• Use in combination with sleep hygiene and stimulus control when these procedures are already established, but have not been sufficient.

• Can be used in conjunction with a sleep diary, FitBit, or patient self-reported estimate.

• Limit the time in bed to the actual number of hours patient is sleeping.

• For example, if they are typically sleeping 4 hours/night and need to get up at 6:00, begin by going to bed at 2:00.

• When able to fall asleep within 15 minutes of going to bed, move bedtime back by 20 minutes to 1:40.

• When able to fall asleep within 15 minutes of going to bed, again move bedtime back by 20 minute increment and repeat this process until 80-85% sleep efficiency is achieved.
Treating Insomnia – Additional Considerations

• If anxiety disorder or anxious rumination are present, additional treatment methods may include:
  – Cognitive behavioral skills for worry management
  – Thought-stopping, questioning automatic thoughts
  – Relaxation/meditation skills
  – SSRI medication

• If environmental or interpersonal (spouse/partner) issues are contributing to insomnia, then problem-solving and communication skills may be helpful.
The two main behavioral approaches to behavioral treatment for insomnia are:

A. Stimulus control and extinction.
B. Sleep hygiene and stimulus control.
C. Sleep hygiene and systematic desensitization.
D. Exposure therapy and CBT.
PTSD in Primary Care

- Lifetime prevalence US adult men: 3.6%; adult women: 9.7%; and overall: 6.8% (Kessler et al., 2005)
- 12-month prevalence US adult men: 1.8%; adult women: 5.2%; and overall: 3.5% (Kessler et al., 2005)
- Prevalence estimates in the primary care population range widely from 2% – 39%, depending on the trauma exposure of diverse samples (Greene, Neria & Gross, 2016; Slone, 2006).
- American Indians & Alaska Natives are 2-3 times more likely to meet PTSD criteria compared to US adult population (Gone & Trimble, 2012).
- Primary care patients may present with sub-threshold PTSD symptoms, which are associated with high comorbidity of other health and mental health conditions (Possemato, 2011). Focus on referral question and patient’s priority.
- Evidence-based practices for brief PTSD treatment in primary care are still in preliminary stages of development (Possemato et al., 2016). Referral to specialty trauma-focused care is best option if feasible.
Single Incident vs. Complex Trauma

- **Single Incident Trauma (Type I)**
  - Single incident/exposure to a traumatic event
    - e.g., accident, medical procedure, single assault
  - Potentially amenable to treatment in the integrated BH setting

- **Complex Trauma (Type II)**
  - Multi-type, chronic and prolonged exposure to events
  - Events are usually interpersonal in nature e.g., abuse, neglect, unresolved parental trauma & substance use, domestic violence
  - Interferes with the ability to form secure attachment relationships
  - Problematic behaviors may acquire multiple diagnoses due to many overlapping symptoms
  - Often begins early in life and may disrupt multiple areas of development
  - Usually requires treatment in specialty MH setting, but avoidance symptoms can make it very difficult for patient to access care.
  - Care in an integrated setting can focus on safety, medication adherence, coping skills, and referral.
Treating Posttraumatic Stress Symptoms: Time-effective Methods (1)

• Psychoeducation about PTSD
  – Adaptive nature and physiological aspects of fear
  – Fight or flight and the sympathetic nervous system
    • These systems can become overly sensitive or reactive due to the intensity of the traumatic experience.
    • PTSD is normal reaction to abnormal events (stigma reduction).
    • Most people treated with psychotherapy recover or improve (Bradley et al., 2005; Foa et al., 2010)
  – Information about the four symptom clusters with reference to how they manifest in person’s life.
    • Intrusions
    • Hyperarousal
    • Avoidance
    • Cognitive disturbance
  – As appropriate for the individual: complex vs. simple trauma; risk factors; impact of chronic PTSD; historical understanding and knowledge of PTSD.
  – Discuss co-occurring depression, anxiety, substance use disorders if applicable.
  – Role of medication in treatment: limitations of benzodiazepines; SSRIs to reduce hyperarousal and depression; enables stronger treatment engagement and action – “create some elbow room”
  – Knowledge = empowerment = safety and active recovery = increased ability to fulfill valued activities.
Treating Posttraumatic Stress Symptoms: Time-effective Methods (2)

• Establishing personal safety to prevent retraumatization, exacerbation of symptoms, and critical incidents
  – Safety planning to address suicidal ideation
  – Problem-solving approaches to improve environmental safety
  – Cognitive-behavioral coping to support effective decisions and interpersonal boundaries
  – Communication skills to support effective boundaries
• Reducing anxious or irritable hyperarousal:
  – Relaxation skills, mindful awareness, acceptance and self-soothing
  – Anger management skills
• Treat insomnia if necessary.
• Identifying and altering avoidance behaviors: Emotion regulation, mindfulness
  – Encourage engagement with specialty care
• Cognitive-behavioral strategies to realign thoughts e.g. about self, others, and safety
• Trauma processing/exposure therapy is empirically supported treatment, but the integrated care setting usually does not provide capacity for this; depending on local constraints, may be able to treat Type I trauma.
Treating Posttraumatic Stress Symptoms: Time-effective Methods (3)

• How mindful awareness can help persons with posttraumatic stress:
  – Lead the individual through a brief mindfulness practice: focused breathing (diaphragmatic breathing); or engaging your senses.
  – Explain how mindfulness is a way of paying attention to our experience that helps us stay grounded in the moment, with less reactivity and more adaptive decisions about our actions.
  – Provide a brief handout explaining mindfulness and offering suggestions for further reading.
  – Provide a brief handout that describes ways to practice and increase proficiency and benefits of mindful awareness or meditation.
  – Mindfulness practice can be therapeutically linked to emotion vocabulary and emotion identification if needed due to chronic PTSD avoidance/numbing.
  – Mindful meditation can be linked with focused relaxation skills if needed due to severe anxiety or panic symptoms.
  – If the individual has a particular faith or spiritual practice, they may wish to combine or parallel these practices.

• Discuss how practicing mindful awareness helps us recognize that thoughts, feelings and sensations inevitably rise and fall; and that judging, fighting or avoiding them is not very useful (acceptance).

• Follow-up to address any challenges, identify positive effects and reinforce continuing practice.
Question: When treating PTSD in integrated BH & primary care the priority is usually:

A. Safety and reducing hyperarousal.
B. Trauma processing or exposure therapy.
C. Psychoeducation and medication options.
D. Both A and C.
Community and System Considerations

• Coordinating with prescribers regarding reduction of benzodiazepine medications and sleep medications
• Coping with high prevalence of trauma in certain populations
• Supporting patients with complex trauma or comorbidity who are not currently able to access specialty MH care
• Creating linkage and “safe access” to specialty PTSD treatment
• Secondary trauma and provider self-care
• Population health: linkage with prevention of community violence and accidental injuries.
Client/Patient Resources


Clinician Resources


