Serving the Underserved: Preparing Psychologists for Effective Practice in the Public Sector

Plenary 4: Speaker 3

Psychology Education for the Future: Some Imperatives: Changing Structures of Education to Fit Needs for the Future

Morgan Sammons, PhD & Steven. Tulkin, PhD, presented by Dr. Tulkin

Good morning, it is a pleasure to be here and very exciting to be on this panel following the two outstanding presentations that have been given thus far. This is a good segue to Dr. Woods presentation and, since I am directly involved in the psychopharmacology training, I can give a little bit of an update bringing you up to date--even as to progress that was occurring last night.

We now have over 100 U.S. psychologists who are prescribing. Best estimates--and boy we really do need research because I was emailing with Glenn Alley in Louisiana yesterday and he was also bemoaning the fact that they don't have specific numbers, but with the 100 psychologists prescribing--our best guess is that there are close to 500,000 prescriptions that have been written by psychologists, and no reports of any significant adverse effects. I would also point out that there is a scarcity of psychiatry and psychiatrists in rural counties in California also;- it's not just New Mexico and Louisiana. And I want to really take advantage of this opportunity to encourage all of you here, and ask you to encourage the psychologists that you work with and the psychologists in training, to become active in Division 5 of CPA, to join if you are a psychologist and to join as a student for the students that you see in training because this is a significant aspect of what psychologists are going to need to be involved with in the future. Also in terms of the state by state update, progress is being made in prescription authority in Hawaii and in Montana and the bill has passed the Montana senate overwhelmingly.

I think it was 39 to 13 and last night it was a committee meeting in the Montana House and I was just checking my email, I don't have any results of that hearing and our Montana colleagues said that they thought that the actual vote in the committee would not take place till next week but they were enthused about it. So that is the psychopharmacology update.

So I'm going to be presenting a talk that was mostly put together by Dr. Morgan Sammons, and certainly the recommendations that will be shown in the latter part of the talk are his, but I do have experience in primary care having worked with the Kaiser redesign of primary care and actually worked in primary care myself for several years before joining CSPP. So does mental health work in primary care? It definitely does and I would go beyond mental health to say that behavioral health works in primary care, because obviously one of the things that we're learning is that, and you certainly know these statistics also, the vast majority of issues that people come to primary care to work on are issues that are impacted by behavioral health. And we're talking about everything from cardiovascular disease to diabetes to just adherence to medical suggestions and medications.

The Health Care Act talks about Accountable Care Organizations, and these are provider led organizations with joint accountability for achieving quality improvement and spending growth reductions. They're slightly different from the medical home aspects because the Accountable Care Organizations are anticipated to have a larger range of providers. Certainly the evolution is here, there's no question about the evolution. Primary care psychologists are in the Veterans Administration, Indian Health Service, the military, federally qualified primary care clinics, Kaiser and other HMOs, and we've even had the experience in California of having some psychologists actually form joint corporations with physicians for private practice. Primary care access, referral, and evaluation studies definitely showed that when care managers are provided in primary care, individuals with significant mental illness are shown to improve their mental, but not physical, health-related quality of life; and its certainly easier to impact the psychological and psychiatric aspects than it is the physical aspects such as breathing better and having greater energy. But longer term studies are likely to yield changes in those areas also.

______There is positive evidence for primary care interventions. This meta analysis--and I don't know if you can catch the name on the bottom but if you email me we can give you the reference—it is a meta analysis of randomized controlled trials of brief psychological therapies with anxiety, depression and mixed mental health problems in primary care, compared to treatment as usual, and the evidence supported. brief CBT, problem solving therapy and counseling for these problems, and significant improvement over treatment as usual. We're hoping that as the studies get longer term that we also find improvement in other aspects of physical care.

______It's important to have our psychology students and practicum interns and students understand something about other medical conditions besides the mental health conditions that can be impacted by psychological therapies and I've just put up a couple here. Randomized control trial, comparing medication alone and medication plus CBT, and I want to emphasize something here. This study did the CBT delivered by trained primary care <u>nurses</u>. So this is a red flag and Pat Deleon talks about this all the time day after day, day and night. If we don't get our psychologists involved in understanding these conditions and being involved in irritable bowel syndrome, cardiovascular disease and for heaven's sakes diabetes, and even depression care management by nurses is taking place across the country for depression. We have got to get moving and get our psychologists involved, get our psychologists being able to talk to primary care physicians about the behavioral aspects of irritable bowel, COPD and other medical conditions and have the primary care physicians and the medical centers like the VA and Kaiser begin to understand that psychologists can make greater contributions to behavior change in these medical conditions because of our training in the biological basis of behavior because of our understanding of cognitive behavioral therapy; and this is one of the greatest lessons, and if there's one pearl I want you to take away, it's that psychologists understand the concept of resistance. It's not just CBT, it's not just understanding the medical conditions, but to go back to what two other speakers on this panel have talked about: We don't use psychoanalytic therapy certainly these days and certainly not much in primary care but understanding the concept of resistance is really important for successful work in primary care and for helping the poor physicians who have no idea what resistance is about. And when I train physicians, and I work with physicians and I'm in the exam room with physicians, I tell them you didn't learn this in

medical school but not everybody that you're seeing in your exam room is totally convinced that they want to get better. They're scared of getting better for a variety of reasons. And I remember getting a referral for a diabetic who was refusing to move from oral insulin to injectable insulin, and the physician was absolutely at a loss because they had a good relationship with this patient. So I did a little motivational interviewing, I think it took five minutes, what's going on for you, what would it mean to you if you started injecting yourself with insulin. Well it would mean that my disease had advanced so far that I'm going to die real soon anyway so what the heck difference does it make, I don't want to inject myself with a needle, so it was misinformation, it was fear, and presto change-o the psychologist was able to get the patient to go home with the needles. Now the physician had been trying to do this for a couple of months. Our understanding of resistance, our integrating this into our experiences in cognitive behavioral therapy is key.

Also a randomized controlled trial comparing CBT versus educational classes for COPD showed that the CBT group had decreases in depression and anxiety but again no difference in physical functioning. I'm sure that if they carried this further they would find that. Other areas of psychological intervention in primary care: You could almost talk about any medical condition and there are aspects of psychological knowledge that are going to be appropriate. We need to help our students in their academic course work and in the practicum settings in understanding that they need to know about medical conditions and pharmacological agents not just for psychopharmacology but for the medical conditions also. Morgan relates this article that talked about the changes that the physicians are going to need as we move into Accountable Care Organizations. And sure enough there are plenty of changes, but psychologists are going to have to learn new information in new areas also.

So these are Morgan's suggestions for curriculum as a specialty track, primary care curriculum. His emphasis here is on basic pharmacology suggesting that 15 units be spent in basic pharmacology. I know that for me in going through the post doctoral training, the post doctoral masters degree, I found the clinical medicine much more relevant than the basic pharmacology so I would add to Morgan's suggestion to emphasize that clinical medicine understanding how the cardiovascular system works, understanding how the renal system works,

so I understood something about liver metabolism and renal clearance and the endocrine system. Very, very important. Certainly emphasis on psychopharmacology, and Morgan is suggesting a 15 hour course, that might not even be enough because we need to also, and in the post doctoral masters program in psychopharmacology, we have a basic course covering all of these medications but then we move into the special populations.

______And special populations is not just about ethnic differences. It has to do with gender differences, basic biological differences in reactions to psychoactive medication and certainly cultural differences. When you see those ads on TV you don't see men at their desks slumping over. You see the happy housewife who's not happy any more and that's who they're focusing on. And certainly the gender differences in who gets prescribed psychoactive medication is important; and I remember a case at primary care at Kaiser when again a patient referred to me, a primary care physician who wanted her to get anti depressants. Speaking with her she wasn't really depressed, she had very very significant marital problems, was infantilized by her husband, was psychologically abused by her husband, and she said she had to get some medication because she just couldn't take this anymore. And I told her that I thought that her primary issue was not that she was depressed and in fact an anti depressant I didn't think was going to help her situation very much and I suggested that she think about what she was talking to me about, about her marital situation and talk to a counselor or talk to her priest or her chaplain and think about other issues than just a medical solution to what I considered to be a non medical problem. So we need to talk about children, we need to talk about geriatrics so again my suggestion is that maybe we need more than 15 hours of psychopharmacology.

______We certainly need to talk about various kinds of assessment in primary care. I want to point out a particular book called Integrated Behavioral Health in Primary Care, Step By Step Guidance for Assessment and Intervention, a great book. There are actually specific two and three question protocols for behavioral issues in various kinds of medical conditions and I think that these can be a part of internship training as well as academic training. The first author is Christopher Hunter and it's put out by APA. Patricia Robinson also just put out a book on ACT the use of ACT Acceptance and Commitment Therapy in primary care, that's another one that I think is useful. So we need not only for the psycho diagnosis and outcomes assessment but we

need to learn something about assessment for the medical conditions. My own thought is that certainly every psychologist ought to know what hemoglobin A1C is, every psychologist ought to be knowledgeable about blood glucose levels and we could go on from there. Healthcare economics is something that I think psychologists also need to be aware of and there are specific aspects there that Morgan has pointed out.

Then we move on to a conceptual qualitative change in our thinking about how we're training psychologists as we think about primary care. We're talking about disease management, condition based protocols, which, and these are Morgan's words, are not algorhythmic, address all facets of the patients conditions, are outcome based and accountable, and integrate physical and psychological concerns and are syndromic. I think this is the kind of word that we need to pay some attention to. So we may use evidence based treatment but not protocol driven. So what does he mean by this? Non-specificity of diagnosis, treatment and response make this unavoidable. So goodbye to manualized protocols and let's begin to put some life into dismantling studies that teach us the common effect of elements of interventions. Manualized protocols tends to address one symptom complex and they might account for a minor portion of variance in terms of overall outcome but disease management requires multi factorial genesis. Interventions can be therapist directed, possibly through a manual but also patient driven, considering lifestyle, relational and behavioral change and collaborative dealing with adherence to medical regimen. So is there a specific diagnosis? We need to have non-specific but co-morbidity factors including, psychological stresses, relationship dysfunction, lifestyle issues, caffeine, alcohol, tobacco intake and have potentially contributory medical and medication issues been addressed. So this was certainly something Pat talked about in the last presentation. We need to understand what can happen with medical conditions and with medications that are prescribed for medical conditions. So do the patient, psychologist and other members of the treatment team understand and agree on the desired outcome.

We need to understand that not all psychological conditions are amenable to primary care. The distinction is not the severity because substance abuse, psychosis or even severe depression can be dealt with in primary care with the additional treatment that can be offered by psychologists and by care managers. Other legitimate applications or psychology expertise are

best suited for specialty mental health, personal growth, vocational and relationship issues. So I want to brainstorm about what aspects of primary care training we can introduce even now in mental health practicum settings. Certainly every intake that's done in a practicum setting should include medical history, current medical conditions, current medications and let the intern who might not know what these medicines are, write them down phonetically and then go find out what they are. We need to know what a particular medication is, its trade name, its generic name, and understand what people are taking it for. Interns and practicum students can begin to do readings on a psychological effects of medical condition, psychological effects of medications. Let them write down that someone's taking an anti-hypertensive medication, let them think that maybe this is contributing to a depression. These are the kind of things that they need to know about. Certainly most folks know that you need to do thyroid testing before you give an antidepressant. But do they need to know that maybe you also need to do testosterone testing when you have low energy, they probably don't know that. These are the kind of things that we can begin to train our students on now. And rather than the students feeling overwhelmed with all of this new information that they have to be familiar with, my guess is that they're going to begin to see themselves as a much more integrated care practitioner.

______I know that when I took the psychopharm training I felt like this was adding a big piece to my knowledge base that helped me feel like a practitioner who knew a lot more than I did when I was only studying mental health. Everybody in an internship setting, every clinician ought to also be studying what adherence issues are, it's not just the diabetic who's afraid of the injection. It's a depressed patient who won't take medication. To understand the adherence issues, and people also ought to be reading about what it's like to work in primary care, what the integrated team issues are, how to deal with setting up a collaborative care interpersonal atmosphere so that you understand something about physician's personalities, what motivated them to go to medical school, what their practice is like, it's unbelievable what it's like trying to be a primary care physician these days. I run stress groups for physicians at Kaiser and I feel really sad about what primary care is becoming, not just in Kaiser but it's across the country. It's what's happened to the health professions as we have undergone dictation by insurance companies and a business model. It's very stressful being a primary care physician and what we as psychologists can offer primary care really is to use that simple phrase just what the doctor

ordered. And the more research we can do showing that our presence in primary care and our being active in primary care and our prescribing in primary care because there's a lot of prescribing in primary care in the military, in the Indian health service and certainly in the states that have approved prescription authority and we are going to be able to collect data and we're going to have data showing that outcomes are better not only for the psychological and psychiatric diagnoses but for long term care of medical problems also. Thank you very much and look forward hearing from you.

GARCIA-SHELTON

______We have a few more minutes before we're scheduled to move into our discussion groups and I want to play on all these topics here. There are a number of internships that are in primary care medical settings. There are also a larger number of post doc training programs in primary care health psychology. Many are two years because it takes that long when you're changing your mindset about thinking.

______Let me follow my order here, you're next. And now we come to our discussion time again, I think you have lots to chew on relative to the issues we've talked about today and remember identify as you talk in the group for yourself what you think you want to identify as a change goal and how you might imagine yourself implementing that because at the end of this day that is what I hope comes out of this symposium. We can change things. Thank you.