I have great admiration for the strong writing of this accomplished team of clinicians, researchers, and teachers. This book, their third edition, provides easy-to-use guidance for students, new practitioners, and seasoned mental health clinicians alike. This is truly a desktop essential for all mental health providers aspiring to apply time-efficient and powerful interventions, informed by the current evidence.

—**Patti Robinson, PhD,** coauthor of *Behavioral Consultation and Primary Care: A Guide to Integrating Services, Second Edition*

This book is in my top three recommended books on primary care behavioral health (PCBH). It is a must-have especially for clinicians new to PCBH who are struggling with understanding how behavioral health consultants (BHCs) can achieve substantial results in a 30-minute consult. Chock full of practical tips, forms, and checklists, this resource needs to be on every BHC's bookshelf.

—**Neftali Serrano, PsyD,** Chief Executive Officer, Collaborative Family Healthcare Association, Chapel Hill, NC

I have been waiting for the next edition of this book and here it is! This new edition provides research updates so the busy clinician can be up-to-date with evidence-based approaches for primary care. If you provide clinical services as a behavioral health consultant (BHC) in primary care or supervise BHCs, this book is for you.

—**Stacy Ogbeide, PsyD, ABPP, CSOWM,** Associate Professor of Family & Community Medicine, UT Health San Antonio, San Antonio, TX

CONTENTS

INTRODUCTION

Much has changed since the second edition of this book. In the United States, the shift in primary care service delivery through the patient-centered medical home (PCMH), an increased focus on the Triple Aim (see Chapter 1), and an increasing awareness of the importance of integrated behavioral health service in the PCMH continue to drive change (Dunn et al., 2021; National Committee for Quality Assurance, 2017; Ratzliff et al., 2017). Our goal with this volume is to deliver straightforward information and guidance about what evidence-based/informed screening, assessment, and intervention services a behavioral health provider (e.g., clinical psychologist, clinical social worker) or any provider who has appropriate training to address behavioral health needs can provide to patients in the context of effective integrated primary care service delivery. Every chapter has been updated with the latest research evidence and includes an evidence-informed clinical practice focus. We have added additional information on the primary care Quadruple Aim and a new chapter on behavioral health consultant (BHC) core competencies and clinical practice management skills.

https://doi.org/10.1037/0000380-001
Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention, Third Edition, by C. L. Hunter, J. L. Goodie, M. S. Oordt, and A. C. Dobmeyer

WHAT IS PRIMARY CARE?

The World Health Organization (n.d.) defined primary care as

> a model of care that supports first-contact, accessible, continuous, comprehensive and coordinated person-focused care. It aims to optimize population health and reduce disparities across the population by ensuring that subgroups have equal access to services. There are five core functions of primary care:
>
> - *First contact accessibility* creates a strategic entry point for and improves access to health services.
> - *Continuity* promotes the development of long-term personal relationships between a person and a health professional or a team of providers.
> - *Comprehensiveness* ensures that a diverse range of promotive, protective, preventive, curative, rehabilitative, and palliative services are provided.
> - *Coordination* organizes services and care across levels of the health system and over time.
> - *People-centred* care ensures that people have the education and support needed to make decisions and participate in their own care. (paras. 1–6)

The American Academy of Family Physicians (n.d.) further expanded the definition:

> Primary care is the provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.
>
> Primary care physicians specifically are trained for and skilled in comprehensive, first contact, and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis. Additionally, primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, schools, telehealth, etc.). Primary care is performed and managed by a personal physician who often collaborates with other health professionals, and utilizes consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective and equitable care by coordination of health care services. Primary care promotes effective communication with patients and families to encourage them to be a partner in health care. (paras. 2–3)

We believe it is important for BHCs to know that the operations and goals of primary care require them to have a skill set for assessing and intervening on the wide range of problems that people bring to this setting.

WHAT IS INTEGRATED CARE?

The terms "collaborative" and "integrated" care are often used interchangeably, which can lead to confusion regarding the type of service that is being delivered

or evaluated. Thus, it is important to provide operational definitions of these terms.

Collaborative care is not a fixed model or specific approach. It is a concept that emphasizes opportunities to improve the accessibility and delivery of behavioral health services in primary care through interdisciplinary collaboration (C. L. Hunter & Goodie, 2010; Parkhurst et al., 2022). It can be performed through a range of practice models geared to provide effective patient services across a full spectrum of medical and behavioral health needs.

Models of collaborative care fall on a continuum of integration (Heath et al., 2013; for a review of models, see also C. Collins et al., 2010). On one end, there is collaboration between primary care providers (PCPs) and behavioral health providers who work in separate systems and facilities, delivering separate care. They exchange information regarding patients on an as-needed basis. This type of collaborative care has been referred to as *coordinated care* and involves minimal/basic collaboration at a distance. In the middle of the continuum is *colocated care*. This level of collaborative care can involve closer interactions between behavioral health providers and PCPs who share the same practice space and some shared systems like medical records. The team works together to address specific types of patient presentations. An example of this is the collaborative care model (also referred to as the IMPACT model, care management model, or care facilitation model). This model usually focuses on depression alone, using a specific process of assessing, planning, facilitating, and advocating for options to meet the patient's needs. This model has been shown to improve treatment of depression over standard primary care depression treatment (Katon, 2012).

At the other end of the continuum is *integrated care*. This is care that results from a practiced team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization (Peek & the National Integration Academy Council, 2013).

An example of an integrated care model is the primary care behavioral health (PCBH) model. Reiter et al. (2018) operationally defined the PCBH model using the "GATHER" acronym detailed in Robinson and Reiter (2016) because it provided a clear initial list of components that were important to operationalize in the definition. In that acronym, "G" is for a "Generalist approach," "A" is for "Accessibility," "T" is for "Team-based," "H" is for "High productivity," "E" is for "Educator," and "R" is for "Routine":

> The PCBH model is a team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such problems/conditions, with resulting improvements in primary care services for the entire clinic population. The model incorporates into the primary care team a behavioral health consultant (BHC), sometimes referred to as a behavioral health clinician, to extend and support the primary care provider (PCP)

> and team. The BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and a routine part of primary care. Specifically, the BHC assists in the care of patients of any age and with any health condition (Generalist); strives to intervene with all patients on the day they are referred (Accessible); shares clinic space and resources and assists the team in various ways (Team-based); engages with a large percentage of the clinic population (High volume); helps improve the team's biopsychosocial assessment and intervention skills and processes (Educator); and is a routine part of biopsychosocial care (Routine). To accomplish these goals, BHCs use focused (15–30 min) visits to assist with specific symptoms or functional improvement. Follow-up is based in a consultant approach in which patients are followed by the BHC and PCP until functioning or symptoms begin improving; at that point, the PCP resumes sole oversight of care but re-engages the BHC at any time, as needed. Patients not improving are referred to a higher intensity of care, though if that is not possible, the BHC may continue to assist until improvements are noted. This consultant approach also aims to improve the PCP's biopsychosocial management of health conditions in general. (Reiter et al., 2018, p. 112)

WHY HAVE A PCBH FOCUS?

The strategies we cover are likely to be useful in any integrated care model, but they are particularly germane to the PCBH model of integrated care. This integrated model has been implemented as the primary model or blended with other types of behavioral health services delivered in primary care in several noteworthy health care system efforts, including the Veterans Health Administration (serving 8.9 million patients), the Department of Defense Medical Health System (3.3 million), Cherokee Health System (66,000+), and Presbyterian Medical Group in New Mexico (190,000+; C. L. Hunter et al., 2018).

In short, the PCBH model is designed to facilitate the delivery of a variety of evidence-based interventions (which we present in this volume) for a range of problems across the lifespan that include prevention as well as treatment of acute and chronic conditions that focus on symptom reduction, functional improvement, and better quality of life. Although care in the PCBH model is typically focused and brief, there is no limit to the number of appointments a patient can have with a BHC. Rather, the number of contacts depends on the patient's progress. Services can occur prior to, within, or after an appointment with a PCP or be provided through psychoeducational groups, shared medical appointments, clinical pathways, or some combination of these, based on the patient population and available clinic and community resources. We discuss the important components of clinical pathways and shared medical appointments and how the BHC might promote these approaches to improve population health impact in more detail in Chapters 1 and 18. We believe the PCBH model can be used effectively in most primary care settings and aligns with the goals of population health care, the Triple Aim, and PCMH goals discussed in Chapter 1.

It has been argued that optimized integrated care models would involve attention to mission, clinical outcomes, physical location, operations, informa-

tion, and financial and resource integration (Peek, 2008; Strosahl & Robinson, 2008). Integrated behavioral health care brings the skills and expertise for addressing behavioral health needs to a setting in which the patients who can benefit from those services are already receiving care. It normalizes the need for behavioral health support and reduces the stigma associated with it.

Most behavioral health providers have been trained in the traditional specialty mental health care model. In this model, patients either seek help themselves or are referred to a behavioral health provider for problems identified as psychological (e.g., anxiety, depression, interpersonal problems). In specialty mental health care, the practitioner may see the patient in their office for brief psychotherapy (e.g., 8–10 sessions) or for long-term therapy of indefinite duration. In either case, sessions last for 45 to 50 minutes on a regularly scheduled basis (e.g., weekly). This type of behavioral health assessment and intervention can support the lower end of the continuum of integrated care (i.e., collaborative care and colocated care); however, it will not work in an integrated care model. To be an effective primary care team member, the behavioral health provider has to be readily available. Because the integrated approach expects a much wider range of patients to be referred for behavioral health assistance to address not only mental health disorders but also subclinical problems, prevention, adverse health behaviors, and chronic medical conditions, the demand for appointments will quickly exceed the behavioral health provider's ability to meet that need using a specialty mental health model of care. Patients will have extended waiting times for services and, in all likelihood, the behavioral health provider will quickly become an irrelevant team member as a result of not being able to assist the PCP in a timely manner. Thus, behavioral health providers working within an integrated care model must redefine how they think and what they do to provide behavioral health services that will work in the primary care environment. In other words, to be most effective, behavioral health providers must work within the same structures that other PCPs (physicians, physician assistants, and nurse practitioners) use to deliver care.

BECOMING AN INTEGRATED CARE PROVIDER

We have been teaching behavioral health providers to adapt their training and professional practices to the primary care environment for over 20 years. Common questions we have received include "Where do I start?" and "What do I do?" Answers to these questions typically elicit the response "I can't do that in 30 minutes!" We then explain why, in the primary care setting, the typical conventional model of psychological assessment and intervention will not work. The typical 50-minute interview cannot simply be condensed to fit in a 15- to 30-minute appointment. Time demands and practice expectations are structured differently in the primary care setting; behavioral health services must be adapted to this fast pace. The practicalities of adapting one's assessments and interventions to patient problems in the primary care setting are the main focus

of this book. We use the abbreviation BHC throughout this volume when referring to a behavioral health provider working in primary care. However, the strategies we describe are applicable to all providers (i.e., behavioral health providers and PCPs) working in this setting.

ETHICAL CONSIDERATIONS

Behavioral health providers engaged in integrated PCBH services quickly learn they face unique circumstances not always addressed by their discipline's ethical guidelines. Ethical guidelines that do address the "content" areas of concern are typically not written to apply to the context of integrated team-based PCBH service delivery, which includes team professionals with different ethical guidelines, expectations, and culture-of-care standards. Common areas of concern for behavioral health providers who are new to primary care include informed consent, confidentiality, complex relationships including whole-family care, multiple relationships, scope of practice, and competence. Ethical guidance for PCBH has received increased attention as BHCs are actively seeking this information. Although a complete review of ethics guidance is beyond the area of focus for this volume, we strongly encourage BHCs to inform this part of their work. Additional information can be found in a special issue devoted to ethics in collaborative care in the journal *Families, Systems, & Health* (Runyan et al., 2013). BHCs might also be interested in reading the journal article "Ethical Challenges Unique to the Primary Care Behavioral Health (PCBH) Model" by Runyan et al. (2018). The authors of this article highlighted conflicting ethical principles and guidelines occurring with PCBH model interprofessional collaboration. They reviewed the extant literature across disciplines, identified gaps, and proposed new ethical guidelines to bridge those gaps. They also discussed common ethical dilemmas unique to the PCBH model of service delivery with case examples and illustrated the application of the proposed guidelines to effectively navigate those dilemmas.

CULTURAL SENSITIVITY AND EVIDENCE-BASED ADAPTATION/TAILORING

Although there is general agreement that cultural sensitivity involves the awareness of cultural influences on patients' behaviors and health beliefs and application of this knowledge to effectively serve culturally diverse patients (one size does not fit all), there is still no uniform definition of cultural sensitivity, and key terms are used interchangeably (Huey et al., 2014; Liu et al., 2021). *Cultural adaptation/tailoring* has been defined as the "systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meaning, and values" (Bernal et al., 2009, p. 362). Cultural

sensitivity and evidence-based cultural adaptation/tailoring of primary care behavioral health services goes beyond the area of focus for this volume. Nearly all the research in this area has been done in specialty settings, not primary care. In fact, entire books (e.g., Benuto et al., 2020; Bernal & Domenech Rodríguez, 2012; T. B. Smith & Trimble, 2016) have been written on cultural sensitivity and the adaptation/tailoring of EBT for diverse groups. We encourage readers to pursue these resources as a way to improve their awareness of what they might adapt, based on the unique patient populations they serve. A comprehensive review and summary (Huey et al., 2014) of multiple qualitative and meta-analytic reviews on cultural sensitivity and treatment adaptation/tailoring came to the following conclusions:

- Adaptation targeting a specific ethnocultural group is more effective than tailoring targeting a mixed group.
- Some evidence suggests that matching patients with a provider who speaks their preferred (non-English) language might improve treatment outcomes.
- Patient variables like age and acculturation may be particularly important to assess before making cultural adaptations because those adaptations may be most effective for older, less acculturated patients.
- Some evidence suggests that provider–patient agreement on treatment goals and using metaphors/symbols that match the patient's cultural worldview may improve treatment outcomes.
- Myth adaptation that includes the patient's beliefs about symptoms, etiology, course, consequences, and appropriate treatment may improve treatment outcome.
- Addressing cultural factors implicitly rather than explicitly may be a way to get the benefits of cultural adaptation without the risk of iatrogenic effects.

Huey et al. (2014) went on to say,

> These results provide some preliminary guidance to researchers and therapists when deciding what types of cultural tailoring are likely to be most beneficial; however, additional research is necessary to replicate these findings in well-controlled trials before causality can be inferred. (p. 321)

We have included a cultural and diversity considerations section in Chapters 5 to 16 describing information BHCs might want to consider when addressing these clinical content areas.

THE FIVE As

Our format for assessment and intervention is based on the 5As model (Whitlock et al., 2002): assess, advise, agree, assist, and arrange. The 5As format has been strongly recommended for assessment and intervention across a range of

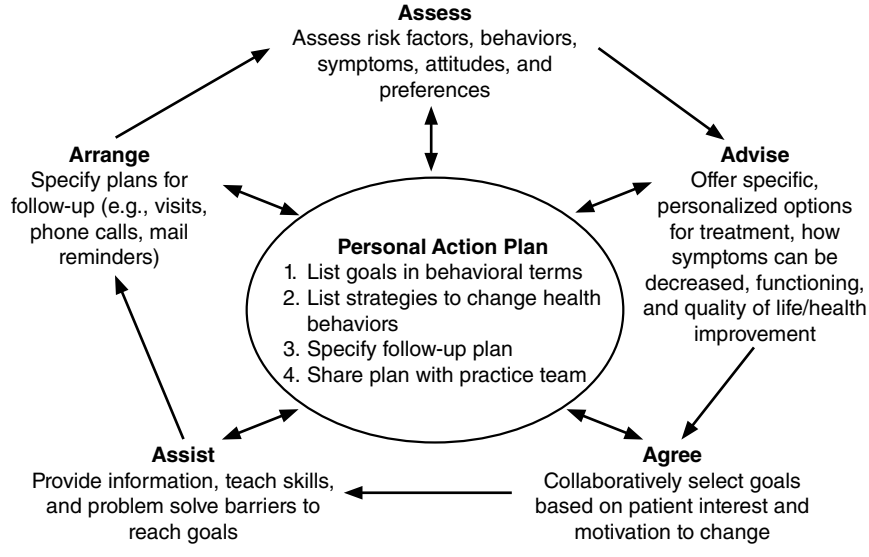
problems in primary care (Goldstein et al., 2004). The specific tasks within each of the 5As vary depending on the nature of the problem as well as its severity and complexity (Whitlock et al., 2002). Nevertheless, the 5As model can be applied to any patient in any clinic with any problem. We have found this flexible patient-centered model invaluable in providing behavioral health services in the primary care setting. Figure I.1 provides an overview of how the 5As connect and how they lead to a personal action plan.

The *assess* phase involves gathering information on physical symptoms, emotions, thoughts, behaviors, and important environmental variables, such as family, friends, or work interactions. From a biopsychosocial perspective, the goal is to determine what variables are associated with patients' symptoms and functioning and then, on the basis of patients' values and what they have control over, to determine what they could change or alter that would decrease symptoms and improve functioning.

The *advise* phase involves describing to patients their options for intervention, on the basis of the data gathered in the assessment phase. The goal is to describe the intervention and the expected outcomes.

During the *agree* phase, patients decide on their course of action on the basis of the options discussed. They also might decide that they do not like any of the options, might have other options they would like to pursue, or might take more time to think about their options and discuss them with a significant other. If the patient does not like any of the options initially presented by the BHC or perhaps is ambivalent about moving forward with them, motivational

FIGURE I.1. The 5As Model of Behavior Change in Primary Care



Note. Adapted from "Self-Management Aspects of the Improving Chronic Illness Care Breakthrough Series: Implementation With Diabetes and Heart Failure Teams," by R. E. Glasgow, M. M. Funnell, A. E. Bonomi, C. Davis, V. Beckham, and E. H. Wagner, 2002, *Annals of Behavioral Medicine*, *24*(2), p. 83 (https://doi.org/10.1207/S15324796ABM2402_04). Copyright 2002 by Oxford University Press. Adapted with permission.

interviewing strategies (see Chapter 4) may help guide them toward considering other solutions. These strategies may also help to engage them in shared decision making, which is an interactive process in which the BHC and patient work together to come to a decision about care (National Institute for Health and Care Excellence [NICE], n.d.). Shared decision making involves examining care options with a review of the evidence for those options, taking into consideration a patient's values, beliefs, and preferences (NICE, n.d.). It is designed to make sure the patient understands the potential benefits and risk of different options. See the NICE (n.d.) website for additional information and tools to facilitate shared decision making.

If the BHC and patient cannot agree on a course of action to address the presenting problem, they should not move forward to the assist phase. The BHC might let the patient know that they understand the patient's ambivalence about moving forward and that they will talk with the PCP about their appointment and discuss what, if any, additional options might be available.

In the *assist* phase, the BHC's job is to help patients learn new information, develop new skills, solve problems, and overcome environmental or personal barriers to implementing the behavior changes. This is where the formal intervention takes place.

In the *arrange* phase, we specify when or if patients will follow up with the BHC, PCP, or specialty mental health provider. If the patient will be following up with the BHC, we also discuss what will be evaluated or what information or skill will be the focus of the next appointment.

Using the 5As helps produce a meaningful and personalized health care action plan. The plan is specific and focused on health behavior change and is an integrated piece of the patient's overall health care plan. Ideally, the plan is then monitored and managed by the entire health care team.

PURPOSE AND ORGANIZATION OF THIS VOLUME

With the increased need for efficient evidence-based care, this volume provides BHCs working in primary care (e.g., psychologists, social workers, psychiatrists, counselors), PCPs, and other medical care providers (e.g., physician assistants, nurses, health care educators) with practical strategies they can use immediately. Our suggestions are drawn from evidence-based data as well as our experience in translating evidence-based care to our clinical settings. Overall, our book is designed to give practical step-by-step guidance for targeting biopsychosocial factors in primary care. Students may also find this text useful. Undergraduate and graduate courses focused on preparing individuals to work in primary care can use this book as part of a seminar on assessment and intervention in primary care or as part of a larger class focusing on brief treatments for common behavioral health problems.

The book is divided into three parts. Part I consists of four chapters that lay the foundation for an integrated behavioral health care practice. In Chapter 1,

we describe foundational concepts of population health service delivery and the PCMH. In Chapter 2, we discuss what we believe are important core competencies and clinical practice management skills necessary to work efficiently and effectively in primary care. In Chapter 3, using the 5As, we outline the steps for an initial consultation appointment. This chapter provides a template for addressing patient problems in the primary care setting and provides the foundation for conducting the initial consultation. In Chapter 4, we describe the basic tools of interventions for behavioral health problems that can be implemented in 15- to 30-minute consultation appointments. These include the following 11 interventions: relaxation training, mindfulness exercises, goal setting, cognitive disputation, acceptance and commitment therapy techniques, motivational enhancement techniques, problem solving, self-monitoring, behavioral self-analysis, stimulus control, and assertive communication. We have found these 11 interventions to be effective for a variety of symptoms and functional impairments. For each intervention, we apply the 5As format and show how to present the intervention to the patient in plain, easily understandable language. In Part II, we apply the foundations presented in Chapters 1 through 4 to the most common patient problems the BHC will encounter in the primary care setting. Each of the 12 chapters in Part II is structured as follows:

- description of the problem area, with emphasis on relevant biopsychosocial factors;
- cultural and diversity considerations;
- review of evidence-based interventions in the problem area;
- adaptation of interventions for the primary care setting;
- use of the 5As format for assessment and intervention;
- websites, mobile applications, and books for patients; and
- assessment and intervention tools, such as BHC scripts, handouts, worksheets, checklists, and monitoring forms (these tools can also be downloaded from the American Psychological Association Books website [https://www.apa.org/pubs/books/integrated-behavioral-health-primary-care-third-edition] and tailored to one's particular needs and setting).

In Part III, we address managing suicide risk, clinical pathways, and shared medical appointments.

For clarity, throughout the volume, the term *specialty mental health* refers to traditional or standard assessment and treatment in an outpatient mental health clinic. The term *behavioral health* refers to activities that are performed within the primary care clinic. Our goal is to provide straightforward, easy-to-use information to assist in addressing particular problems in the primary care setting. We believe readers will find, as we have, that this way of working with

patients will result in functional improvement and symptom change over a surprisingly short period.

We include recommended scripts and patient educational handouts throughout the book. These scripts and handouts are meant to serve as starting points; they can and should be altered to meet the needs and values of the patients coming to a given clinic. For ease of adaptation the companion website to this book has the scripts and handouts available to download.

We have had the opportunity to spend thousands of hours in primary care settings, including family medicine, internal medicine, and women's health clinics, as part of successful integrated behavioral health services. We have also taught hundreds of behavioral health providers to deliver effective behavioral health care in integrated settings. We hope that by using these evidence-based assessments and interventions, coupled with our shared experiences, BHCs can become more effective in their primary care work and can continue to improve the health of the population.