

# INTRODUCTION

Much has changed since the first edition of this book. In the United States, the shift in primary care service delivery through the patient-centered medical home, a focus on the Triple Aim (see Chapter 1), and the passage of the Patient Protection and Affordable Care Act have set the stage for patients, primary care service professionals, and payers to expect integrated behavioral health services as an essential component of primary care service delivery (Baird et al., 2014; National Committee for Quality Assurance, 2014; Nielsen, Gibson, Buelt, Grundy, & Grumbach, 2015). Additionally, the American Psychological Association (APA; 2015) has published guidelines regarding the competencies necessary to practice in primary care. Unfortunately, most behavioral health providers do not have the training or requisite skill set to provide evidence-based/informed primary care—appropriate behavioral health services to meet this growing need (McDaniel et al., 2014). 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 psychologists, social workers), or any provider who wants to address behavioral health needs, can provide to patients in the context of effective integrated primary care service delivery.

## WHAT IS INTEGRATED CARE?

The terms *collaborative* and *integrated* care are often used interchangeably and 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). It can be done in 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, Wise, & Reynolds, 2013; see also K. R. Collins, Hewson, Munger, & Wade, 2010, for models review). 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 a *coordinated care* and involves minimal or 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

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share the same practice space and some shared systems such as 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 the treatment of depression over standard primary care depression treatment (Katon, 2012). At the other end of the continuum is *integrated care*.

The care that results from a practice 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, p. 2)

An example of an integrated care model is the primary care behavioral health (PCBH) model. In this model, the behavioral health provider works as a member of the primary care team and is referred to as a behavioral health consultant (BHC). The BHC usually sees patients for an initial 15- to 30-minute appointment to conduct a focused assessment and to develop a treatment plan based on the health care goals of the patient and PCP. The BHC then provides feedback to the PCP about the patient's symptoms and functional impairments and details a behavioral health change plan. On the basis of the PCP's preference and patient needs, the BHC may implement, monitor, or change the intervention, typically using focused 15- to 30-minute appointments until the patient starts to show significant functional or symptom improvement. When focusing on chronic conditions (e.g., diabetes, obesity, chronic pain), BHCs may periodically meet with patients over months or

years to help the PCP manage the patient's health care plan through continuity consultation. The BHC also makes recommendations as to how the PCP and team members can support this plan and what the PCP and team might do to assist the patient in the future. It is fundamental to this model that the BHC is always working as a consultant to the PCP, helping the PCP manage patients' needs.

### Why 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 (Robinson & Reiter, 2016) has been used by several large health care systems, including Kaiser Permanente, the Veterans Administration, the Health Resources Service Administration and Bureau of Primary Care through Federally Qualified Health Centers, and the Department of Defense (C. L. Hunter, Goodie, Dobmeyer, & Dorrance, 2014; Strosahl & Robinson, 2008).

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 life span that include prevention, as well as treatment of acute and chronic conditions that focus on symptom reduction, functional improvement, and better quality of life. 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 before, 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 17. 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 Patient-Centered Medical Home goals discussed in Chapter 1. For a more comprehensive review of the PCBH model, see Robinson and Reiter (2016).

It has been argued that optimized integrated care models would involve attention to mission, clinical, physical location, operations, information, and financial and resource integration (Peek, 2008; Strosahl & Robinson, 2008). Integrated behavioral health care is a way to bring 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 his or her 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 must 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. As such, behavioral health providers working within an integrated care model have to redefine how they think and what they do to provide behavioral health services that will work in the primary care environment.

## 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 the past 15 years. Common questions we have received include “Where do I start?” “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 primary care behavioral health services, quickly learn that they face unique circumstances, which are 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 primary care behavioral health 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 primary care behavioral health has received increased attention over the past 5 years.

Although it is beyond the area of focus for this volume, we strongly encourage you to inform this part of your work. Additional information can be found in a special issue devoted to ethics in collaborative care in the journal *Families, Systems, and Health* (Runyan, Robinson, & Gould, 2013) and in Robinson and Reiter (2016).

### CULTURAL COMPETENCE AND EVIDENCE-BASED ADAPTATION/ TAILORING

Although there is general agreement that cultural competence 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 competence, and key terms are used interchangeably (Huey, Tilley, Jones, & Smith, 2014). Cultural adaption/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, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Cultural competence 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., Bernal & Domenech Rodríguez, 2012; T. B. Smith & Trimble, 2016) have been written on cultural competence 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 recent comprehensive review and summary (Huey et al., 2014) of multiple qualitative and meta-analytic reviews on cultural competence and treatment adaptation/tailoring came to the following conclusions:

1. Adaptation targeting a specific ethnocultural group is more effective than tailoring targeting a mixed group.
2. Some evidence suggests that matching patients with a provider who speaks their preferred (non-English) language might improve treatment outcomes.
3. Patient variables such as 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.
4. Some evidence suggests that provider–patient agreement on treatment goals and using metaphors or symbols that match the patient's cultural worldview may improve treatment outcomes.
5. Myth adaptation that includes the patient's beliefs about symptoms, etiology, course, consequences, and appropriate treatment may improve treatment outcome.
6. 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 4 through 16, which describe information you might want to consider when addressing these clinical content areas.

### THE 5A'S

Our format for assessment and intervention is based on the 5A's model (Whitlock, Orleans, Pender, & Allan, 2002): assess, advise, agree, assist, and arrange. The 5A's format has been strongly recommended for assessment and intervention across a range of problems in primary care (Goldstein, Whitlock, DePue, & the Planning Committee of the Addressing Multiple Behavioral Risk Factors in Primary Care Project, 2004). The specific tasks within each of the 5A's vary depend-

ing on the nature of the problem as well as its severity and complexity (Whitlock et al., 2002). Nevertheless, the 5A's 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 1 provides an overview of how the 5A's 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 might also decide that they do not like any of the options and suggest some of their own, or they might take more time to think about their options and discuss them with a significant other.

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 a 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 5A's 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.

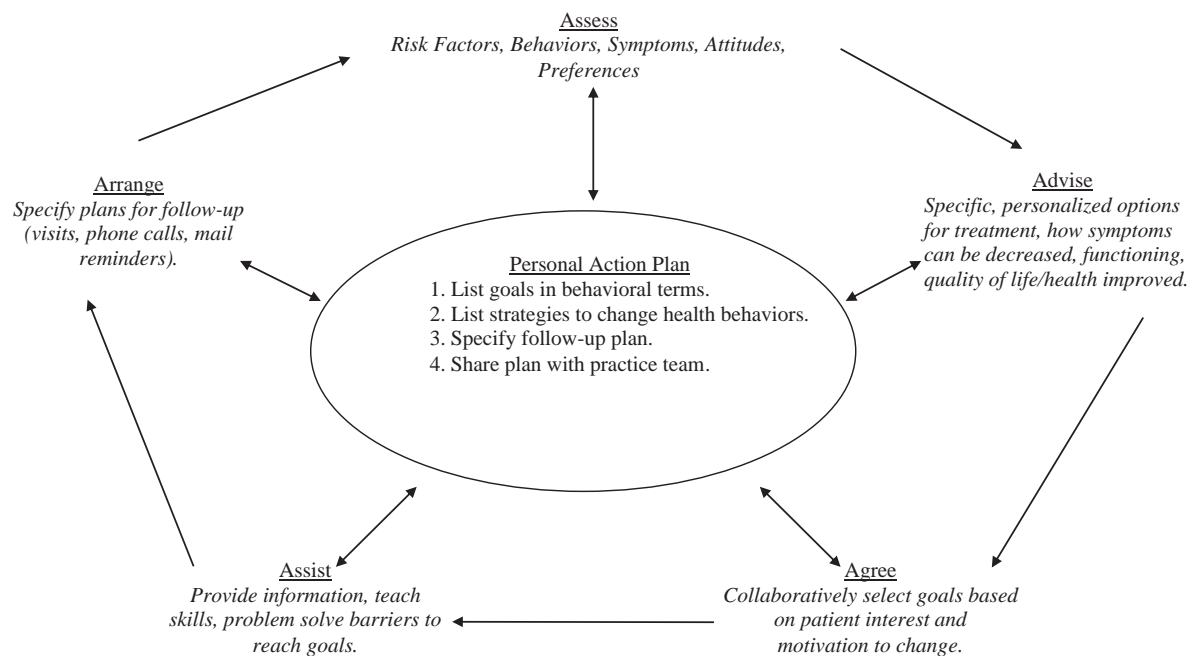


FIGURE 1. The 5A's model of behavior change in primary care. From "Self-Management Aspects of the Improving Chronic Illness Care Breakthrough Series: Implementation With Diabetes and Heart Failure Teams," by R. E. Glasgow, M. M. Funell, A. E. Bonomi, C. Davis, V. Beckham, and E. H. Wagner, 2002, *Annals of Behavioral Medicine*, 24, p. 83. Copyright 2002 by Springer. Adapted with permission.

## 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 three 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 patient-centered medical home. In Chapter 2, using the 5A's, 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 3, we describe the basic tools of interventions for behavioral health problems that can be implemented in one to four 15- to 30-minute consultation appointments. These include the following 10 interventions: relaxation training, mindfulness exercises, goal setting, cognitive disputation, motivational interviewing, problem solving, self-monitoring, antecedent-behavior-consequences analysis, stimulus control, and assertive communication. We have found these 10 interventions to be effective for a variety of symptoms and functional impairments. For each intervention, we apply the 5A's 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 3 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 5A's format for assessment and intervention;
- websites, apps, 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 APA Books website (<http://pubs.apa.org/books/supp/hunter2>) and tailored to one's particular needs and setting).

In Part III, we address managing suicide risk in Chapter 16 and clinical pathways and shared medical appointments in Chapter 17.

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 have had the opportunity to spend thousands of hours in primary care settings, including family medicine, internal medicine, and obstetrics and gynecology, 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, you can become more effective in your primary care work and can continue to improve the health of the population.