

Behavioral Health Consultation and Primary Care: Lessons Learned

Patricia J. Robinson · Kirk D. Strosahl

Published online: 31 January 2009
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Abstract This article provides an overview of 20 years of professional experiences with developing and implementing a model for integrating behavioral health services into primary care. The Primary Care Behavioral Health (PCBH) model is designed to provide immediate access to behavioral care for a large number of primary care patients by positioning a behavioral health consultant in the exam room area to function as a core member of the primary care team. In an initial era of discovery, the authors were directly involved in developing and testing a variety of new approaches to providing behavioral health services in general medicine. In a second era focused on feasibility, the authors worked with Kaiser Permanente, the United States Air Force and Navy, the Veteran's Administration, and the Bureau of Primary Care to system test this innovative model of integrated care. Now in an era devoted to dissemination, the authors review the various roles formal research, system level quality improvement initiatives and stakeholder analysis play in promoting integrated care. The authors also describe current efforts to (1) create a tool that helps systems develop integration targets and (2) use the PCBH model as a platform for teaching medical residents and behavioral health providers to work together in a redesigned primary care team model.

Keywords Primary care · Integrated care models · Behavioral health consultation · Health psychology

This article provides an overview of our professional experiences as we look back over the last 20 years during which we pursued our mission of integrating behavioral health services into primary care. We organize the review around three eras: *Discovery* the early years when our activities involved developing and testing a variety of new approaches to providing behavioral health services in general medicine; *Refinement* the era in which we used the experiences of the discovery era to evolve a sophisticated and highly refined integration model (the Primary Care Behavioral Health or PCBH model); *Dissemination* contemporary times where our focus has shifted to helping develop strategies for dissemination and evaluation of the PCBH and demonstrating its utility to all of the stakeholders involved in health care transformation. In reviewing each period, we begin with a summary of our clinical, consultation, and training activities, move into a brief summary of research conducted in that period, and then review the mistakes we made and lessons learned. Our overall goal is to put the contemporary primary care integration movement into some historical perspective so that we not only know where we are coming from, but more importantly where we are headed. An old Chinese proverb says it well: “If you don’t figure out where you are going, you are bound to end up where you are headed”.

The Era of Discovery

It is actually quite difficult to trace the origins of the integration movement. During our travels, we have heard many stories of grant-funded projects where a mental health professional was placed in a medical clinic. Sometimes, these stories date back to the 1960s. So, the idea of

P. J. Robinson (✉) · K. D. Strosahl
Mountainview Consulting Group, 507 Ballard Road,
Zillah, WA 98953, USA
e-mail: patti1510@msn.com; mountainconsult@msn.com
URL: behavioral-health-integration.com

providing mental health services in general medicine has been around for a long time. The other seminal feature of these stories is that all of these novel programs died on the vine. When the grant funding disappeared, so did the mental health provider. Another historical line is the role of behavioral health in family practice residency programs. As early as 1971, accredited family practice residency programs were required to have a “behavioral scientist” on the teaching faculty. Many of the early thinkers in the integration movement worked in university based family practice residency or medical school programs. Overall, we would describe these efforts as quite diffuse in focus and just based in the shared philosophy that mental health was an important component of primary care.

In the 1980s, the authors both worked at Group Health Cooperative of Puget Sound, the second oldest and most progressive HMO in the United States. Group Health was unique in that it was consumer owned and governed. Members of the HMO exercised voting rights concerning optimal cost-effective strategies for delivering health promotion and health intervention services to its members. The other feature of Group Health that made it an attractive beta site was the fact that it offered both medical and mental health services, supposedly as part of an “integrated” insurance package. In reality, although it was financially integrated, Group Health was structurally very segregated. Most of the mental health clinics were free standing facilities located a long way away from primary care centers. Not surprisingly, all of the negative aspects of segregated mental health services (lack of communication between providers, battles over ownership of the patient, inconsistent or conflicting care plans, lack of access to services) were present to varying degrees. A very public survey of the primary care provider staff at Group Health revealed widespread dissatisfaction with the mental health department, leading to a directive from the CEO and Medical Director that models of service integration be explored and implemented.

It was in this turbulent environment that we began to explore several new directions in integrated care, some of which continue to this day. We latched onto the idea of better serving older adults by bringing behavioral interventions into primary care clinics. We began an active dialogue about behavioral interventions that could target the entire spectrum of human suffering seen in primary medicine rather than being tied to specific treatments that would work on only mental health diagnosis. So rather than target depression per se, we experimented with the idea of pursuing improved functioning and greater satisfaction with life in our first clinical, research and training activities in primary care. Prior to detailing the lessons we took from these experiments, we will provide more details about these initial forays into primary care.

Consultation, Training, and Research

One of our first goals was to engage our primary care colleagues in a dialogue about their experience with the mental health system. Of course they referred their patients to us, and we puzzled over the fact that many never showed for mental health intakes or came only briefly and then returned to their Primary Care Provider (PCP) often with the same problems that had lead to their referral. Our primary care colleagues invited us to join them in primary care to see if co-location would help with the sense of stigma that their patients seemed to feel when they brought up the subject of mental health. However, there were many barriers to co-locating, including staffing models, continuing problems with long wait times for mental health services, and apprehension about how to adapt traditional mental health practices to the fast pace and high demand in primary care. As time wore on, it became clear that the conversion to a general model of treating human suffering would be the single most important achievement needed to support our vision of fully converting from mental health specialists to primary care generalists.

In the mental health clinic, we had an active cognitive behavioral training program and churned out mental health providers prepared to treat depressed and anxious patients with the latest empirically supported treatments. We noticed that therapists perusing the group referral file in search of ideal candidates for a new group often passed over a group of patients sharing some commonalities. This growing group of patients at the back of the file typically had more than one mental health diagnosis, a longer history of problems with functioning, and physical as well as mental health problems. We strategized about ways to move these passed over people from individual therapy where they were making little or no progress to a group where state-of-the-art treatment might lead to better outcomes.

In 1985 at the University of Washington, we found a potential answer to our question. Dr. Steve Hayes introduced us to the basics of radical behaviorism (Wulfert & Hayes, 1988) and a little known treatment called “comprehensive distancing” (now called Acceptance and Commitment Therapy). We left his workshop with a plan of offering a special group to all of the not-chosen patients in the group therapy referral folder in our mental health clinic (and of forging a professional relationship with him). This “Kingdome” (named after a local domed stadium) group started a month later with 24 patients who began their participation with a commitment to come to every class and to participate in no other form of treatment for 12 weeks. While we offered standard cognitive behavioral treatments to the group, we did so only after exposing them to a variety of radical acceptance procedures, including

writing several versions of their autobiography (starting with a very sad and tragic take on life, moving into a very optimistic and exceptional perspective, and finally to a descriptive in contrast to an evaluative version). We also helped them make commitments to staring into the eyes of their class partner for 5 min and to identify the rules they used to direct their lives and to look at the actual workability of these rules using their experience as the measure of truth. While this experience occurred in a mental health setting and not in primary care, it created confidence that we could shift from being enslaved by diagnostic labels to addressing a patient's ability to pursue valued directions in life. With this transition, we felt more prepared to make additional changes to mental health practices and protocols in the service of providing meaningful (and briefer) services to a larger and more diverse group of patients by joining with our primary care colleagues (some of whom worked across the street from us).

At the time, we were also reading and pondering the implications of early studies about targeted mental health services, particularly the work of Dr. Nick Cummings. Dr. Cummings and his colleagues provided targeted services to Medicaid enrollees in Hawaii that reduced medical service costs and utilization by 23–40% relative to control groups (Pallak, Cummings, Dorken, & Henke, 1994). For patients with chronic medical diagnoses, the targeted treatment reduced medical costs by 28–47%, while the medical costs for fee-for-service enrollees increased by 17%. These studies certainly caught the attention of administrators at our HMO and other HMOs. The time was ripe with opportunities for integration.

Research at Group Health provided a strong impetus for the internal integration effort. For example, we discovered that psychological distress was a huge driver of medical service use. Slightly more than half of a group of 767 identified high utilizers of primary care reported significant psychological distress. Many had chronic medical problems and their daily activities were limited by illness (Katon et al., 1990). Psychiatric services resulted in their receiving more diagnostic assessments, but clearly this high impact patient group and their providers needed more than diagnostic labels.

We participated in a health promotion study involving delivery of a variety of preventive services in the primary care setting to older adults. This study involved delivery of a preventive services benefit package for a 2-year period to Medicare beneficiaries at Group Health (Patrick et al., 1999). Results indicated that the treatment group had completed more advance directives at the 24- and 48-month follow-up. The treatment group also participated in more exercise and consumed less dietary fat than the control group. Surviving treatment group patients also reported higher satisfaction with health, less decline in self-rated

health status, and fewer depressive symptoms than surviving control patients. Our part included development and delivery of a 6-session cognitive behavioral therapy class, which we modeled after the Life Satisfaction Class (Molinari et al., 2003). The class was a favorite for patients, and our primary care colleagues insisted at the conclusion of the study, "You can't leave. Life satisfaction is what all of our patients need." The success of this early project led to a departmental decision to move forward with a system wide integration initiative. As a result, we (along with one other psychologist and a psychiatrist) were asked to immediately implement part-time practices in primary care, to isolate a model of integrated care that would work system wide and to continue taking advantage of research opportunities to answer important questions about the impact of integrated care.

On the research front, we entered into a series of studies involving team-based, combined treatment of depression in primary care patients (Katon et al., 1995, 1996; Lin et al., 1995; Robinson, Afari, & Ludman, 1995; Simon et al., 1996, 1998). The first involved training PCPs to use behavioral techniques and to prescribe newer, more easily tolerated antidepressants, in conjunction with consultation liaison psychiatry services. Without a manual to define psychiatry's role, it was difficult to structure the intervention adequately and to control costs associated with longer-term consultations that developed between some of the depressed patients and study psychiatrists. The imputed cost of this psychiatry driven treatment model was far greater than expected and the conclusion reached was that the day in day out provision of integrated care would have to be the responsibility of psychologists, master's level therapists and perhaps primary care nurses.

In a second widely sited study, we developed an intervention that included less than three hours of contact between a depressed patient and psychologist. To our knowledge, this was the first attempt of its kind to develop a highly condensed behavioral protocol that could be disseminated in a non-research setting. This daunting task was somewhat anxiety-provoking for us at the time, so we focused not just on building evidence based session modules, but also on building a series of shared processes and protocols to closely link the BHC and the PCP (see Robinson, 1996; Robinson, Wischman, & Del Vento, 1996 for curriculum). It is one thing to deliver services in primary care, it is quite another to engage the PCP in a process of active co-management. Some preliminary studies suggested that PCPs responded well to brief training in depression interventions and valued interactive patient education materials (Robinson et al., 1997). We also wanted to test patient responses to various patient education methods. We developed 2 brief interactive booklets (Using Medications Successfully, Seven Ways to

Cope) and a short video on the same subjects. In a telephone survey conducted 1 week after patients received the materials, three quarters reported that they read or viewed all of the educational products. The majority rated the products as somewhat to significantly helpful: medication booklet 81%; behavioral health booklet 82%; and video 60%.

Results from the larger randomized trial were equally positive. Results indicated that patients exposed to the highly condensed depression treatment modules reported better clinical outcomes compared to usual primary care, which included the ability to refer patients to a nearby mental health center for medication evaluation as well as psychotherapy (Katon et al., 1996). Surprisingly, ratings of consumer satisfaction with treatment were much higher in the integrated care group and physician satisfaction ratings greatly favored the integrated care approach. Another stunning finding was the low patient drop out rate in the integrated care group, something that has since been replicated in a number of trials. Ninety-one percent of the patients who came to the first consult with the psychologist completed at least 4 of the recommended 4–6 half-hour visits. Patient adherence to antidepressant medications was also significantly better in the integrated care group, and integrated care patients were more likely than usual care patients to be following relapse prevention plans supported by their primary care physicians at follow-up.

The mid 1990s involved fierce competition between health plans for consumers, leading to an incredibly cost conscious environment. On the integrated care front, this involved expanding the possible role of primary care nurses in the provision of behavioral interventions. One of the first studies involved the behavioral health provider supporting a nurse telephone intervention designed to improve patient adherence to medications and patient development and implementation of behavioral activation plans (Meresman et al., 2003). While intervention effects were less substantial than in the 4–6-session intervention with a psychologist, they did represent an improvement over usual care, and we felt encouraged about the possibilities of cross training with our new colleagues.

Early research efforts also included exploring primary care physician use of cognitive behavioral techniques (Robinson et al., 1995). We conducted phone surveys of 155 depressed primary care patients 1 and 4 months after they visited their physicians with a complaint of depression. Sixty-one percent reported that their physician advised them to identify activities they were already doing that helped them feel better. Between 22% and 44% reported that their physician recommended planning pleasurable activities, problem solving, challenging depressive thoughts, and planning activities that boost confidence.

Additionally, physician suggestion of CBT strategies was associated with patient use of the strategies in the months following the visit and with better adherence to pharmacotherapy during the first month of treatment.

Later we participated in the development of a program designed to strengthen primary care plans for patients with chronic pain. In this program, we implemented a stepped care plan that gave PCPs an array of choices for obtaining support and expertise in caring for chronic pain patients. Providers could consult with any member of a multi-disciplinary team of chronic pain experts by phone or e-mail, request the team come to the primary care clinic for an in-clinic morning or afternoon assessment of 5 chronic pain patients, refer the patient to a team-taught 30-hour behavioral program that included acceptance and mindfulness-based techniques along with standard CBT, or refer the patient to the clinic Behavioral Health Consultant (BHC). This program was associated with improved satisfaction among providers and patients and with re-direction of chronic pain patients from specialty care settings to primary care (Robinson & Brockey, 2000).

While we pursued these studies in primary care, we continued to develop and evaluate trans-diagnostic treatment models for application in both specialty mental health and primary care settings (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). One study employed the “manipulated training method” to evaluate the field effectiveness of Acceptance and Commitment Therapy by 17 master’s-level therapists and 1 psychologist over the course of 1 year (Strosahl, Hayes, Bergan, & Romano, 1998). Among other findings, clients of ACT-trained therapists reported significantly better coping than the clients of untrained therapists and were more likely to have completed treatment within 5 months of treatment initiation. After completing this initial effectiveness study, we developed a model for applying ACT principles to the primary care system. These included going beyond the identify-treat-cure philosophy and applying acceptance, mindfulness, and value-driven action strategies to enhance patient-provider interactions (Robinson & Hayes, 1997).

Finally, one of the most exciting findings of the early phase concerned the cost effectiveness of integrated care. In an analysis that combined patients seen in the liaison psychiatry (Katon et al., 1995) and the collaborative care studies (Katon et al., 1996), provision of integrated care increased the costs of treating depression (largely due to the cost of delivering the integrated services), but was associated with not only a huge increase in clinical response rate but also a mental health cost offset. For patients with more significant symptoms of depression, the cost per patient successfully treated was lower for integrated care patient than for usual care patients (Von Korff et al., 1998). This led to a very large cost effectiveness

index, meaning that, although integrative interventions did add cost (compared to doing nothing different), the amount of value gained from this added cost was disproportionately greater than the value of usual primary care treatment. Unfortunately, the investigators did not evaluate the cost effectiveness of the psychiatrist and psychologist interventions separately, even though the interventions were significantly different in terms of direct service costs.

Mistakes

Forcing Mental Health Practices to Fit the Primary Care Setting

In our early emphasis on retaining the structure of our specialty role in primary care services, we probably slowed our progress in developing primary care behavioral health protocols. For example, early studies involving psychiatric services focused on making a diagnosis and sharing this information with the PCP. Family practice residency programs provide another example of this type of mistake. Behavioral science faculty members or “behavioral specialists” located their practice in quiet areas of the family practice residency clinics and saw patients for 45- and 60-min visits for many years. Residents watched this traditional service and tried to take what they could into the brief 3–5 min counseling segments that occur in a 15-min medical exam. It was only when we focused on the end user specifications of primary care practice—brevity, long-term and sustained relationships between providers and patients, a simultaneous focus on mental and physical health—that we were able to begin to redesign the delivery of behavioral technology for primary care.

Being Diagnosis Driven Rather than Focusing on Functional Status and Quality of Life

There are many problems with a diagnosis-focus to treatment, and many of these apply when we take a diagnostic focus in research endeavors. Most mental health diagnoses have poor inter-rater reliability, and when we model “diagnosis-driven” interventions in primary care, we reinforce the “disease model” of mental health. This in turn reinforces the symptom-elimination approach that most primary care providers have been brainwashed into believing. Since very few mental health problems are ever “cured”, the physician is left in the untenable position of doing the impossible with the majority of patients. We would have been better off to decrease the emphasis on symptom reduction and increase the focus on improving functional status and quality of life.

Failing to Complete Early Component Studies

Rather than beginning to isolate the relative value of components of multi-faceted interventions, we continued with combined treatment interventions. Given that many patients prefer non-medication treatments and that patients sometimes have better long-term outcomes with behavioral-only treatments, we should have conducted comparisons of combined and behavioral-only treatments for a variety of common problems long before the turn of the century. Unfortunately, neither the major federal funding agencies nor the major foundations seemed interested in primary care intervention packages that did not involve prescribing drugs. This undeserved bias toward drug treatment continues to haunt integrated care research to this day.

Lessons Learned

Check the Cloak of Therapy at the Door

We can struggle mightily to wear the cloak of therapy in primary care, and many behavioral health providers have and do make this mistake. When we talk with PCPs about their perceptions of behavioral health providers who fail to develop strong consultation skills, we hear comments that suggest empathy and respect—“He always looks sad, but he comes; it’s hard to get anybody in with him”—and not partnership. A therapist can be a resource for a PCP; a consultant is a primary care partner. To succeed in primary care, we need to bring our most powerful, evidenced-based interventions and deliver them in the role of a consultant. The responsibilities of a consultant are to teach and advise; as well as to help consultees develop programs that change systems of care to improve services to patients. Therapy procedures—diagnosis-based interviews, extensive psychosocial history taking, longer intervention protocols, treatment plans and reviews—do not fit with the access to behavioral technology we need to create for both primary care patients and providers.

PCPs are Very Quick Learners (and Good Teachers, Too!)

In early studies, we found that PCPs were quick to take up recommended strategic therapy and cognitive behavioral interventions. The trick appeared to be in dropping the psycho-babble and just giving it to them “straight” in multiple venues, including brief didactics, patient education materials, newsletters, curb-side consults, and chart notes. In one study, we were surprised to find that over 30% of the usual care patients reported that they were

currently working with their PCP on a relapse prevention plan, despite the fact that PCP's had been told that relapse prevention planning was reserved for the intervention group of patients. In effect, PCPs began "bootlegging" parts of the integrated program for depression into their general practice, no doubt because they observed first hand the benefits of forming written relapse prevention plans that could be easily accessed in the medical chart.

Behavioral Interventions Can Complement Physician Practices

The myth that behavioral interventions take longer to implement than prescribing drugs has been the bane of our respective existences! Nothing could be further from the truth. Teaching PCPs to use simple behavioral interventions actually accelerates the pace of the medical visit, decreases repeat visits for the same problem and improves outcomes. For example, prescribing is a common intervention in primary care, and adherence is a big problem. When we provide behavioral assistance and help patients address barriers to adherence, compliance rates improve dramatically (Katon et al., 1996). We developed an adherence risk index that is very short, specific and incredibly easy for the PCP to use when discussing the issue of medication adherence with patients (see Robinson, Wischman, & Del Vento, 1996).

Less is More

Given that our best opportunity for reaching patients with behavioral health problems is in the primary care setting, we need to pay attention to what these patients are willing to tolerate in the way of behavioral interventions. This question has been totally neglected in the specialty mental health community and, as a result, nearly 50% of all patients drop out of therapy without consulting their therapist. Early findings related to this key issue with primary care patients suggested that most would complete treatments that were brief and pragmatic (Katon et al., 1996). We actually began experimenting with a drop-in "Quality of Life" class in which patients were allowed to choose which depression self-management skills they wanted to learn and to attend only the classes that pertained to that strategy (see Robinson, 1996 for curriculum). This forced us to drop the idea of sequentially staged classes in which the patient is required to start at the beginning and go to the end. We also experimented with group medical visits (Robinson, Del Vento, & Wischman, 1998). These were radical ideas in the early 1990s but since have been re-packaged with a number of different names (Drop In Group Medical Appointment or DIGMA; SMA or Shared Medical Appointment; Group

Medical Visit) and are proving to be highly valuable methods for resource-effective integration.

The Era of Refinement

In the mid 1990s, we came to the conclusion that we were part of a large-scale movement involving fundamental reform to the healthcare system worldwide. Due to good luck and the ability to capitalize on good luck, the Group Health Cooperative integration model was showcased as a best practice at many national and regional conferences. The amount of interest expressed at these conferences was truly amazing and it became clear to us that we needed to aim high and articulate a specific model for integrating behavioral health services, even though it clearly meant taking on more than one sacred cow.

As a result of the early success we had with the integration initiative, we realized we had to refine it into a simple, sophisticated model of care and an underlying explanatory rationale that would address the concerns of all the stakeholders in our health care system. This forced us to move from living in the bubble of scientist practitioners into the world of marketing and selling a set of ideas to a very diverse audience with multiple agendas. We began creating materials for working with Group Health administrators, financial experts, board members, line physicians, behavioral health providers and mental health and medical leaders. We chose the name, Primary Care Behavioral Health or PCBH, for our model of care because it conveys the essence of a new approach to behavioral health service delivery—behavioral health services as primary rather than specialty services.

Consultation, Training, and Research

We participated in the development of an evidence-based pathway for treating depression at Group Health, and we watched as researchers in the Center for Health Studies continued to explore ways to address depression in primary care with increasing concerns about reducing the costs of anti-depressants, which at the time were the second leading cost drug of the entire Group Health formulary. This was also the time that Group Health and Kaiser Permanente were developing an approach now known as the chronic care model, which involves developing evidence based critical pathways designed to promote consistent medical care for identified conditions. This offered us the rare opportunity to really think about integration at the process of care level. What types of screening and outcome tools would PCP's really be willing to use in practice? What activities should be the responsibility of the PCP and which

should be handled by the behavioral health provider? How would these two providers share information in real time? This, and a host of other very practical issues, started to be of paramount importance. In addition, it became increasingly unclear who this pathway was designed to benefit. The primary care physicians who had to handle the health care needs of 25–30 patients per day, or the researchers who could make their careers brighter and grants bigger by developing a complicated, multi-step program.

The result of 2 years of work was an evidence-based pathway that PCPs had difficulties implementing. While it included nice diagrams and excellent tools, PCPs lacked the time and on site behavioral health support needed to implement it. Sadly, by the time the pathway was rolled out, most of the behavioral health providers working in primary care had been pulled back to mental health to try to save the disappearing mental health service (and this of course only made it disappear faster). We learned first hand about the politics and conflicts of interest that sometimes invade a very well intentioned system change initiative. We also learned that a serious financial crisis like the one endured by Group Health challenges the existence of any program that is not completely owned and operated by the primary care system.

Our second major activity was to develop a specific model of integration and then develop the technology to disseminate the model throughout the entire Group Health system. This was a “grounding” experience on multiple fronts. First, it introduced us to the complexities involved in system level initiatives such as the need for a written program manual that specified all aspects of the model of care. The creation of a program manual took months of work and many players were involved ranging from human resources specialists to billing, coding and reimbursement specialists. We had to develop policies about informed consent, discussions between non-psychiatric mental health providers and physicians about medications and so forth. Each time a new policy issue surfaced, a new set of stakeholders would surface with it. We did not know it at the time, but this “devil is in the details” experience taught us what it would take to disseminate the PCBH model in other systems of care. The issues we faced are nearly universal to health care systems any time a new model of care is introduced.

Second, since only therapists in the mental health department had any work experience in primary care, it became obvious that some type of training program would be needed to prepare therapists for the transition to primary care work. This created a dialogue about how to best teach therapists and physicians the new practice skills required for successful integrated practice. Rather than focus on content oriented trainings (i.e., workshops, lunch time trainings), we opted for a skill based approach built around

two basic training concepts: core competencies training and the mentor-trainer role. Core competencies are the specific skills required for a mental health provider to function effectively as a BHC. The mentor trainer model involves training a core group of “experts” in the model of care to act as both trainers and mentors over time for the behaviorists they train. Much of this approach was derived from studies of how corporations maintain quality control despite having thousands of workers produce a product in a geographically dispersed system. The entire Group Health project was a learning lab for what competencies really make a difference in primary care work, and it taught us which methods to use to develop these skills. The approach we developed relied heavily on *in vivo* observation of the trainee providing clinical services, conducting consultations with physicians and demonstrating behaviors designed to market the PCBH model so as to increase the volume of referrals. By the time we had completed the implementation of the PCBH model, we had developed the framework needed to disseminate this approach within other healthcare systems.

Stimulated by the success of the Group Health collaborative care studies, researchers conducted a string of studies looking at the effectiveness of this approach for different kinds of conditions (anxiety, panic, suicidality, depression and diabetes, etc.). These tended to fall into one of two categories: replication studies that simply shifted the focus to a new mental health condition or a new population; or studies looking at the impact of services provided by less trained, less expensive professionals (i.e., care managers, nurses). An example of the former is a study that compared the effects of combined cognitive behavioral treatment (CBT) and medication treatment with usual care on primary care patients with panic disorder (Roy-Byrne et al., 2005). Results suggested that the combined treatment was superior to usual primary care as was the case with the earlier depression study (Katon et al., 1996). Again, inexplicably, there was no follow-up study exploring the relative contribution of the components of combined treatment; namely CBT and medication. It is interesting that this type of follow-up is not pursued, particularly when rates of remitting and responding patients were higher in the integrated care group at 3 and 12 months, in spite of similar rates of delivery of guideline-concordant pharmacotherapy in the integrated care and usual care groups.

Consistent with a goal of maintaining some type of role for specialty mental health providers (e.g., training non-behavioral health providers in diagnosis, pharmacotherapy, CBT), studies of this period also focused on delivery of interventions in primary care by non-behavioral health providers with the hope of improving care. For example, one study focused on teaching nurses to do problem solving therapy and medication adherence coaching with

diabetic patients with depression symptoms (Katon et al., 2004). The nurses in this study received a 1-week training course on diagnosis and pharmacotherapy and an introduction to problem-solving treatment methods based on the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study (Unützer et al., 2002), which was developed for a study concerned with late-life depression in primary care. Findings suggested that 10% more intervention patients versus usual care patients improved 50% or more from baseline on the Symptom Checklist—90 scores at 6 and 12 months, but these trends were not statistically significant. Further, there was no significant difference between the groups in level of blood sugar control. With the burgeoning number of patients with diabetes and other chronic diseases and with most patients with chronic disease burden experiencing symptoms of depression at some point, we urgently need studies that assume that behavioral health providers are a part of the team and ready to work smarter-not-harder by partnering with diabetes nurse educators and PCPs and offering empirically supported treatments that address mood, lifestyle and diabetes management simultaneously (see for example, Gregg, Callaghan, Hayes, & Singer, 2007 for an empirically supported integrated curriculum).

Mistakes

Assuming that Research Evidence Answers All of the Important Questions

As clinical-scientists, we assumed that books and peer-reviewed journals had the answers that health care systems needed. However, this was not the case and the stakeholders described a different agenda. In reality, only occasionally was research evidence able to assist us in solving a system level question. System change is largely a political process, partly a financial process and only minimally an evidence based process. We can plug evidence based care into a system with new processes and new providers but it is raw politics and organizational vision that creates new care processes.

Focusing on a Pathway Before We had a Platform

If we build a house without a foundation, we will be forever wed to pulling a mobile home in and out of primary care parks. The quick-in and quick-out approach that supports research careers does not support health care system change, and, in the long run, probably hampers relationship building between PCPs and behavioral health providers. Group Health became so enamored of the chronic care model that it ignored the critical need to

redesign the primary care team to include a behaviorist. Without the support of the behaviorist, physicians were only able to follow a fraction of the elements specified in the depression pathway.

Lack of Component Studies

We still do not know what the active elements are in the typically combined treatments delivered in publicly funded studies of the impact of delivering behavioral health services to depressed and anxious primary care patients. We also lack empirical data about the costs and relative value of solo behavioral, solo pharmacological and combined treatments. Prevailing research paradigms have also failed to adequately address the very basic factor of patient preference. Rather than pursue these admittedly difficult studies, researchers have continued to basically do the same study again and again, sometimes watering down the intervention to reduce delivery cost while maintaining high cost at the research/product development end.

Lessons Learned

Primary Care Buy-in is Crucial

Regardless of the common sense appeal of integration, it still has to be “sold” at the level of the line physician. We learned to appreciate the realities of primary care practice by working side by side with medical colleagues. The better we understood their reality, the more effective we were in describing the benefits of integration from their point of view. The biggest compliment we could receive from a PCP was, “It is obvious that you think like a primary care provider!” The bigger message is that what we see as important about integration as behavioral health providers may mean very little to a PCP. The failure of the Group Health depression pathway was an object lesson in how conflicting agendas at the decision making level can create the impression that there is buy-in when in fact there is no buy-in.

Operationalizing a Model of Care is Different than Inventing an Approach

In the era of discovery, we had the freedom to experiment with all kinds of different integration ideas but as the system matured, we had to confront the realities of system design. We would never have thought about writing a program manual designed to articulate every last detail of the system. Interestingly, this emphasis on planning and program description has emerged as a core attribute of our consulting model in contemporary times. The time spent on

planning and describing all facets of an integrated care program will directly reduce the time spent correcting defects in the program once it is up and running. There are always going to be problems that no one anticipated once the program is up and running. At the same time, failing to plan, document, and develop important policies and procedures is a formula for catastrophe. The program manual is the “bible”; it is the repository of all of the important policy and procedure decisions that are made. It is what allows a new BHC to arrive at a clinic and understand what services are to be delivered, how, and to whom. The program manual is a living, breathing document that helps transfer accumulated knowledge over months, if not years.

Condition-Specific Models of Integration are not the Answer

The research on integrated behavioral services has largely ignored the elephant in the living room. There are literally hundreds of conditions treated in primary care and they all have a behavioral component. Getting a person to take a pill is a behavior change that involves addressing attitudes, expectancies and changing habits. The reality is that most patients with behavioral needs in primary care do not fit into a single clean category. Research studies create clean categories by systematically excluding all patients except those that fit in clean categories. A simple analysis of this issue leads to an unavoidable conclusion: condition specific programs will never be the answer to the search for a broad based, cost effective integration model. The cost of even one condition specific approach, when multiplied by all the other conditions that should also be treated, is so exorbitant that our health care system could never afford it. We would argue that one major reason integration is not moving forward at a faster rate is that research based models of integration, while creating “buzz” about the subject, also deter decision makers because of the imputed cost of such approaches. Health care decision makers look at these studies, estimate the costs to expand these models to all relevant patient populations, then turn away and begin to look for far cheaper alternatives.

The Era of Dissemination and Evaluation

In 1998, we were contracted by Kaiser Permanente of Northern California to help implement an integration program as part of a larger redesign of the adult primary care system. While the decision makers at Kaiser were well aware of the collaborative care studies for depression, they were convinced that this approach would be cost prohibitive. They were looking for a “generic” approach to integration that would allow all of their patients to receive

instantaneous access to behavioral services, regardless of the type of problem. This was the largest dissemination project in the history of integrated care, as Kaiser has roughly 2 million members served by a network of hospitals and primary care centers spread throughout Northern California. Interestingly, the appeal of the PCBH model to Kaiser decision-makers was that it helped leverage physician time; the presence of an on-team behaviorist or BHC would allow doctors to transfer time-consuming patients with behavioral issues to the behavioral health provider, thus freeing the physician to see patients with higher Relative Value Units (RVUs) conditions. In other words, although the medical leaders were certainly aware of the research, they mainly were concerned with increasing physician productivity and believed the PCBH model could help accomplish that goal. Internal studies at Kaiser are not available for public consumption but the “grapevine” rumor is that fully integrated primary care teams were producing roughly 12% more patient care than non-integrated teams. Most importantly, the integrated program continues today, nearly 10 years after it was started. Anyone who is familiar with the business mentality of Kaiser knows that this program would not be alive today unless it had passed numerous internal reviews of its cost utility.

In 1999, we became the primary technical assistance vendor for the HRSA Bureau of Primary Health Care (BPHC), the funding parent for all of the community health centers in the United States. Upon being informed that we had been awarded the contract, we were told that integration was probably just another flash in the pan and that most of the other technical assistance programs died out after a year due to a lack of requests for technical assistance from the community health center system. Five years later, we had presented over 150 specific trainings to individual health centers and had helped produce an advanced on-site consulting program funded by HRSA that allowed us to work individually with over 50 health centers spread across the lower 48 states, Alaska and Hawaii. Requests for additional technical assistance were still coming into the Bureau at a steady rate when the Bush Administration cancelled all technical assistance programs in its overhaul of the BPHC in 2005.

At about the same time, we began a long and productive relationship with the United States Air Force to implement the PCBH model throughout their medical system, comprised of over 70 medical facilities across the globe. Our work with the Air Force helped us better understand methods for assuring a consistent set of services regardless of location. We developed a comprehensive method for assessing the quality of integrated care programs and applied it in over half of the Air Force bases in the world. The Primary Care Behavioral Health Integration Tool

(PCBH-IT) focuses on three critical parameters of integration: clinic systems, communication practices, and population impact. We used results of the PCBH-IT to help stakeholders and decision makers identify targets for increasing the level of program integration at each site. We were able to measure change in all parameters on bases where we made follow-up visits and it does appear that the PCBH-IT is sensitive to system and practice level change. We are revising the tool extensively and adding a far greater level of operational detail. We hope to conduct a large-scale validation study of it during 2009.

The core competencies training model has also served us well, as we were able to standardize such things as how the BHC introduces the patient to the purpose of the visit, the way the visit will be conducted and how information gleaned in the consultation will be used to promote quality of life. We discovered that training mentors and geographically dispersing them was a very powerful way to expand the system within a very limited time frame. The Air Force now requires that all behavioral health providers being assigned to primary care be trained and certified by a BHC mentor prior to delivering services. Specific standards have been put in place regarding core competency ratings necessary for BHCs at the conclusion of basic BHC training and mentor BHC training. There is now a standardized training system that is accessible throughout the system. To create an ample supply of qualified BHCs, Air Force residency programs in psychology and social work now provide practical training in the BHOP model as part of the residency requirement. We are in the process of working with Air Force Family Medicine residency programs to use the PCBH approach as the framework for training family medicine residents in integrated care practices.

Despite two wars and the deployment and re-deployment of numerous BHCs and BHC mentor-trainers, the Air Force “Behavioral Health Optimization Project” or “BHOP” held steady and was transformed over a matter of years to the “Behavioral Health Optimization Program”. In Air Force jargon, the shift to program status means that the model has been tested, found to be useful and is accorded the status of being a regular primary care program. This system level acceptance occurred despite the absence of high quality program evaluation data about clinical outcomes. The outcomes that were most important were obtained in physician satisfaction studies, which showed inordinately high ratings of BHOP on a number of different dimensions.

In 2002, one of us (PR) commenced full-time BHC work in a community and migrant health center and the other (KS) moved into full-time BHC work in another community health center several years later. While these endeavors were pursued for the satisfaction inherent in

providing clinical services in primary care, they also deepened our understanding of the needs of under-served people and how integrated behavioral health services could be used to improve outcomes for this vulnerable group. Here, we learned about the critical importance of developing services that maximize productivity. In an initial pilot effort to screen patients for conditions of concern identified by PCP staff (which included substance abuse, depression, domestic violence and chronic pain), we found that over half of the people in the waiting room on 5 continuous days of care were positive for one or more of the conditions. For the first time, we identified a set of productivity standards for daily practice that have since been applied in other systems of care. We used brief instruments including the Duke Health Profile (Parkerson, 1996) at all visits with adults (and different assessment instruments for children and adolescents) and wove assessment results into collaborative treatment planning with referring PCPs. At follow-up visits, we re-administered the instruments to evaluate the impact of our team-based interventions. We looked at clinical data in aggregate, along with survey data, to evaluate the impact of the PCBH model. Results were uniformly positive and included improvements in health-related quality of life, high levels of physician satisfaction and patient satisfaction, and interestingly, an increase in PCP use of behavioral interventions and a concurrent reduction in psychotropic medication prescribing. Soon, PCPs were asking for copies of the assessment forms we used, and we provided them and trained their assistants to administer and score them.

Perhaps one of the most exciting experiences during our work with community health centers was the creation of a pathway program for patients with chronic pain. In developing an integrated pain program, we found new and more meaningful opportunities to share behavioral technology with our primary care colleagues. We developed screening tools to help PCPs identify acute pain patients that were at risk for developing chronic pain. We devised behavioral health prescription pads to help physicians work with their patients on pain acceptance and valued based goal setting in important life domains. We found that PCPs did not mind if we left off diagnostic labeling and focused on functioning. Even more, we found that they readily adapted mindfulness and acceptance techniques and liked the idea of using values in their discussions of living life with chronic pain. We measured PCP satisfaction with treating this challenging group over a 5-year period of pathway development. In the fifth year, PCPs were agreeing with the statement, “I usually have a new idea about how to help my most challenging chronic pain patient.” Patient satisfaction surveys indicated that they too were more satisfied. Cost-savings equal to annual salary for a BHC were documented in a clinic that implemented an

almost identical pathway. We also participated in pathway development for other high impact conditions, including Attention Deficit Disorder and obesity prevention in children, and depression throughout the lifespan.

Our experience in the field also revealed a sobering truth: PCPs are not adequately trained to address the behavioral health issues that are the bread and butter of primary care practice. They lack important interview and assessment skills (e.g., functional analytic assessment, solution focused interviewing, motivational interviewing), and they are basically ignorant about principles of behavior change, habit formation, strategic intervention, solution focused interventions and so on. This explains the most consistent finding when family residents are surveyed 5 years after going into the field. When asked which area they wish they had more training in, the two most common answers are mental health issues and practice management. This problem is also a serious indictment of the behavioral scientist model that is used in family medicine residencies. It simply does not work and needs to be overhauled from top to bottom.

One of us (KS) joined the faculty of a family practice residency program several years ago. Prior to signing on, the faculty agreed to a new plan for training residents in psychosocial medicine. They would convert to the PCBH model in the family medicine clinic and dispense with the behavior scientist model. They would increase the time residents spent with the BHC, and the focus of training would be on developing fluency with behavioral assessment and brief interventions skills. They would no longer spend time at the local mental health agency watching psychiatrists prescribe drugs or watching therapists perform one and one half hour intakes and one-hour therapy sessions. Beginning in the first year, residents would shadow the BHC, while s/he delivered care to patients in the family medicine clinic (which also happens to be a community health center) and, after an initial period of observation, begin to function as the lead provider in delivery of BHC services to patients. From year one, the resident would be required to learn to provide a full assessment and intervention in 20-min visits while being observed and coached by the BHC. Deficits in knowledge could be easily identified in the approach and the resident could correct gaps in knowledge through targeted readings (i.e., CBT approaches to depression, motivational interviewing, acceptance and commitment therapy, solution focused therapy, principles of brief therapy). In this new approach, core competency assessments are conducted at the conclusion of each psychosocial medicine rotation with specific learning objectives identified. Residents are also observed and coached in application of assessment and intervention skills during brief medical exams.

Research during this era has broadened beyond the clinical trial model and has increasingly addressed real world issues related to integrated primary care. There are a number of studies looking at the needs of veterans returning from current wars and ways to deliver needed services to them. In a study of veterans seen in VA health care facilities between September 30, 2001 (US invasion of Afghanistan) and September 30, 2005, 25% received a mental health diagnosis and over half of this group had 2 or more mental health diagnoses (Seal, Bertenthal, Miner, Sen, & Marmar, 2007). Most initial mental health diagnoses were made in primary care settings, reinforcing the idea that delivery of behavioral health services in the primary care setting can support early detection and intervention and prevent onset of chronic mental illness and disability.

Research at the St Louis Veterans Affairs Medical Center suggests that provision of integrated services can significantly increase patient and PCP access to mental health services while decreasing the burden on specialty mental health clinics. Specifically, evaluation of a large integrated care program found a decrease of 48% in PCP rate of referral to mental health and a concurrent increase in patient access to mental health services in primary care (including via “warm handoffs” to primary care psychologists) of 170% (Martielli, Brawer, Metzger, & Gaioni, unpublished manuscript). Data from the St. Louis VA also suggests high fidelity to the BHC model of integration (Brawer et al., unpublished manuscript). In an evaluation of integrated care services provided to over 1500 patients in VA primary care settings, results indicated high fidelity to the model of integration with the overwhelming majority of patients being seen for 30 min or less and participating in an average of 3.49 contacts with the BHC. In regards to cost issues, one recent study found that primary care based depression treatment is associated with fewer missed days at work (Wang et al., 2007), and this type of data may help convince employers to choose insurance plans that cover primary care based behavioral health services.

Mistakes

Confusion About Terms

Next to the word “love”, the word “integration” is among the most frequently used and abused words in the English language. Almost any activity involving two or more people is now labeled “integrated”. For a long time during this era, we were very permissive about how this word was used. It was politically correct and often helped initiative opportunities to allow systems change. However, we have also noticed there is a downside. People are getting

confused about the essential elements that go into true integration. We kept hearing people proudly proclaim that they had an integrated medical clinic, only to discover in site visits that it was nothing more than a co-located psychotherapist seeing physician referred patients for traditional therapy. There are similar issues when we discuss terms like “coordinated care”, “collaborative care” and “integrated care”. These are not the same things, but we have not done as good a job as we should have in helping people make the sometimes subtle discriminations between terms. Part of the impetus for developing the comprehensive integration assessment tool for the Air Force was to begin the process of identifying the core domains of integration and to quantify how well a particular program is doing in each domain.

Lack of Published Effectiveness Studies of the PCBH Model

We have been so busy helping systems adopt the PCBH model over the last 10 years that we have not stimulated enough effectiveness research on this model of care with an unscreened population. This is partly due to a lack of funding opportunities for studies of system change, as opposed to studies of clinical outcomes with a particular condition seen in primary care. Another barrier has been the paucity of instruments capable of simultaneously measuring health status, psychological health and social health. Fortunately, there are a number of research efforts underway to assess the effectiveness of the PCBH approach with an unscreened primary care cohort. One American study (Bryan et al., *in press*) has demonstrated wide spread clinical and functional benefits from a very limited number of contacts with the BHC. In Sweden, we have seen preliminary data on 75 patients showing very large changes on the Duke Health Profile among patients seen in the PCBH model, with effect sizes of .92 on the overall instrument (Wisung, personal communication).

Lessons Learned

Integration is a Healthcare Priority, Not a Mental Health System Priority

Most major integration projects start on the health care side of the fence, not in the mental health sector. Indeed, the mental health community has been the biggest single drag on the emergence of integrated primary care. Mental health administrators often view integrated programs as a threat to their existence or at least a competitor for what is most often limited funding.

Internal Quality Improvement Initiatives, not Research, Trigger Integration Projects

Very few system redesigns we have been involved in have been triggered by academic research. Most of the time, it is an internal quality improvement effort that stimulates the movement toward integration. Integrated care is easy to sell as an alternative to the existing mental health system, which medical providers believe is dysfunctional.

Identify and Address the Needs of the Stakeholders

Because nearly all integration conversions are internal initiatives, it is critical to understand what the interests of actual stakeholders in a system are. The medical director wants physicians to be productive and to report high job satisfaction; the chief executive officer (CEO) wants to sell the board on improved access to behavioral care, high numbers of patients receiving care, and high patient satisfaction; the chief financial officer (CFO) wants to see the services reimbursed and to see increased revenue generation from PCP's. In capitated plans, senior decision makers want to see a reduction in medical service use, which effectively increases the capacity of the delivery system; it can absorb new patients without having to add new providers, nurses and facilities. When program evaluation data meet the requirements of the various stakeholders, the integrated care program will be assimilated into the system. That is why almost all of the clinics with which we have consulted in the past 10 years continue to offer integrated services. Ironically, the only system we have worked in that has shut down its integrated care program is Group Health, the seedbed of the PCBH model!

Training is Essential

Integration efforts succeed most rapidly in systems where primary care and behavioral health providers receive both structured didactic and *in vivo* instruction in integration practices. Teaching PCPs integrative practice competencies is no less important than teaching the newly arrived behavioral health providers. We developed core competency tools for PCPs, as well as behavioral health providers and wrote a book that included a draft of a policy manual, along with extensive information concerning start-up, ethical issues, clinical interventions, and design of group and pathway programs. We also began to understand the importance of operational details in making the multiple changes required to change patient flow, support patient scheduling, complete billing, and enhance communication among clinical staff.

Resistance in the Insurance Industry is the Single Biggest Deterrent to Integrated Care

Most of the seminal projects in integrated care have occurred in staff model systems that can absorb the impact of integrated behavioral services not being reimbursed. Unfortunately, the first rule of insurance is to not pay for anything that you can get away with not paying. This means that most new health care services go un-reimbursed, often for years. A good example is nutritional counseling and diabetes education services. For years, payment was denied for these services on claims they were “experimental”. If the private and public insurance systems in the United States agreed to reimburse for integrated behavioral care, there would be a virtual explosion of such programs within a matter of 2–3 years. Integrated behavioral care is such a good idea that the only real barrier is reimbursement for services. It is truly a testament to the sticking power of the PCBH model that large systems of health care continue to incur the costs of behavioral health providers who cannot bill for their services.

Changing the Way PCPs are Trained will Facilitate System Change

Our efforts to change the way family medicine residents are trained in psychosocial care have produced an unexpected result. After 3 years of training and supported practice in the PCBH model, graduating residents are exponentially more sophisticated in detecting and addressing behavioral health issues during medical exams. They are more confident in their skills and view the integrated care model as a superior way to provide primary care. When they look for jobs after residency, they are asking about the composition of staff in medical clinics or group practices with which they are considering affiliation. They are looking for a situation that involves integrated care because they are convinced it is a superior way to do business. Just think about what would happen to the health care system if the PCBH training model became the standard for family medicine residencies across the United States! That is our new conspiracy designed to change the health care system.

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