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## A PRIMER ON THE CONSULTATION MODEL OF PRIMARY CARE BEHAVIORAL HEALTH INTEGRATION

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In both scientific and health care administration venues, there has been an explosion in writings about the integration of mental health services into primary care clinics over the past decade. The dramatic increase in models for integration and research in this area parallels the substantial change that has occurred in primary care medicine. Specifically, the nature of primary care has shifted from an acute care model to providing “integrated, accessible health care services by clinicians 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

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community” (deGruy, 1996, p. 33). To meet the demands of this shift, mental health providers and services have become increasingly more important in the delivery of primary medical care as a means to effectively and efficiently address the myriad of mental health complaints that commonly occur in primary care settings. This chapter briefly describes the rationale for a consultative model of integrated behavioral health care, draws on a clinical example to further illustrate this model of care, and discusses typical pitfalls encountered when transitioning from the specialty mental health role to the primary care behavioral health consultation role. The goals of this chapter are to expose the reader to a nontraditional model of mental health care delivery, to demonstrate how and why a consultative model of behavioral health care is symbiotic to the goals of today’s primary care environment, and to provide a foundational understanding of what this model of care looks like in actual clinical practice.

## RATIONALE FOR INTEGRATION

The benefits of mental health programs integrated with primary care in a variety of practice settings, patient populations, and clinical modalities have been well documented. Previous studies have shown that integrating mental health services into primary care clinics can improve patient satisfaction (e.g., Katon et al., 1996), improve provider satisfaction (e.g., Corney, 1986; Katon et al., 1996), improve patient outcomes (Balestrieri, Williams, & Wilkinson, 1988), and decrease health care costs (e.g., Von Korff et al., 1998). Numerous studies have also found that collaborative care models designed to improve the recognition and management for specific diseases or conditions within primary care are both clinically effective and cost-effective. For example, several successful collaborative care models have been developed for depression and have uniformly demonstrated improved recognition of depression that, if followed by multidisciplinary, multicomponent interventions, improve both disease-specific as well as overall health outcomes (Bower, Richards, & Lovell, 2001; Pignone et al., 2002; Schoenbaum et al., 2001; Unutzer et al., 2002; U.S. Preventive Services Task Force, 2002). Improved patient satisfaction, increased adherence to medications, decreased medical utilization among “high utilizers,” and cost offsets (Brown & Schulberg, 1995) have also been reported using collaborative care models. Behaviorally based lifestyle interventions delivered in primary care are also likely to have cross-cutting beneficial effects because unhealthy lifestyle habits such as smoking, sedentary lifestyle, and high calorie diets are known risk factors for multiple

chronic illnesses such as diabetes, ischemic heart disease, and chronic obstructive pulmonary disease (COPD). In fact, evidence is currently mounting that self-management for these chronic conditions can be effectively taught in non-disease-specific primary care based groups, leading to significant impact on aspects of health status, health behaviors, and fewer hospital days (Lorig et al., 1999).

Integrated care can take many forms, ranging from a minimal combination of behavioral health and physical medicine services to providers regularly working together in delivering health care services as a unified team. Merely colocating mental health providers into primary care does not equate to integrated care and has been found to be an insufficient solution. In the absence of changed processes, colocated mental health providers are likely to revert to delivering specialty services and to treating only the small proportion of the population that are easily identified by primary care providers as needing clinical intervention. Rather, the common elements of successfully integrated programs appear to be full integration of mental health providers within the clinic, behavioral and lifestyle interventions, a structured program of treatment, an emphasis on follow-up care, and a focus on depression (Simon & Von Korff, 1995).

Moreover, if integrated care is also being used as one means to make an impact on the entire population of interest, this requires yet another echelon of integration. For this to occur, the model of integration must be consultative in nature and rooted in a public health perspective of service planning and delivery. In this type of model, behavioral health providers support improved detection of behavioral health problems through targeted or universal screening, focused assessment, brief interventions, and follow-up. Such a model of integration requires a fundamental shift away from many of the basic tenants of specialty mental health care, as shown in Table 1.1.

In the integrated care model, the focus is on brief behavioral health services that are provided to patients at an earlier point in their progression along the health continuum, in a setting that minimizes resistance to care and provides different types of services to more closely match patients' needs. The focus is on resolving problems within the primary care service structure, as well as assisting patients to engage in health promotion activities. Because integrated care allows symptoms to be more easily recognized and treated when they first emerge, it is also likely to reduce the duration and intensity of treatment required to move individuals back toward the healthier end of the continuum. Integrating behavioral health providers on the front lines of primary care to deliver consultative behavioral health care allows for a shift toward a population-based approach.

**TABLE 1.1**  
**Key Differences Between Behavioral Health Consultation and**  
**Specialty Mental Health**

Dimension	Primary care behavioral health consultation	Specialty mental health care
Primary goals	<ul style="list-style-type: none"> <li>▪ Performs appropriate clinical assessments</li> <li>▪ Supports primary care provider decision making</li> <li>▪ Builds on primary care provider interventions</li> <li>▪ Teaches primary care provider core mental health skills</li> <li>▪ Educates patient in self-management skills through exposure</li> <li>▪ Improves primary care provider-patient working relationship</li> <li>▪ Monitors, with primary care provider, at-risk patients</li> <li>▪ Manages chronic patients with primary care provider in primary provider role</li> <li>▪ Assists in team building</li> </ul>	<ul style="list-style-type: none"> <li>▪ Delivers primary treatment to resolve condition</li> <li>▪ Coordinates with primary care provider by phone</li> <li>▪ Teaches patient core self-management skills</li> <li>▪ Manages more serious mental disorders over time as primary provider</li> </ul>
Appointment structure	<ul style="list-style-type: none"> <li>▪ Limited to one to three visits in typical case</li> <li>▪ 15- to 30-minute visits</li> </ul>	<ul style="list-style-type: none"> <li>▪ Session number variable, related to patient condition</li> <li>▪ 50-minute visits</li> </ul>
Intervention structure	<ul style="list-style-type: none"> <li>▪ Informal, revolves around primary care provider assessment and goals</li> <li>▪ Less intensity; between-session interval longer</li> <li>▪ Relationship generally not primary focus</li> <li>▪ Visits timed around primary care provider visits</li> <li>▪ Long-term follow-up rare, reserved for high-risk cases</li> </ul>	<ul style="list-style-type: none"> <li>▪ Formal, requires intake assessment, treatment planning</li> <li>▪ Higher intensity, involving more concentrated care</li> <li>▪ Relationship built to last over time</li> <li>▪ Visit structure not related to medical visits</li> <li>▪ Long-term follow-up encouraged for most clients</li> </ul>
Intervention methods	<ul style="list-style-type: none"> <li>▪ Limited face-to-face contact</li> <li>▪ Uses patient education model as primary model</li> <li>▪ Consultation is a technical resource to patient</li> <li>▪ Emphasis is on home-based practice to promote change</li> <li>▪ May involve primary care provider in visits with patient</li> </ul>	<ul style="list-style-type: none"> <li>▪ Face-to-face contact is primary treatment vehicle</li> <li>▪ Education model ancillary</li> <li>▪ Home practice linked back to treatment</li> <li>▪ Primary care provider rarely involved in visits with patient</li> </ul>

*continued*

TABLE 1.1 (Continued)

Dimension	Primary care behavioral health consultation	Specialty mental health care
Termination/ follow-up	<ul style="list-style-type: none"> <li>▪ Responsibility returned to primary care provider</li> <li>▪ Primary care provider gives relapse prevention or maintenance treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Therapist remains person to contact if in need</li> <li>▪ Therapist provides any relapse prevention or maintenance treatment</li> </ul>
Referral structure	<ul style="list-style-type: none"> <li>▪ Patient referred by primary care provider only</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient self-refers or is referred by others</li> </ul>
Primary information products	<ul style="list-style-type: none"> <li>▪ Consultation report goes to primary care provider</li> <li>▪ Notes made in medical record only</li> </ul>	<ul style="list-style-type: none"> <li>▪ Specialty treatment notes (i.e., intake or progress notes)</li> <li>▪ Part of a separate mental health record with minimal notation to medical record</li> </ul>

*Note.* From "A Novel Approach for Mental Health Disease Management: The Air Force Medical Service's Interdisciplinary Model," by C. N. Runyan, V. P. Fonseca, J. G. Meyer, M. S. Oordt, and G. W. Talcott, *Disease Management*, 6, p. 179. Copyright 2003 by Mary Ann Liebert, Inc. Adapted with permission.

## THE PRIMARY CARE BEHAVIORAL HEALTH CONSULTATION SERVICE

In general, the goal of a primary care behavioral health consultative service is to position the behavioral health provider in the second tier of the primary care delivery system (Population Health Support Division, 2002). *Behavioral health consultant* (BHC) is a term used to describe any behavioral health provider who (a) operates in a consultative role within a primary care treatment team and within primary care and (b) offers recommendations and care delivery regarding behavioral interventions or psychotropic medications. Second-tier providers support the primary care provider, bringing more specialized knowledge to bear on problems that the medical provider believes require additional support or that are identified through systematic screening processes. In some cases, the BHC may only provide consultation to the primary care provider but more commonly will also see the patient for a limited assessment and intervention. The consultant's interventions are always designed and delivered to support the medical provider's impact on the patients' overall health. The BHC is, in essence, working on behalf of the physician because he or she can offer more specialized knowledge and skills in behavioral health, but these interventions are never in contradiction to or irrelevant to the physician and patient's overall health care plan. Ongoing communication with the physician regarding recommendations and the patient's status is key to the consultant's role. In contrast to specialty mental health settings, consultation by

the BHC does not require a separate informed consent document because behavioral assessment and intervention are a part of the primary health care team's service. Moreover, documentation is recorded only in the medical record rather than in a separate mental health chart. In summary, both patients and providers experience the consultant and the care provided as part of the overall approach to primary health care. The primary care behavioral health consultation model is tailored to and integrated within the process of normal primary health care services. The consultation model has been implemented effectively in the Air Force Medical Service (AFMS) and has been well received by its primary care providers and patients alike (Runyan, Fonseca, & Hunter, 2003).

### ROLE OF THE BEHAVIORAL HEALTH CONSULTANT

The BHC is typically a social worker or a psychologist with specialized clinical training in consultative behavioral health care. The consultant's role is to provide support and assistance to both primary care providers and their patients without engaging in any form of extended specialty mental health care. The model and associated interventions rely heavily on cognitive-behavioral theory because cognitive-behavioral interventions flow out of a problem-focused assessment, can be implemented quickly using handouts and other instructional aids, and have strong empirical support. Some consultations are single visits with immediate suggestions for intervention strategies made to the referring provider. Other times the consultant will meet with the patient for a few additional appointments to help establish momentum toward change. Interventions with patients tend to be simple, "bite-sized," and compatible with the types of interventions that could be provided or reinforced in a typical 15- to 20-minute health care visit (i.e., interventions that can be done in 2 to 3 minutes). It is also clear to the patient that the consultant is being used to help the physician and patient come up with an effective plan of attack to target the patient's concerns. Follow-up consultations are choreographed to reinforce provider-generated interventions. The goal over time is to maximize what often amounts to a limited number of visits to either the consultant or the medical provider. Thus, the consultant is able to follow patients who need longer term surveillance at arm's length, in a manner that is consistent with how primary care providers manage many of their at-risk patients. At all times, care is coordinated by the medical provider, who is still responsible for choosing and monitoring the results of interventions. In other words, the primary care providers "own" these cases. Integrating behavioral health providers into the primary care setting in

**EXHIBIT 1.1**  
**Expected Benefits of Integrated Behavioral Health Care**

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- Immediate access to behavioral health care
  - Improved recognition of behavioral health needs
  - Improved collaborative care and management of patients with psychosocial issues in primary care
  - An immediate and internal resource for primary care providers to help address a patient's psychosocial concerns or behavioral health issues, without referring the patient to a specialty mental health clinic
  - The provision of rapid feedback to the medical provider
  - Improved fit between the care patients seek in primary care and the services offered
  - Prevention of more serious mental disorders through early recognition and intervention
  - Triage into more intensive specialty mental health care by the BHC
  - Facilitation of the transfer of empirically supported treatments into primary care
  - Improved efficiency in the delivery of empirically supported treatments
- 

this manner is expected to yield the beneficial results demonstrated by other collaborative models over time (see Exhibit 1.1).

**CLINICAL PROCESSES**

The remainder of this chapter provides a foundational overview of what this model looks like in actual clinical practice and references the case of Mrs. Smith to illustrate these processes:

Dr. Jones consulted the BHC on Mrs. Smith, a 29-year-old female with migraine headaches that have been refractory to standard medications. Dr. Jones informed the consultant that Mrs. Smith reports significant stress in her life and Dr. Jones believes this is contributing to her headaches.

**The Initial Appointment**

The initial appointment, which is typically 25 to 30 minutes, can be broken down into three distinct phases, with a bridge between each. These phases, which are discussed in turn, are the introduction, the assessment, and the intervention (see Table 1.2).

*Introduction*

The first few minutes of the initial appointment are spent introducing the BHC's role and what the patient can expect to happen in the appointment. In addition, patients are informed of the following: (a) the consultant

**TABLE 1.2**  
**Phases of the Initial Evaluation Appointment**

Stage	Time
Introduction	1–2 minutes
Bridge to assessment	10–30 seconds
Assessment	10–15 minutes
Symptoms	
Functioning	
Bridge to intervention	1–2 minutes
Intervention	5–10 minutes

has the same reporting requirements as the patient’s doctor; (b) the consultant will give feedback to the patient’s provider; and (c) the appointment will be documented in the patient’s medical record (see sample introduction in Appendix 1.1). In addition, most providers give patients a brochure about the BHC service that contains much of this information at the time they discuss the initial referral to the consultant.

#### *Bridge to Assessment*

The consultation assessment is problem-focused; therefore, the bridge seeks to move the patient quickly into a discussion of the referral question. The transition to the assessment will usually be a single question that directs the patient to the reason for referral. The bridge used with Mrs. Smith was the following:

In talking with Dr. Jones, it sounds like you have tried extensive medical interventions with insufficient effect and she is wondering if stress may be contributing to your migraine headaches. Is that your understanding of why Dr. Jones wanted me to see you, or do you have another take on this?

Sometimes, the physician is not able to inform the BHC of the specific referral question in advance. In this case a BHC might say the following:

I wasn’t able to talk with Dr. Jones before I saw you today, so can you tell me what you and she were talking about when she mentioned it might be a good idea to have you talk with me?

Questions such as these focus the session much more effectively than traditional mental health bridges such as, “So, what brings you in today?” The traditional bridge, when used in primary care, often prompts patients to talk about things not related to the consultation problem, leading to several minutes being wasted as a consultant tries to redirect the patient to the referral question and still maintain rapport.



## *Assessment*

The assessment phase usually lasts about 15 minutes, depending on the complexity of the problem and the tendency of the patient to get side-tracked. Although 15 minutes may not sound like much time, once BHCs become skilled in the model, this is usually plenty of time to assess the referral problem. In addition, the primary care setting, combined with the BHC's introduction, sets the patient's expectations to be consistent with this type of interview and generally makes it easier to get and keep the patient focused. During this phase, the consultant seeks to obtain information regarding symptoms and functioning.

Symptom assessment is based on the referral question and the patient's presentation. Thus, with Mrs. Smith, the consultant focused on information regarding her headaches and stress. For referrals that suggest a possible psychiatric disorder, a diagnostic scan should be done for disorders consistent with this information. If a cursory assessment suggests a possible disorder, a more thorough but directive evaluation is in order to make the appropriate diagnosis.

An assessment of the patient's daily functioning gives the consultant a picture of how the symptoms are affecting the patient's life and often leads to the identification of possible intervention(s). Typical functional areas assessed include impacts on work, marriage, family roles, social roles, leisure time, exercise, and so forth. An initial question that often yields an abundance of information quickly is, "Tell me what you do in a typical day."

An important and often neglected part of the assessment is inquiry regarding what the patient has already done to try to reduce or manage the symptoms and their impacts. This information enables the consultant to avoid heading down an intervention road the patient has already tried (and thus will reject with only a few minutes left in the appointment). In addition, the BHC may be able to identify the reason a previous intervention failed (e.g., patient gave up too early or did not practice the technique properly), enabling the consultant to address these factors when proposing the intervention.

The assessment of Mrs. Smith revealed that her primary stressors were work related (pressure of deadlines, long hours, and hectic pace). She usually developed a migraine by mid-afternoon on about 50% of workdays, which lasted until she went to sleep, but she rarely developed a headache on her days off. About once per week she would have to leave work early because of a headache, but they had little impact on her personal life. She had tried multiple medications with little success. Mrs. Smith recognized stress as a contributor to her headaches and had tried a relaxation tape, which she did three times when her headache was particularly unrelenting. She stated that the relaxation exercises did not help so she threw the tape away. She

works 10 hours, 6 days per week, and does not take a lunch break (eating at her desk). She exercises when she gets home, which reduces tension, but she is unable to exercise on days she has a headache. She has good social support, does not smoke or drink alcohol, denies illegal drug use, reports good adherence with her medications, and denies other notable triggers for the headaches.

### *Bridge to Intervention*

An effective way to shift into the intervention is to summarize the assessment. As part of the summary, the BHC should provide a conceptualization of the problem, focused on the areas of potential intervention. Summarizing the things the patient has already done that have been helpful can provide a positive, encouraging quality to the intervention. In this way a consultant can build on or enhance what the patient is already doing. The bridge with Mrs. Smith was as follows:

Okay, it sounds like you clearly see how stress is making your headaches worse. You recognize your primary stress is at work and the tension builds up through the workday. You exercise when you get home which relieves the tension, at least on days you don't have a headache, but you don't have any ways to reduce the tension during the workday or in the evening when you have a headache. Thus it sounds like it would be helpful to develop a way to more effectively manage work stress throughout the day so that you could reduce the tension that contributes to your headaches. Would you be interested in pursuing something like this?

### *Intervention*

The intervention phase typically lasts about 10 minutes. The proposed intervention flows directly from the conceptualization provided to the patient and should be concrete and practical. The focus should be on effective symptoms reduction techniques when possible. When symptom reduction is not possible, the intervention becomes focused on improving functioning. The intervention needs to be supportable by the primary care provider in that it is both consistent with the medical interventions being conducted by the physician and easy for them to reinforce during follow-up medical visits.

If the patient has agreed with the BHC's conceptualization, the patient will usually be receptive to interventions that are clearly tied to this conceptualization. Therefore, it is important not to move into the intervention phase until the patient concurs with the conceptualization. Also, it is beneficial to provide a menu of options to address the identified problem. Finally, the patient can be asked if he or she has ideas of changes or strategies

that would be helpful and doable. Having choices increases the patients' involvement in and control over the process and often increases their investment in the chosen intervention or helps them to be open to interventions in the future if they choose not to pursue change at the present time.

Mrs. Smith was offered the options of (a) doing nothing, (b) working together to develop a plan to take brief breaks at work or to take a short lunch break to go for a walk, or (c) learning a relaxation technique and how to use it appropriately. Relaxation training was recommended because she had not previously given it an adequate trial. When these recommendations were given, the BHC first said the following:

You've tried a relaxation technique before, which we know helps the majority of headache patients; however, it sounds like you didn't receive good training or instruction on how to use the technique to reduce your headache. Therefore, it might be helpful to try relaxation again.

She opted to learn a relaxation technique. The consultant briefly explained how relaxation techniques work, introduced the key components of the diaphragmatic breathing technique, and taught her how to breathe with her diaphragm. The rest of the education and instruction was done through a detailed five-page handout covering the sympathetic and parasympathetic responses, the rationale for the technique, instructions in all components of the technique, and instructions for practice and trouble-shooting.

### **Follow-Up Appointments**

Follow-up appointments can range anywhere from 5 to 25 minutes, with the length of the session based on clinical necessity rather than the scheduled time allotted. Thus, even though the appointment slot was scheduled for 30 minutes when Mrs. Smith came in, she was doing much better and the consultant determined no further intervention was needed. The appointment ended after 7 minutes. Follow-up appointments can be scheduled every 15 to 30 minutes, depending on the skill level of the BHC and the needs of the population. Follow-up intervals are also based on clinical necessity rather than historical convention. For example, some patients may have an initial follow-up visit 3 to 4 weeks following their initial BHC encounter to allow sufficient time to practice a newly learned technique, whereas others may be seen within the same week or at their next scheduled medical visit. For some, follow-ups may only be done if a patient has problems using a newly learned skill or if it does not help. In such cases, the primary care provider may simply include a progress check at the next scheduled medical visit. The consultant typically involves the patient in collaboratively determining both the timing and method of follow-up. Schedulable appointment slots are available for about 75% of the consultant's time; the remaining

25% is typically left open for same-day walk-in appointments or to “catch up” on note writing, phone follow-ups with patients, and giving feedback to referring physicians.

Other than these differences, follow-up appointments are similar in structure to a typical cognitive-behavioral therapy (CBT) follow-up in specialty mental health treatment. Specifically, the appointment begins by assessing how the patient did on the tasks from the last appointment. The impact of these efforts on their symptoms is then determined and the need for additional skill training assessed. If there is a need for additional intervention, it will be conducted and the task for the next follow-up period discussed. Given the similarity with standard CBT, new consultants typically find the practice adjustments necessary for follow-ups much easier to make than those required for doing the initial assessments. Although structured similarly, these appointments are briefer because of the focus on the referring problem, the selection of “bite-sized” targets of intervention, and the use of “self-help” oriented educational materials.

## FEEDBACK TO THE PRIMARY CARE PROVIDER

Communicating back to primary care providers is one of a BHC’s highest priorities, even if it means handwritten notes or staying late to have a face-to-face conversation. Feedback is best given the same day the patient is seen. Ideally this feedback is given verbally and in person. When this is not possible, a phone call, voice mail message, secure e-mail, or a copy of the consultant’s note will suffice.

The feedback given to Dr. Jones regarding Mrs. Smith was as follows:

Dr. Jones, I just saw Mrs. Smith today. Her headaches do appear to have a significant stress component, primarily work stress. I trained her in a relaxation technique she can use at work and will follow up in 1 month. When you see her again, you might ask her how the practice of the technique is going and encourage her progress toward better management of her work stress. If she has problems or is not making progress, feel free to re-consult me and I can teach her some additional skills.

## PITFALLS TO AVOID

### **Introduction Phase**

A common pitfall for new consultants is to significantly abbreviate the introduction phase. The introduction script in Appendix 1.1 was care-

fully crafted to quickly but fully inform patients of key information related to their care. Therefore, we recommend new BHCs memorize this introduction or a similar script suitable for the health care setting of practice. The consultant should seek to present this information in its entirety, using a smooth, natural communication style.

Informing the patient about the length of the evaluation and that it will be problem focused are often neglected by new consultants. However, these parameters serve to decrease the likelihood of the patient bringing up minor concerns or issues peripheral to the chief complaint. Neglecting to provide this information often results in the patient spending several minutes discussing tangential information and the BHC losing valuable time as he or she tries to refocus the patient on the problem.

### **Assessment Phase**

There are two primary pitfalls to avoid during the assessment phase. The first is a tendency to “go fishing” for problems. The role of the BHC is to expound and clarify the nature of the referral problem and develop recommendations to help the physician address the particular health issues pertinent to the consultation. As in all types of primary health care, although other problems are likely to exist, they are not the target of this visit or consultation. Primary care providers do not do a complete physical each time the patient comes with a new complaint. In primary care, the physician assesses and treats the factors causing the current symptoms, knowing that as new problems arise or surface, the patient will come back. By being present in primary care, the BHC will be available to assist with future problems as they arise. For example, in evaluating Mrs. Smith, the consultant did not inquire about neurovegetative signs of depression, suicidality, homicidality, or full mental health and physical health treatment history because no indicators of such were included in the consultation, revealed in the assessment, or observed in the patient.

The second primary pitfall is the tendency to move too fast to the intervention phase. Because of the time pressures in this environment, there is a natural tendency to start an intervention as soon as any problem that the BHC has an intervention for is identified. This is the opposite of the first pitfall, in that in this case the consultant fails to gather enough information. For example, as soon as the he or she heard Mrs. Smith acknowledge “stress,” the consultant might quickly recommend training in a brief relaxation technique. When this happens, the BHC typically meets resistance from the patient. Even if the consultant has successfully identified the issue, completing the assessment phase enables a more effective bridge to be made to the intervention. Therefore, it is best to complete an adequate, yet focused, assessment before identifying the intervention target.

## Intervention Phase

Cognitive-behavioral therapists often have an extensive array of handouts that they will bring into the primary care setting. However, given the short appointment times in primary care, more extensive handouts than the ones typically used in specialty mental health practice are useful. In traditional mental health care, a full 45 to 50 minutes is usually available to do the intervention. Thus the therapist can take the time to explain, demonstrate, or practice whatever is being trained in that session. As a consequence, handouts are usually brief and focused on providing reminders of what was trained. In contrast, handouts used in the primary care setting are more similar to traditional self-help literature. Specifically, they should be concise but provide all the details necessary for patients to do it on their own. In the appointment, especially the initial one, the consultant will often only have time to introduce the technique and possibly discuss/demonstrate a few key points. Most of the teaching will be done through the handout.

Similarly, new consultants often tend to limit interventions to those they have handouts about. However, not all interventions require handouts. For example, if Mrs. Smith opted to work on increasing breaks at work and taking a walk at lunch, the consultant would work with her to develop a specific plan to accomplish this goal. In these cases, the BHC will often write down the plan or have the patient write it down. In our practice, we have developed “behavioral prescription” pads in which we record the plan and follow-up appointment time and give it to the patient.

Another pitfall is for the consultant to be overly conservative about who can be managed at the primary care level. One of the goals of the initial consultation is to determine the likelihood that the patient’s behavioral health needs can be supported in primary care. In general the BHC is available to see any patient for an initial consultation, unless the initial discussion with the physician indicates the patient’s needs clearly exceed the scope of care for consultation. If the initial assessment reveals a serious psychiatric disorder, the medical provider should be given the recommendation to refer directly to specialty mental health services. For patients in crisis, the BHC should initially take the person off the physician’s hands, thereby allowing the physician to stay on schedule. If the crisis cannot be quickly managed in the clinic or if the patient is imminently suicidal and thus beyond the scope of the consultation service, an immediate referral to a specialty mental health service should be recommended. The BHC can help facilitate the transfer. Aside from these situations, the primary indicator for a recommendation to specialty mental health care is the patient’s failure to respond to a reasonable collaborative treatment effort between the consultant and physician. Mrs. Smith did not have a serious psychiatric disorder and was not in crisis; therefore, no referral was recommended. However, if

after attempting these recommendations, her headaches were not significantly improved, the consultant would likely recommend a referral to a specialty clinic that would conduct a full evaluation and provide a more intensive regime of CBT for headaches.

### **Follow-Up Phase**

A common pitfall in the follow-up phase is having too brief of an interval between appointments and scheduling follow-ups when unnecessary. The default follow-up time in specialty mental health care is typically 1 week. In contrast, the BHC follow-up default is approximately 1 month, with modification based on clinical need. Thus some patients may come back in a week or less, some in 3 months or more. The benefits of the delayed follow-up include (a) more time for the patient to have practiced and benefited from the intervention; (b) the patient develops a greater sense of responsibility for carrying out the intervention; and (c) appointment availability is maintained for the entire population without compromising the clinical care provided to each individual patient. Consultant follow-ups are typically used for patients with whom additional interventions are planned when the accountability provided through a follow-up is expected to help the patient maintain behavior change motivation, when it is expected the patient will encounter problems in implementation, when it will save the physician time, or when the patient prefers it.

The BHC will sometimes do an intervention and not schedule a follow-up, similar to when a patient sees his or her medical provider, is given a medication and told to come back if he or she does not get better. If the consultant working with Mrs. Smith assessed that she had a high motivation level, was responsive to the instruction in the initial appointment, and seemed like she managed other aspects of her life well, the BHC might conclude it would be reasonable to have Mrs. Smith come back only if she had trouble learning the technique or if it was not helpful but would otherwise follow-up with her doctor at the planned 3-month follow-up visit. Dr. Jones could reconsult if Mrs. Smith needed further assistance. However, in discussing follow-up options with Mrs. Smith, if she indicated it would help her to follow up earlier, the consultant would usually agree to follow-up with her in 1 month rather than recommend Dr. Jones use one of her appointments to schedule an additional follow-up, thereby saving the physician an appointment slot.

### **Physician Feedback**

Case presentations in the mental health field tend to be in-depth (i.e., full history, psychosocial factors, etc.). However, primary care providers

are busy and the consultant typically is catching providers between patients. Therefore, feedback should be brief, usually a minute or less, concise, free of psychological jargon, and limited to essential information. If the BHC presented cases in the style typically done in a specialty mental health setting the provider would begin avoiding the consultant because he or she would take up too much time. In general, the BHC should seek to mimic the way physicians present cases to each other. Key feedback to providers includes a statement of the problem, the intervention conducted by the consultant, and recommendations for the physician. The recommendations the consultant gives to the provider should be specific, behavioral in nature, and doable in 1 to 2 minutes during the provider's follow-up with the patient.

## CONCLUSION

Integration of behavioral health providers into primary care offers an incredible opportunity to identify and intervene with problems before they develop into significant pathology, to reach people with effective treatments who would not otherwise seek out mental health treatment, to increase access through more efficient use of providers, and to enhance the behavioral health care that is already being provided by primary care providers. In the consultation model, clinical services mirror those delivered by the physician, enabling true integration into the primary care clinic. However, this requires BHCs to adapt their service delivery methods to the rapid, problem-focused primary care environment. Because primary care based behavioral health consultation differs substantially from traditional specialty mental health care, an adaptation of existing skills and the development of new skills requires time and training.

As this model has been implemented throughout the Air Force Medical Service, it is apparent that reading about the model is not sufficient. Obtaining clinical training is critical to becoming a BHC and especially to developing the understanding and skills necessary to maximize the effectiveness of the consultative model of integration. As previously mentioned, the model relies heavily on CBT. Thus solid CBT skills are necessary to function effectively in this model, but they alone are not sufficient. Even established CBT providers require practice at being flexible as they apply existing clinical skills in new and challenging ways. For providers not yet trained in CBT, extensive behavioral training is necessary as well as learning how to use these newly developed skills in the primary care clinic. In conclusion, although a foundation is presented, we strongly recommend organizations that already have or that are seeking to implement a model of integrated care invest in a didactic and clinical training program for their providers.



APPENDIX 1.1  
SAMPLE SCRIPT OF BEHAVIORAL HEALTH CONSULTANT  
INTRODUCTION (U.S. AIR FORCE MEDICAL OPERATIONS  
AGENCY, POPULATION HEALTH DIVISION 2002)

Hello, my name is \_\_\_\_\_. Before we get going today, let me explain to you a bit about who I am and what I do here.

I'm a behavioral health consultant for the clinic and a psychologist by training. I work with the medical providers here in situations where good health care involves paying attention not only to physical health, but also to emotional and behavioral health and how these things interact with each other. Whenever a provider is concerned about any of these things, they can call me in as a consultant. As a consultant, I help you and your provider better address things that are affecting your health or sense of well-being. To do this, I want to spend about 20 minutes with you to get a quick snap shot picture of what's going on in your life—what's working well and what's not working so well. Then, we'll take this information and come up with some recommendations that might help and that are doable for you.

The recommendations might be things you begin to do differently or they might include things we can do differently here at the clinic. Often they will involve some self-help materials. Additionally, we may decide it would help to have you come back to see me a couple of times if we think it would get some positive momentum going on specific skills. Sometimes, we decide that people might benefit from more intensive specialty services. If that were the case, I'd make that recommendation to your provider and help them arrange the referral.

After we're done today, I'll go over with your provider the recommendations we came up with so they can be incorporated in your overall health care plan. Also, I'll write a note in your medical record so in case you see other providers they can follow up on how the plan is going.

Finally, I want you to be aware that I have the same reporting requirements to ensure your and other's safety as other providers in this clinic.

Do you have any questions about this before we begin?

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