PART I.

THE PERFECT STORM OF PRIMARY CARE

The forces pressuring and buffeting primary and mental health care are like a series of interconnected weather conditions. Escalating rates of physical and mental health problems in the country are combining with escalating health care costs to whip up a vortex of problems. Lifestyle and behavior issues are at the heart of the vortex, playing a major role in the escalation of health problems. Yet, while the pharmaceutical industry has grown in influence, attention to basic behavior change approaches has strayed. Our shelter, the mental health system, is collapsing, leaving many patients out in the cold and forcing many others into primary care for help. They join the growing ranks of patients seeking help in primary care for chronic medical problems, many of which have a significant behavioral component. As more people live with poor health, physicians are pressured to work faster and harder, and, not surprisingly, their patient relationships have suffered and their job satisfaction has declined. Patients have also become frustrated as they face the behavioral challenges of managing chronic diseases while fighting for access to their health care providers. We are no doubt in the midst of a violent storm and it is centered in primary care. Yet, there are emerging strategies for getting through it. Better integration of primary care and behavioral health services is one approach that may help see us through, and in this Part 1 we provide the rationale for it. We introduce a specific approach to integration, the primary care behavioral health consultant model, that we believe holds particular promise. Along the way we also introduce the reader to the structure, players and milieu of the primary care world.

An Overview of Primary Care Behavioral Health Consultation

"Far better it is to dare mighty things, to win glorious triumphs, even though checkered by failure, than to take rank with those poor spirits who neither enjoy much nor suffer much, because they lie in the gray twilight that knows not victory nor defeat."

Theodore Roosevelt (1858-1919) U. S. President

For a number of years, both of us authors worked in traditional specialty mental health care (MH) settings. Like most MH providers, we worked hard, kept up on clinical innovations and had the best interests of our clients at heart. We most certainly had clients who progressed and many who appreciated our assistance. However, we couldn't help but wonder what happened to clients who didn't show for follow-up appointments. On a typical day we and our co-workers would have seven clients scheduled, of which two or three wouldn't show. What happened to the no-shows? Were they still struggling? Why didn't they come in? Further, we felt frustrated that by the end of the day we might have only seen a handful of clients (many of whom were the same clients seen week after week). Thus, how many people were we really helping? First time clients often failed to show as well, which was frustrating because the wait list was typically lengthy. We rationalized that a "no-show" meant the client probably wasn't ready for change. Yet, the questions also nagged of whether the wait might have deterred the client, and how the client was doing if s/he wasn't getting care from us.

Down the hall, but unbeknownst to us, our primary care (PC) colleagues also had some nagging questions. Why do so few of the patients referred to MH follow through on the referral? Why are so many "psych" patients coming in for care when a MH system exists to tend to their needs? How can we get patients with chronic conditions like diabetes to change

the behaviors so crucial to managing their disease? How can a primary care provider (PCP) be expected to meet all of a patient's needs with 15-minute visits?

Unfortunately, as we have since learned, our experiences and questions were not unique. The MH system of this country simply is not meeting the needs of the population, and the PC system is picking up the slack. Approximately 28% of Americans experience a diagnosable psychiatric disorder in any given year, but half of this group receives no care at all. Of those that do, only about half get the care from a specialty MH clinic. Instead, most rely on other health care providers, especially PCPs (Narrow, Regier, Rae, Manderscheid, & Locke, 1993). In keeping with these statistics, an overwhelming majority of prescriptions for psychotropic medications are written not by psychiatrists but by non-psychiatric physicians (Beardsley, Gardocki, Larson, & Hidalgo, 1988). Primary care providers end up delivering most of these prescriptions because, with 80% of the population visiting a PCP in the course of a year, they penetrate the population the deepest (Strosahl, 1998). These statistics begin to answer some of the questions we and our PC neighbors had. When clients didn't show for appointments, they probably eventually ended up in a PCP's office.

In this book we hope to present readers a guide for providing health and MH care in a radically different fashion; one that begins to better meet the needs of the population. Called Primary Care Behavioral Health (PCBH), this model of care involves delivery of Behavioral Health Consultation (BHC) services in a PC clinic and differs in many respects from traditional MH care. It is also designed to change the way PC is conducted. As noted by Strosahl (1998), an early developer and proponent of the PCBH model, this model is best considered a form of *health* care rather than *mental health* care. The goal is not to replace the specialty MH care system, but rather to improve the treatment of behavioral problems in PC. In doing so, the

functioning of the PC system in general can improve and attention to other health needs of the population can increase.

The model as well as the general rationale for integrating primary and behavioral health care have been discussed in other texts (e.g., Blount, 1998; Bray, Frank, McDaniel, & Heldring, 2004; Gatchel & Oordt, 2003). Rather than rehashing those writings, this book will focus on how to actually implement and practice the BHC model. Although a BHC approach alone will not solve society's MH problems, it represents an important step toward improving overall population health. Before describing the BHC model in more detail, some history and background information might help underscore the need for a change.

THE NATURE OF BEHAVIOR PROBLEMS IN PRIMARY CARE

Up to 70% of PC medical appointments are for problems stemming from psychosocial issues (Gatchel & Oordt, 2003). These concerns can take many forms, the most obvious being bona fide psychiatric disorders. For example, a survey of consecutively scheduled adult PC patients found that 19% met criteria for major depression, 15% for generalized anxiety, 8% for panic, and another 8% for substance use. Between 36% and 77 % had more than one disorder (Olfson et al., 2000). The average PCP will see the full spectrum of MH disorders, from depression and anxiety to substance abuse to psychotic disorders within a week of practice. Primary care providers regularly handle care for chronic psychiatric problems as well as acute flare-ups (e.g., a suicidal patient). Because they provide care across the lifespan, many PCPs also treat child behavior problems (e.g., ADHD) in addition to the problems of adults and older adults. Keep in mind that they do all of this while also tending to the medical needs of their patients. A PCP must truly be a generalist! Recalling our earlier comments that non-psychiatric physicians treat the majority of psychiatric patients and prescribe the majority of

psychotropic medications in this country, it is no wonder that PC has been labeled the country's "de facto mental health care system" (Regier et al., 1993).

Activities of the prescription drug industry have played an important role in shifting psychiatric treatment from the MH specialist realm to the PCP realm. As described by Gray et al. (2005), the delivery system for MH care changed dramatically over a 10-year period. Starting with the introduction of Prozac in 1986, there were increases in the number of people treated for depression, the percentage of depressed patients who received medication, and the percentage of patients receiving depression treatment by PCPs (Olfson, Marcus, & Druss, 2002). At the same time, the percentage of patients receiving psychotherapy for depression dropped (Olfson et al., 2002). Specialty behavioral services accounted for about 6% of medical costs in 1988 and 3% today, and this decrease is roughly equal to the costs of behavioral pharmaceuticals prescribed by PCPs (Gray et al., 2005). While MH clinics downsized, drug companies marketed additional SSRI medications to providers and, when the Federal Drug Administration lifted its ban on advertising directly to consumers, they marketed to patients.

Psychiatric disorders, though, are only the tip of the iceberg in primary care. Behavioral issues arise in many other forms as well. One oft-cited study revealed that of the ten most common complaints in a PC clinic, 85% had no clear organic etiology over a three-year follow-up period (Kroenke & Mangelsdorff, 1989). Irritable bowel syndrome, tension headaches, insomnia, and chronic nonspecific pain are but a few examples of somatic complaints that can have a significant stress component. Most patients, however, view these as medical problems and seek help for them from a PCP rather than a MH provider. Many patients also seek help from a PCP for "subthreshold syndromes", such as marital conflict, domestic violence, bereavement and other life stressors. Kroenke and colleagues (1997) obtained a prevalence of

8% for primary care patients who struggle with somatization, and people in this group often use PC services excessively. They often do not need medications, but their distress level tends to be high and PCPs may not be able to offer them the time and skill training necessary to improve their functioning.

Primary care providers also spend much time and energy counseling patients on behavior change issues important to health. According to the United States Department of Health and Human Services (2000), unhealthy lifestyles are responsible for most of the top ten causes of mortality and morbidity in this country. Behaviors such as smoking, poor diet, lack of exercise, and problematic alcohol and drug use are prime examples. Other behaviors such as the wearing of seat belts and bike helmets, the use of contraceptives, high-risk sexual behavior, and numerous others, also have implications for health. Most any MH professional in a traditional MH setting would be surprised and perplexed if a client presented for help with one of these behavioral issues. However, PCPs confront and counsel patients regarding these issues everyday.

Behavioral issues also arise in PC when patients present with chronic medical problems. Primary care systems have historically been focused more on treating acute problems but they increasingly must tend to chronic problems. Indeed, chronic conditions are the fastest growing part of PC (Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). This is due to several factors, including an aging population; an increase in conditions such as diabetes, lipid disorders, and obesity, and medical advances that allow people to live longer with diseases that would have been fatal in earlier years. The trend toward more chronic disease means that more patients must learn to cope with conditions that can disrupt lifestyle and relationships. Moreover, self-management practices such as complying with a medication regimen and

maintaining a healthy lifestyle are often basic to good outcomes. Once again, PCPs are called upon to help patients navigate these issues. They must counsel patients on how to cope with a chronic condition, educate family members about it, and motivate patients to make the lifestyle changes needed to manage it. Unfortunately, estimates suggest that up to 60% of patients with chronic disorders adhere poorly to treatment (Dunbar-Jacob & Mortimer-Stephens, 2001).

BARRIERS TO RECOGNIZING AND TREATING BEHAVIORAL PROBLEMS IN PRIMARY CARE

At the same time that PCPs are being inundated with these various behavioral needs of patients, other factors combine to make meeting these needs difficult. One often cited factor is under-recognition of behavioral problems by both PCPs and patients. Given the chronic nature of many MH problems, they may persist and result in frequent PCP visits if not recognized and treated. Unfortunately, with 10-15 minutes per visit and on average three health concerns voiced by patients per visit (Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995), PCPs have little time to explore problems in detail. Moreover, they may be reluctant to even ask about stressors, fearing the patient will become defensive or require a lot of extra time (Snugg & Inui, 1992). Patients often don't help this situation. They frequently fail to report emotional problems and are often more focused during physician visits on the physical manifestations of stress than on the stress itself (Bray et al., 2004; Patterson et al., 2002).

Stigma regarding MH care also makes it harder for PCPs to recognize and treat the behavioral needs of patients. Many patients and even many health care providers continue to be swayed by an obsolete mind-body distinction that separates mental health from physical health. Thus, rather than viewing a referral to MH as a routine part of health care, patients often interpret it as a sign the PCP has given up on them or doesn't want to deal with their

emotional health (Patterson et al., 2002; Strosahl, 1998). Many patients also are deterred from seeking treatment because of a fear that discrimination will result from it, or because of an internalized prejudice against mental illness (Corrigan, 2004). Other patients might simply refuse to trust anyone other than their PCP for care (Von Korff & Myers, 1987). Whatever the reason, when patients refuse to pursue specialty MH care, PCPs usually end up providing it.

Even when a problem is recognized and the patient is eager for treatment, poor access to MH care may frustrate the patient and the PCP. Under the current system, many patients who genuinely need and desire MH care simply cannot get it. The carving-out of MH care reimbursement (whereby it is considered separate from medical care) has allowed third-party payors to deny or restrict access to MH services, often severely. Additionally, most third-party payors only reimburse for DSM-IV-TR diagnoses, thereby stranding many patients with subthreshold syndromes. Mental health professionals have also not been able to bill for physical health diagnoses, making it difficult to help patients with diabetes, obesity, headaches and other problems in that realm. The American Psychological Association (APA) has recently made some strides toward lessening this dilemma by successfully lobbying for new "health and behavior" reimbursement codes, but obtaining reimbursement with them has been difficult for many practitioners (Gray, Brody, & Johnson, 2005; Dittmann, 2004; Johnson, 2001). All of these issues and others, combined with the successful pharmaceutical marketing described earlier, have shrunk the MH funding stream to a muddy trickle. As resources have become sparser, so have services.

These problems, of course, are in addition to those posed by the growing ranks of the uninsured. Between 1990 and 2001, the number of uninsured persons in the United States grew 19%, from 34.7 million to 41.2 million (DeLeon, Giesting & Kenkel, 2003). These uninsured

do not have easy access to any type of health care, let alone MH care. If they do seek help for behavioral problems, they will most likely receive it not from a community *mental* health center but from a community *health* center, i.e., a PC clinic (DeLeon et al., 2003).

THE EFFECTS ON PRIMARY CARE

One can easily imagine that PC clinics suffer many adverse effects from the deluge of behavioral issues and the lack of integrated behavioral services. Job satisfaction of clinic staff is a concern, and staffing shortages, particularly in rural areas, have lead to concerted efforts to improve marketing and recruitment (Dickinson, Kenneth, Carter, & Burke, 2004). PCPs often do not feel that their training adequately prepared them for the daily barrage of psychosocial problems, and some are bitter about the lack of referral possibilities. Until PCPs feel better trained and prepared for the problems they face, as well as supported, they will likely continue to experience frustration on the job.

Given the team environment of medical settings, it is also true that if PCPs feel frustrated, ancillary clinic staff probably do as well. Medical assistants, nurses and lab technicians are no more prepared to deal with behavioral problems than PCPs, yet they interact with patients sometimes even more frequently than do PCPs. Receptionists and other staff often must handle psychotic, depressed or otherwise challenging patients, and referral coordinators must try (often in vain, due to the factors previously identified) to locate accessible MH services. All of this places additional strain on a PC system that is already very busy.

THE EFFECTS ON PATIENTS

Patients also suffer under the current system. The lack of access to therapy services means that most problems are treated solely with medications. Primary care providers have neither the time nor the training to provide therapy, so most rely heavily on medications. The

use of psychotropic medications has gone up dramatically since the mid-1980s amongst all prescribers, and psychotropic medications are now among the most widely prescribed medications in the United States (Pincus et al., 1998). Given the wealth of data on the insufficiency of medication-only treatment and on the importance of a more comprehensive approach (see for example, Badamgarav et al., 2003), one can easily argue that most patients receive inadequate treatment for psychiatric problems in PC.

More than being insufficient, this heavy reliance on medications may also make some problems worse. For example, when a PCP (desperate to help) is faced with a patient with chronic anxiety (desperate for a respite), the end result may be chronic use of a habit-forming anxiolytic. The patient and PCP may then end up with two problems; continuing anxiety plus dependence on a medication. Actually, they may end up with three or four problems, because without a behavior therapy component the anxiety will likely continue, and the frustrated patient may become depressed or begin to self-medicate with substances.

Even patients with no significant behavioral problems suffer under the current state of affairs. There is, of course, limited time in a day and PCPs are being asked to see more patients than ever. Thus, a lengthy visit with a patient with multiple behavioral issues means a provider may need to recapture time from subsequent patients' visits to stay on schedule. In addition to more lengthy visits, patients with psychosocial problems utilize medical services more frequently (Simon, Von Korff & Barlow, 1995; Unutzer, et al., 1997), which makes accessing services harder for other patients. One study of "high-utilizers", i.e., patients who utilize medical services the most, found that about half had significant problems with depression and anxiety (Katon at al., 1990). Not surprisingly, several studies have suggested that a significant cost-offset can occur in the health care system if recognition and treatment of behavioral

problems is improved (see for example, Friedman, Sobel, Myers, Caudill, & Benson, 1995). The inference from all of these findings is that without sufficient care for behavioral problems we all are paying the price.

CALMING THE STORM:

THE MOVE TO INTEGRATE BEHAVIORAL HEALTH AND PRIMARY CARE

What hopefully becomes clear from our previous discussion is that the present health care system victimizes many people. Patients with behaviorally-based problems are not getting the care they deserve, PC teams are overwhelmed and underprepared for dealing with behavioral problems, and health care for the entire population is thus compromised. Fortunately, as health care professionals have begun to recognize these problems, new models of care have emerged that aim to alleviate them. These models all attempt to bring MH services into PC in some fashion, in an effort to break down barriers to MH care and reduce the strain on PCPs.

The approaches developed to merge PC and MH care vary widely. One way to categorize them is by the degree of "co-location", "collaboration" and "integration" they possess. These are the three components Strosahl (1998) explains are crucial to the success of a PCBH service. "Co-location" refers to the actual placement of the behavioral health service. Placing it inside a PC clinic is ideal, as this will facilitate communication between providers and ease referrals. Additionally, this tactic may reduce stigma by linking physical and MH care in a tangible, visible fashion. "Collaboration" refers to the quality of the relationship between PC and MH providers. A collaborative relationship includes frequent sharing of information, joint treatment planning, and a truly biopsychosocial approach to care. It is entirely possible, though not desirable, for co-location to occur without collaboration. Such is the case with

services that are in close physical proximity to each other yet rarely communicate. The third component, "integration", occurs when the MH provider is considered a regular part of the health care team. In an integrated service, a visit with the MH provider is as routine a part of care as a visit with the nurse. Truly integrated services require no special paperwork or processes to see the MH provider. Instead, behavioral health services are incorporated seamlessly into care, and both patients and staff view the MH provider as just another member of the PC team. Integration is important because without it many barriers to behavioral care will persist. There are plenty of examples of MH providers who co-locate with PC and collaborate closely with PCPs, but do not actually integrate. In this "house shrink" arrangement, the MH provider usually utilizes traditional lengthy assessment and therapy strategies, and as a result becomes quickly overwhelmed by the demand (Strosahl, 1998). Additionally, patients often continue to resist referrals in this situation, because of the stigma of going for MH services.

The various models developed to bring behavioral health into PC all attempt to co-locate, collaborate, and/or integrate to one extent or another. An excellent and concise review of the models can be found in a recently published text written by Gatchel and Oordt (2003). In their book, they review five types of PC behavioral health services and note that the decision of which to use will depend on several issues such as budgetary priorities, skills and preferences of medical and MH staff, logistical considerations (e.g., office space), and buy-in from organizational leadership. We believe the PCBH model makes the most sense for the majority of PC clinics, because it is the only model that offers a MH provider (the Behavioral Health Consultant or BHC) that is co-located, collaborative, and fully integrated. The PCBH model is particularly suited to federally qualified health centers, which have the greatest behavioral

health needs. However, before detailing the PCBH model and our partiality to it, we will briefly review the others.

First of the models described by Gatchel and Oordt (2003) is the *co-located clinics* model. This approach consists of a MH service run as a specialty service (comprehensive intakes, hour-long appointments) but co-located with PC. The two clinics might share some space or staff but are run as separate services. As discussed, co-location *might* improve collaboration between providers and ease referrals, but running MH as a specialty service means the usual problems with accessibility will continue. In addition, the lack of integration increases the likelihood of patient resistance to MH care. When accessibility is limited by these or other factors, the perceived and actual usefulness of the service diminishes. A *primary care provider* model is a bit more integrated. It similarly uses a traditional MH approach but the MH provider works out of PC and is considered a PC staff member rather than a specialty provider. Partial integration is obtained by linking MH care with regular health care, but it is not completely integrated because the traditional MH visits still have a very different feeling from a PC visit. Additionally, the lengthy visits will continue to limit the accessibility of the MH provider. In a *staff adviser* model, the MH provider acts solely as a consultant to the PCP, perhaps seeing patients with the PCP or advising a PCP via phone. Gatchel and Oordt note this works well for training PCPs, but limits the assistance the MH provider can provide. A *stepped-care approach* may also be used, in which some aspects of each of the discussed approaches are combined. Psychological care begins at the lowest intensity possible (e.g., simple consultation to the PCP) and graduates upward (ultimately to more frequent, hour long visits) as needed. This approach has been called the Med-Plus model by Pruitt, Klapow, Epping-Jordan, and Dresselhaus (1998). The flexibility afforded by this model improves

accessibility, and the components of co-location, collaboration and at least partial integration all exist. A disadvantage is that even a few lengthy (e.g., 50-minute) appointments in a day quickly begin to limit accessibility.

THE PRIMARY CARE BEHAVIORAL HEALTH MODEL

We favor the PCBH model because its design allows it to have the largest effect possible on the population and to provide maximal help to PC patients and providers. This model is widely used, having been implemented in over one hundred community health centers across the country and in PC clinics throughout the United States Air Force and Army. A number of Veterans Administration clinics and many private health care organizations such as Group Health Cooperative of Puget Sound and Kaiser Permanente also utilize the PCBH model. Our description of the model comes largely from the work of Strosahl (Strosahl, 1998; 1997; 1996a; 1996b; Strosahl, Baker, Braddick, Stuart, & Handley, 1997).

In the PCBH model, the BHC provides service side by side with PCPs, ideally sharing an office with them and/or seeing patients in exam rooms (co-location). The BHC may see 10-15 patients a day but follow-up is usually limited to 1-4 visits. The goal is simply to develop a well-rounded treatment plan that the PCP then follows, thus ensuring the patient receives comprehensive biopsychosocial care, and to help the PCP to learn more about behavior change strategies (collaboration). The BHC operates as a member of the PC team whose role is to help PCPs manage the psychosocial needs of their patients (integration). The PCP retains control of the patient's care (hence the consultant title), which may feel more comfortable to both provider and patient and may reduce resistance to seeing the BHC. Given the close working relationship between PCP and BHC in this model, truly holistic care is enabled.

A key ingredient to the success of a BHC service is the easy access it affords to behavioral health care. This allows the BHC to meet the high demand for services to patients with acute, chronic and preventive needs. Typically patients are seen immediately after a PCP visit, when a problem is identified, which means the BHC must maintain a very flexible schedule and avoid obstacles to referrals. Visits are brief, typically lasting 15-30 minutes, which requires a very different approach from that seen in traditional specialty MH. Instead of focusing on diagnosis, assessments focus on functional assessment, and treatment plans are geared toward functional restoration rather than symptom elimination. Brief, problem-focused notes are kept in the medical record, and no additional paperwork is required to see the BHC. Psychoeducation plays an important role in BHC visits and less time is devoted to development of therapeutic rapport (this is possible largely because of the close collaboration between the BHC and PCP, which allows the BHC to inherit the rapport between PCP and patient).

Another important component of the BHC model is the ability of the BHC to help with a wider variety of problems than s/he would see in specialty MH. Although a BHC will frequently help with MH problems such as depression and anxiety, a goal is to also see medical problems such as diabetes, chronic pain, headaches, obesity, hypertension, etc. The BHC may also assist with subthreshold problems, such as thumbsucking in a child or calming a patient who is overly anxious during a minor surgical procedure. A wealth of opportunity exists for BHCs to help with prevention efforts as well, especially secondary prevention activities such as smoking cessation, weight management and stress management education. With the abundance of chronic diseases seen in PC, a BHC can also be readily incorporated into the routine care of these conditions. Algorithms can be developed that routinely and automatically include the BHC in the care of a given condition, rather than waiting for a PCP to refer a patient.

The consultant aspect of the BHC model denotes a significant difference between the services of a BHC compared to a specialty MH provider. As noted previously, the goal of a patient encounter in the BHC model is to develop a well-rounded treatment plan that the PCP can then follow. Thus, a BHC must learn to make clear, specific, evidence-based recommendations after seeing a patient. Feedback to the PCP regarding the plan can be accomplished either in person or via the chart note, but must occur promptly. Of course, the PCP may or may not choose to follow the recommendations, but it is through this feedback process that many PCPs will gain knowledge of behavioral treatment strategies. (The BHC will also find discussions with PCPs helpful for learning about the biomedical aspects of problems.) To the extent that the BHC follows up with a patient, the goal is primarily to get the patient started on the treatment plan. Once the patient begins to progress and feels comfortable with the plan, the goal is to turn follow-up over to the PCP. Of course, the patient may be referred back to the BHC if progress stagnates or reverses, or if a new problem develops.

The emphasis in a BHC model is on population management, which again is quite different from specialty MH. However, this approach blends well with family medicine, which is also based on population management strategies. A BHC service is designed to improve overall population health through truly comprehensive health care and by decreasing the MH load on the PC system. In contrast, specialty MH is designed to focus on the individual needs of a given client, providing in-depth and often extensive care. Of course individual patient care is important in a BHC service as well, but questions such as "What can I do to save the PCP some time?" or "What systemic changes might make our care for this condition more effective?" or "How can we capture more people with this condition?" are at least as common as "How can this patient be cured?" A basic point is that the work of a BHC should not be

confused with therapy, which is practiced differently and has different goals. A BHC is much more appropriately considered a PCP than a MH provider.

Although the intensity of the patient contact may seem less in the BHC model (in terms of shorter and fewer visits for a given problem), an advantage of the model is that the BHC may consult intermittently with patients over their lifespan. As new problems develop patients return to see the BHC, just as they would with a PCP. Similarly, for chronic problems, visits may be less frequent than a therapist would be comfortable with, but contact with the patient may extend over years. Numerous opportunities exist with this model to encourage small lifestyle changes or coping practices over time. This is very different from specialty MH, where patients and providers generally only meet for the duration of an acute problem and rarely develop a lifespan relationship. If possible, patients needing intensive MH care may still be referred out to a traditional specialty MH clinic. (However, even patients seen in MH often return eventually to PC for the same or a different problem.)

We recognize that many of the concepts in the BHC approach we are suggesting will leave those new to the model with a host of questions. Hopefully, as we expand on these concepts and provide specific examples of how to conduct BHC work, any confusion will begin to dissipate. We find that most people new to this field grow to embrace the PCBH model as their understanding of it grows. This is especially true of PCPs and staff, who typically welcome a BHC service with arms wide open. In subsequent chapters, we cover all aspects of developing and operating a BHC service, including the administrative, interpersonal and ethical challenges one might encounter. Given the burgeoning demand for integrated services in community health centers (DeLeon, et al. 2003), and given that we both work in such facilities,

our suggestions will be especially geared toward those settings. However, we believe anyone interested in the topic of primary care behavioral health will benefit from the words that follow.

SUMMARY

1. Most PC medical appointments stem from psychosocial concerns. Primary care is the de facto MH system, as it is the setting where most patients with behavioral conditions seek care.
1. PCPs lack time and training to address the large volume of patients who seek help with psychiatric conditions, psychosocial problems, unhealthy lifestyles, and difficulties with making needed changes to cope with chronic diseases.
2. While PCPs may refer to MH, specialty resources are increasingly scarce, and patients have difficulties accessing them. PCPs often respond by offering prescriptions, which seem like an adequate treatment but often are not and may actually create new problems for some patients.
3. The introduction of SSRIs resulted in an increase in use of anti-depressant medications with patients with behavioral problems, and the increased cost of such may have resulted in further financial insults to the collapsing MH system.
4. PCPs report job dissatisfaction, and recruitment is difficult, particularly to community health centers and to rural areas.
5. The move toward integration offers a way to help calm the storm. Integration involves co-location, collaboration, and integration.
6. This book is about the Primary Care Behavioral Health (PCBH) model, which involves delivery of services by a new member on the PC team, the Behavioral Health Consultant

(BHC). The PCBH model differs in many respects from traditional MH care and, by design, changes the delivery of PC services.