

## ABSTRACT

GLUECK, BETHANY PAGE. An Interpretative Phenomenological Study of Behavioral Health Clinicians' Experiences in Integrated Primary Care Settings. (Under the direction of Sylvia Nassar-McMillan).

The purpose of this phenomenological qualitative study was to explore the experiences of behavioral health clinicians (BHC) working in integrated primary care (IPC) to gain a better understanding of their roles, attitudes, and training needs. The theoretical underpinnings of this study explored the historical perspective of health and well-being, influence of the biopsychosocial model, stress and coping research, social cognitive theory, counselor education philosophies, and the contemporary changes in health care reform supporting the rationale for integrated primary care. Ten participants engaged in semi-structured interviews that were transcribed and coded utilizing Interpretative Phenomenological Analysis to develop themes. Results from this study were reported based on three research questions. Participants revealed that they view their role within IPC as multifaceted and that they have multiple responsibilities. Regardless of the setting, be it a primary care office, pediatricians' office, or health center, and across urban and rural areas, five themes emerged that consistently captured these participants' views of their multiple roles in IPC: (a) Program Administration Program Development; (b) Mental Health Brief Screening Intervention; (c) Consulting Teaching; (d) Referral Coordinator; and (d) Chronic Disease Behavioral Interventions. All participants in this study reported positive attitudes regarding integrated primary care. The participants agreed that being on-site in a primary care office offered services to individuals who may otherwise not seek out support and that this model increases access to care, decreases stigma, and provides prevention. Barriers were of IPC were the culture of IPC is different from community or private practice mental health,

policies, and lack of training. All of the participants in this present study expressed having an approach that incorporated mind body approach. The participants reported having limited or no training specific to integrated primary care prior to working in this new setting and training and knowledge for BHCs working in IPC to incorporate medical training and internships in integrated primary care sites. The limitations of this study are reported. The results have broad implications for counselor education clinical mental health programs, particularly for the incorporation of graduate courses to strengthen interdisciplinary medical training. The results of the study inform conceptual models of the emerging roles and attitudes of BHCs and elements needed in a training program for counselor training for counselors working in integrated primary care. In conclusion, future research should seek to develop a measure that evaluates the roles of a BHC compared to the needs of IPC. Such a measurement could then be used on a broader scale to capture when BHCs nationally are evaluating roles of BHCs and if they are provided needed training for services in IPC.

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An Interpretative Phenomenological Study of Behavioral Health Clinicians' Experiences in  
Integrated Primary Care Settings

by  
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## **DEDICATION**

This dissertation is dedicated to my parents for their unwavering support in providing me a foundation that enriched my life with an international worldview, taught me the value of caring for people, and always believed in my academic potential.

This dissertation is also dedicated in memory of Pamela Jo Glueck.

## BIOGRAPHY

Bethany Page Glueck was born in Manila, Philippines. She was raised in the Philippines and Bangkok Thailand before moving to North Carolina during her adolescent years. She received a Bachelor's degree in Psychology from The University of North Carolina in Chapel Hill, North Carolina and a Master's degree in Community Counseling in the department of Human Development and Psychological Counseling from Appalachian State University in Boone, North Carolina. She has been a Licensed Professional Counselor in North Carolina since 2001 and a Nationally Certified Counselor (NCC) since 1999. In 2010, she completed the requirements for and was credentialed as a Licensed Professional Counselor Supervisor (LPC-S). Since 1999, Beth has provided counseling to adolescents and adults seeking positive and meaningful life changes in a variety of settings that include the following: community mental health, in-patient substance abuse, school-based mental health, co-located medical clinic, private practice, and a medical hospital. Her clinical counseling experience in collaboration with family physicians led to her interest in stress, coping, disease management, and ultimately integrated primary care.

As a doctoral student in Counselor Education at North Carolina State University, Beth developed her research, teaching, presentation, and supervision skills. She completed a semester study abroad in Prague, Czech Republic and was awarded the Arthur B. Moss International Travel Grant for her presentation at the European American Counseling Association in Germany. In addition, she is a member of Nu Sigma Chi the North Carolina

State University chapter of Chi Sigma Iota, the Counseling Academic & Professional Honor Society International.

Beth enjoys spending time with her husband, family, and friends. She believes that her developmental years spent living abroad enriched her worldview with an appreciation for respecting and valuing individuals' differing beliefs and cultures, as well as seeing the commonalities in humanity. She has continued to seek out diversity and international opportunities in her adult life. During her dissertation process, she practiced mindfulness through appreciating the beauty of nature, often while hiking or running in the woods with her two chocolate labs.

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*For your kindness I'm in debt to you  
And I never could have gone this far without you  
For everything you've done  
You know I'm bound- -I'm bound to thank you for it.....*

~Kind and Generous by Natalie Merchant

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## CHAPTER ONE: INTRODUCTION

Integrated care is a team-based approach to healthcare that brings together mental health providers and primary care providers for the purpose of addressing an individual's health, spanning prevention to wellness and chronic disease management (Blount, 2003; Christian & Curtis, 2012; Cummings, & O'Donohue, 2011). Over the last 30 years, the grassroots efforts for integrated care have led to global and national changes in the delivery systems in primary care offices (Blount, 2003; Patterson, Peek, Bischoff, Heinrich, & Scherger, 2002). *Integrated Primary Care (IPC)* is the highest level of collaboration care and is meant to improve access of services by having a mental health provider on-site in the primary care office (Blount, 2003; Dickinson & Miller, 2011; Patterson et al., 2002). It also seeks to improve a patient's health using a biopsychosocial approach (Engle, 1977).

As integrated primary care evolves so also is the new role of *behavioral health clinician (BHC)*. At present, mental health providers from various licensed credentials, for example, Licensed Professional Counselors (LPC), Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Psychologists (LP) are filling positions as BHCs working in IPC (Barrett & Warren, 2012). These BHCs are adapting their clinical training skills to meet the needs, filling a new role working in integrated primary care as part of the medical team (Barrett & Warren, 2012). The professional titles that have been used interchangeably to refer to this new role are behavioral health professional (Hegel, Imming, Cry-Provost, Noel, Arian, & Unutzer, 2002); *behavioral health provider (BHP)* (Curtis & Christian, 2012); *behavioral health consultant* (Hunter Goodie, Oordt, &

Dobmeyer, 2009; Ray-Sannerud, et al., 2012) and *behavioral health clinician* (Blount & Miller, 2009). For the purpose of clarity, the term *behavioral health clinician* (BHC) is used throughout this study, unless using direct quotes that refer to mental health counselors working in integrated primary care settings as one of the previously mentioned terms.

Primary care has become the first portal of entry into mental health services and physicians are managing 50% to 70% of all psychological disorders (Curtis & Christian, 2012; Gatchel & Oordt, 2003). And, primary care offices have been referred to as the *defacto* mental health center (deGray, 1997). The term, *primary care*, for this study is defined as the first point of services of which an individual seeks health care, for example, a family physician, pediatrician, or health department. With many primary care office visits originating due to psychosocial issues, there is a need to provide more comprehensive care holistic care to patients within primary care settings (Patterson et al., 2002; Tew, Klaus, & Oslin, 2010).

A behavioral health clinician (BHC) on-site in primary care can offer skills in assessment, interventions, individual counseling, and group facilitation. Using a broad range of clinical skills, the BHC can expand beyond traditional psychotherapy skills and assist the medical team by providing individual and group-based wellness and healthy lifestyle behavior interventions (Beacham, Kinman, Harris, & Masters, 2011; Enochs, Young, & Choate, 2006). According to the Centers for Disease Control and Prevention (CDC, 2010), engaging in unhealthy lifestyle behaviors (e.g. lack of exercise, poor nutrition, tobacco use, and excessive alcohol) leads to chronic illnesses, including lung cancer, obesity, diabetes,

substance abuse, and, ultimately, mortality (CDC, 2010). Early intervention and efforts to change health related behaviors have been demonstrated to improve health outcomes (CDC, 2010).

### **United States Health Care Reform**

In the United States, The Affordable Care Act, signed into law in June 2012, strengthens the coordination of care between mental health providers and primary care physicians (Burtnett, 2012). No longer is integrated care only a *zeitgeist* movement; it is a philosophy that is being adopted. By 2014, The Affordable Care Act aims to improve the access of care, remove pre-existing health problems for insurance, and increase prevention screenings and treatment for individuals needing mental health and substance abuse services (U.S. Department of Health and Human Services, 2011).

Physicians also will be seeking ways to work with mental health providers as part of the Patient-Centered Medical Home (PCMH). The PCMH is defined by the U. S. Department of Health & Human Services as a medical home that improves the quality of care in primary care and delivers specific functions that are as follows: 1) Comprehensive Care; 2) Patient-Centered; 3) Coordinated Care; 4) Accessible Services; and improvement in 5) Quality and Safety (PCMH 2011 Overview, <http://www.ncqa.org/tabid/631/default.aspx>, retrieved 2/25/2012). These changes in primary care offices are changing the current medical model of quality patient care with specific focus on the incorporation of mental health as well as the behavioral interventions necessary for chronic disease management. These include the goals of incorporating mental health and substance abuse screening into well and sick visits, as

well as prevention and brief interventions for the management of unhealthy lifestyle behaviors that impact chronic illness (PCMH 2011 Overview <http://www.ncqa.org/tabid/631/default.aspx>, retrieved 2/25/2012). These changes have been incorporated into The Veterans Health Administration clinics that are emphasizing the PCMH goals in the primary care settings and incorporating behavioral health clinicians (Post, Metzger, Dumas, & Lehmann, 2010; Tew et al., 2010).

With these changes in health care reform, the United States is following a global trend. According to the World Health Organization (WHO, 2008), the integration of mental health services into primary care has been shown to provide significant benefits. The World Mental Health Federation, in celebration of World Mental Health Day on October 10, 2010, has called for integrated care (WMHF, 2010). The National Council for Community Behavioral Healthcare and the Substance Abuse and Mental Health Administration (SAMHSA) have partnered to develop the SAMHSA-HRS Center for Integrated Care to advance the implementation of integrated care. The benefits of integrated care include improving access to care, decreasing economic cost by keeping individuals out of emergency rooms, and improving the coordination for co-morbid mental health and physical health, while also pointing out that the absence of integrated care can decrease an individual's lifespan by up to 25 years (Parks, Svendsen, Singer, & Foti, 2006). SAMHSA has specifically promoted the screening of alcohol and substance abuse in primary care settings using the model of SBIRT (Screening, Brief Intervention, and Referral to Treatment). With global and national support, the delivery of health care originating from primary care settings

will be more inclusive of behavioral lifestyle and mental health services as part of comprehensive care for a patient's health (Humphreys & McLellan, 2010).

### **Mind Body Health: Separated and Joined**

Integrated care is the application of the holistic treatment of health, where health is defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948, p. 100). A challenge for the implementation of integrated primary care is that in contrast to the 1948 mind body definition of health and the influence of the biopsychosocial model (Engle, 1977), the delivery of healthcare has been provided in a fragmented system (Blount, 2003). The experience for an individual is that the field of medicine has provided physical health, while, independently mental health providers have treated psychosocial stressors and mental health and/or substance abuse. The current system of healthcare has not placed as much emphasis on the care of the broader definition of health.

The Biopsychosocial Model, developed by Engle in 1977, is a philosophy that invites clinicians to understand health subjectively from the human experience, culture, social, and psychological situations (Borrell-Carrio, Suchman, & Epstein, 2005). Engle (1977) challenged, the dominant model of health, the medical model, which attributes health issues only to biological causes. Engel (1977) suggested that psychological variables, demands on life, and social and cultural conditions impact the course of any disease progression (physical or mental). It is the psychosocial aspects that will influence how an individual will respond to treatment both successfully and/or unsuccessfully in healing. To implement the philosophy of

the biopsychosocial model in practice has required models that loosely guide how mental health providers and physicians can work together.

### **Models of Collaborative Care**

As previously stated, Integrated Primary Care (IPC) is the highest level of collaboration between mental health providers and primary care physicians. Collaborative care“ is a term frequently used interchangeably with integrated care but which tends to refer to everything from referral to mental health counselors to more dynamic, co-located integrated care agencies” (Krall, Christian, & Curtis, 2012, p. xxi). Whereas the term integrated care (IC) is the highest level of the hierarchal level of collaboration and is defined as “ the seamless and dynamic interaction of PCPs and BHPs working within one agency to provide both counseling and traditional medical care”(Krall, Christian, & Curtis, 2012, p. xxii). In essence, both terms support a philosophy of patient care in which there is an ongoing relationship between a mental health provider and a primary care provider with a focus of treating the whole person (Miller, Mendenhall, & Malik, 2009). The distinction is to consider to what degree and what proximity are the mental health provider and primary care physician working together.

Doherty, McDaniel, and Baird (1996) identified different levels of collaboration. These levels have been adapted by Peek (2007) in a ranging hierarchical system and referred to as the Bands or Levels of Collaboration. The levels provide a general description, ranging from minimal to close collaboration, to a fully integrated system. Levels of collaboration are differentiated hierarchical levels and the amount of shared team based treatment of the

biopsychosocial aspects of health in a shared treatments plan and office location arrangements between a behavioral health provider (BHP) and a primary care physician (PCP) (Blount, 2003; Doherty et al., 1996).

### **Levels of Collaboration**

**Integrated Primary Care (IPC)**, is identified as the highest level of collaborative care (Blount, 2003; Miller et al., 2009). It is defined as “ the seamless and dynamic interaction of PCP’s and BHPs working within one agency to provide both counseling and traditional medical care (Curtis & Christian, 2012, p. xxii). The behavioral health clinician (BHC) is on-site in a primary care office as part of the medical team (Blount, 2003; Dickinson & Miller, 2010). The aim is to reach the general population, literally, meeting patients where they are in the medical exam room for comprehensive coordinated care (Blount, 2003; Dickinson & Miller, 2010).

In IPC, ideally, care is tightly coordinated with exchange of information between the BHC and the physician, typically within the same day, or in joint sessions in the medical exam room with the patient so that treatment is targeted and coordinated (Peek, 2009; Tew et. al., 2010). Behavioral health sessions can be brief, matching the 10-15 minutes pace and same day scheduling needs of a medical practice. Assessments as well as interventions are targeted to address the patient’s complex health concerns from a biological, emotional, and lifestyle behaviors perspective (Dickinson & Miller, 2011; Patterson et al., 2002). For example, the use of brief therapy interventions of cognitive behavioral therapy, stress-management, relaxation, and supportive techniques are given, along with providing patient

education about prevention and mental health diagnosis or behavioral lifestyle changes in coping with a chronic illness (Funderburk, Sugarman, Labbe, Rodrigues, Maisto & Nelson, 2011). Progress notes are typically kept in the primary care office, and a BHC is urged to provide feedback to a physician in language that is brief and problem-focused, avoiding lengthy descriptive psychotherapy history in conceptualization. A mental health provider adapting to the role of a BHC will need to embrace the culture and language of a primary care setting (Patterson et al., 2002; Tew et al., 2010).

IPC does not seek to replace traditional outpatient specialty mental health care. IPC operates as the first point of contact, and when longer-term mental health care is appropriate, referrals are made within the community to mental health providers who are located off-site to provide psychotherapy. Ideally, these mental health providers will continue to coordinate (i.e. provide minimal collaboration) with the primary care providers (Blount, 2003; Patterson et al., 2002; Tew et al., 2010).

**Close Collaboration.** This is one level below integrated primary care. In this model, a mental health provider maintains an independent traditional outpatient therapy practice that may be co-located on-site in a primary care office (Miller et al., 2009). The difference between co-location and integrated primary care is that in a co-located model, the mental health provider continues to function as an independent specialty outpatient mental health practice who receives therapy referrals from primary care providers. In this model, the mental health provider may or may not address biopsychosocial concerns (Miller et al., 2009; Patterson et al., 2002). This arrangement typically includes separate documentation notes,

scheduling traditional psychotherapy appointments with clients, and coordination of care is done as needed through written or verbal exchanges with the primary care physicians.

**Minimal Collaboration** is currently the most prevalent model in the United States health care system. This level is best described as the traditional mental health provider who is located in an outpatient mental health practice and the primary care located in their own separate practice. This model is considered more traditional and what Blount (2003) refers to a silo system. In this model, there may be very little communication between the mental health provider and the physician with limited focus on a biopsychosocial approach of team-based care coordination between the providers for the health and well-being of the patient.

### **Statement of Problem**

With changes in health care reform, the adoption of the PCMH, and implementation of IPC, there is an anticipated national workforce need for qualified licensed behavioral health clinicians to work in integrated primary care settings (Blount & Miller, 2009). The position of a BHC is currently being filled by licensed mental health providers. National leaders in integrated care have expressed concern that mental health providers as a collective group (i.e., Licensed Professional Counselors (LPC), Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Psychologists (LP)) are not prepared with the knowledge and training to work in a primary care office setting (Blount & Miller, 2009; O'Donohue, Cummings, & Cummings, 2009). They argue that the skill set needed for integrated primary care is different from providing mental health in a close collaboration or minimal collaboration (Blount & Miller, 2009; Hunter & Goodie, 2010).

Unlike the Netherlands that over the past 30 years has developed an Integrated Primary Care Psychologist designation (Derksen, 2009), the United States has not adopted specialized training in IPC (Blount & Miller, 2009). A review of the literature suggests that mental health providers, who have been trained in traditional psychotherapy, will encounter challenges in adapting to the rapid pace that comes with working on-site, providing same day brief screenings and intervention in a medical setting with a different culture than the traditional outpatient mental health setting (Derksen, 2009; Farrar, Kates, & Brustolo, 2001; Hudson-Allez, 2000; Miller et al., 2009; Patterson et al., 2002). As such, there are advantages and barriers to be examined with mental health providers as they adapt to the needed role of a BHC working in integrated primary care settings.

In the United States with the rapid adoption of IPC, there are no governing bodies for mental health providers to rely on for guidance specific for working in IPC. This means that no licensure accreditation body exists with ethical guiding principles, and there currently are no standardized models outlining the role and functions of a behavioral health clinician working in a primary care office. As mental health providers from various disciplines (e.g. counseling, social work, marriage & family therapy, and psychology) are filling the role as behavioral health clinicians, they are forced to adapt to a primary care setting without specific integrated care ethical guidelines or training. There is a lack of professional unity, as each of these mental health professional subspecialties has different training, accreditation bodies, and ethical guidelines that are governed independently (Boice, 2012). Regardless of

their new role as BHCs, these professionals are guided by their licensure and accreditation standards and influenced by their prior theoretical training.

At present, the vast differences among all BHCs professional identities and training experiences may shape attitudes toward integrated primary care and therefore need to be explored collectively as a group as well as within the different mental health disciplines, including counselor education. The origins of professional counseling have ties to working in community settings as part of an interdisciplinary team that has adapted to social needs and changes (Pistole, 2004). The American Counseling Association defines professional counseling as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (ACA, 2011). Yet, there are conflicting viewpoints within the counseling profession in regard to how the profession should address health care. A call was set forth in 2004 for counselors to begin to collaborate with primary care providers (Aitken & Curtis, 2004). Since then, there has been limited response in the counseling profession. Hansen (2007) argued that counseling should not be part of health care and that it represents a disregard for the counseling profession’s foundational humanistic philosophy. Meanwhile, Fetter and Koch (2009) urged professional counselors to use their skills to address the health crisis in America to provide interventions for promoting health and wellness.

In contrast to professional counseling, psychologists are taking a more active lead in developing internships and partnerships in planning integrated primary care (Correll, Cantrell, & Dalton, 2011; Bluestein & Cubic, 2009). Psychologist are developing an

awareness toward integrated primary care (Runyan, 2011) and are acting swiftly to meet the workforce demands for behavioral health for the patient centered medical home (Beacham, Kinman, Harris, & Masters, 2011).

### **Need for the Study**

Behavioral health clinicians are vital for implementation in IPC (Blount & Miller, 2009) and in providing a voice to national health care reform changes. There is a gap not only in the counseling literature, but also in the integrated care literature, in examining behavioral health clinicians' experiences working in an integrated primary care setting. No study has examined empirically and exclusively behavioral health clinicians' experiences working in integrated primary care settings to gain understanding about the role, attitudes, and training needed.

North Carolina is leading the way in integrated primary care (Dickens, Lancaster, & Crosbie, 2012). Building on a 2006 co-location project, integrated primary care pilot projects currently are being funded across the state (Dickens, et al., 2012). The North Carolina Institute of Medicine (NCIOM) has been tasked to establish workgroups and examine what the Affordable Health Care Act means for North Carolinians. Major projects for NCIOM in 2011-2012 have been Health Reform, Suicide Prevention and Intervention, Mental Health, Social, and Emotional Needs of Young Children and Their Families; Implementing Evidence-based Strategies in Public Health; and Early Childhood Obesity Prevention (Silberman, 2012). The Affordable Care Act (ACA) in North Carolina has provided grant funding to invest in primary and secondary prevention and to expand health professional

training programs (Silberman, 2012). There is a concern for workforce supply to address the needs for primary care prevention to meet the needs in place by the ACA 2014 requirements (Silberman, 2012). Outcomes from the NCIOM Mental Health, Social, and Emotional Needs of Young Children and Their Families task force for North Carolina has recommended creating a more coordinated and integrated system to meet the needs of children and families (Silberman, 2012).

Funders such as Kate B. Reynolds Charitable Trust and the Health and Wellness Trust fund are providing grant funding to primary care practices to increase access and support efforts for integrated care specifically in rural and underserved counties in which access to health care is limited (<http://www.kbr.org/funding-areas.cfm> retrieved on 8/12/2012). In addition, organizations like the Community Care of North Carolina (CCNC), in connection with North Carolinas Division of Medical Assistance, and non-profit agencies are partnering to improve the quality of medical care across North Carolina with a population management initiative of the integration of behavioral health into primary care practices across North Carolina (<http://www.communitycarenc.com/about-us/history-ccnc-rev>, retrieved on 8/12/2012; Stein, Lancaster, Yaggy, Dickens, 2011).

Behavioral health clinicians' attitudes and opinions are important in the development and implementation of integrated primary care. Clinicians who are on the forefront working on-site in integrated primary care can provide vital information in determining if mental health providers are prepared to meet the workforce needs for IPC. There is a need to uncover the gaps in knowledge and identify the critical topics to incorporate into counselor

education training programs to prepare professional counselors seeking to enter into a career in an integrated primary care setting.

### **Rationale for the Study**

The main goal of this study was to explore and describe behavioral health clinicians' experiences working in integrated primary care practices in North Carolina and to capture their roles, attitudes, and training needs. For the purpose of this current study, a behavioral health clinician is defined as a mental health provider who holds a license in North Carolina for the purposes of providing mental health assessment, diagnosis, and treatment. This definition of mental health provider is broad enough to include Licensed Professional Counselors (LPC), Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Psychologists (LP), all of whom may be working in integrated primary care. The term, integrated primary care, is defined as a primary care location in which a BHC is located on-site and provides team based care with a biopsychosocial approach (Blount, 2003).

*Attitude* is defined by the Oxford Dictionary as a way of thinking or feeling about something (OxfordDictionary.com). Attitudes influence how mental health professionals adapt to working in primary care settings and in adopting a biopsychosocial approach (Derksen, 2009). According to Aarons (2004), who developed the Evidence-Based Practice Attitude Scale (EBPAS) for mental health providers, attitudes can guide decisions about starting a new type of practice, guide training, and affect procedures in real-life settings. This also is supported by the real-practice reflection on 30 years of experience of integrated

primary care in the Netherlands; Derksen (2009) states that attitudes of the provider shape the integrated care experience.

Aarons' (2004) Evidence-Based Practice Attitudes Scale (EBPAS) is validated, but only for evidence-based protocols. IPC is an emerging field, and the implication is not standardized. The EBPAS was developed to be used with evidence-based therapeutic modalities that are taught to a group and then applied within a setting, for example, the use of cognitive behavioral therapy. While integrated care is supported by evidence-based practice of the foundation of a biopsychosocial approach, the implementation mode is not standardized across settings, and therefore, the use of the EBPAS would not capture the lived experience of these behavioral health clinicians as they are beginning to work in IPC.

Despite the increased awareness nationally of integrated care during the past several years, only two research studies were found represented in the counseling education literature related to counselors working with primary care physicians. The first research was conducted in 2004 and solely focused on the level of minimal collaboration between professional counselors and physicians (Miller, Hall, & Hunley, 2004). Miller et al. (2004) had methodology concerns with interchangeably using the terminology *integrative*, *integration*, and *collaborative* in capturing the relationship between counselors and primary care providers. Overall, the participants were not working on-site in primary care offices. However, the results indicated that professional counselors found value in collaboration with primary care physicians and supported the idea of working in the same location. Gersh (2008) conducted a qualitative phenomenological dissertation on identity development of

counselors working on-site in primary care. Gersh (2008) found that counselors found value but also challenges associated with adapting to working in a medical setting and has recommended further qualitative exploration of counselors' training for working in IPC. This current study will use qualitative semi-structured interviews to explore counselors' roles, attitudes, and training needs for working in integrated primary care settings.

A significant issue in previous research that has explored value perceptions (Miller et al, 2004) or beliefs (Todahl, Linville, Smith, Barnes, & Miller, 2006) was methodological challenges in terminology defining the level of collaboration. The terms, *integration*, *co-location*, and *minimal collaboration*, have been used interchangeably along with the term collaboration or integrated care. In 2009, clear definitions and terminology were identified providing guidance in how best to operationalize integrated care, with the recommendation to be specific in the level of collaboration when conducting research (Miller et al., 2009). Moreover, in a review of previous research, no study has specifically explored the lived experiences of behavioral health clinicians working in integrated primary care settings.

The implication of this current study is that as IPC is on the national forefront with health care reform changes, primary care practices are already employing behavioral health clinicians. Therefore, it is important to examine behavioral health clinicians as an independent collective group. Equally important is that there is a gap in the literature, and a need exists to take an active approach in understanding the role of behavioral health clinicians in IPC. It is important to hear from the BHCs who are on the front lines, trained in a traditional system, as they begin to implement services in primary care offices. The results

ultimately will provide an understanding for counselor education training programs and continuing education trainings for preparing licensed professional counselors to work in integrated primary care settings.

### **Research Questions**

The primary research questions that guided this current study were the following:

- 1) How do behavioral health clinicians view their role in integrated primary care?
- 2) What are behavioral health clinicians' attitudes toward integrated primary care?
- 3) What training is needed for behavioral health clinicians to work in an integrated primary care setting?

### **Definitions of Key Terms**

The following are terms, individuals, and groups that are mentioned in this study.

1. Attitude- a way of thinking or feeling about something (OxfordDictionary.com)
2. Behavioral Health Clinician (BHC)- a mental health provider who holds a license as a Licensed Professional Counselors (LPC), Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Psychologists (LP), for the purpose of providing mental health assessment, diagnosis, and treatment and is working in an integrated primary care setting.
3. Biospycosocial Model – a perspective on health away from biomedical to incorporating and understanding the relationship between biological, psychosocial, and social as a way to explain the connection between health and illness (Engel, 1977).

4. Close Collaboration- a collaborative care model in which a mental health provider maintains an independent traditional outpatient therapy practice that may be co-located on-site in a primary care office (Miller et al., 2009). In a co-located model, a mental health provider continues to function as a specialty outpatient mental health counselor who is not trained in working with primary care and who may or may not want to address biopsychosocial concerns as a team (Patterson et al., 2002; Miller et al., 2009).
5. Collaborative Care- a term that describes a philosophy of patient care in which there is an ongoing relationship between a mental health counselor and a primary care provider with a focus of treating the whole person (Miller, et al., 2009).
6. Health - a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948, p.100).
7. Integrated Primary Care- is identified as the highest level of collaborative care; level IV-V (Blount, 2003; Miller et al., 2009), places a mental health provider on-site in a primary care office as part of the medical team as a behavioral health clinician (BHC) (Blount, 2003); care is tightly coordinated with exchange of information from the BHC communicating with the physician, typically within the same day, or in joint sessions in the medical exam room with the patient so that treatment is targeted and coordinated.
8. Mental Health Provider- an individual who holds a license in North Carolina for the purposes of providing mental health assessment, diagnosis, and treatment as a

Licensed Professional Counselor (LPC), Social Worker (LCSW), Marriage and Family Therapist (LMFT), and Psychologist (LP)

9. Primary Care- the first the point of services where an individual seeks health care, for example, a family physician, pediatrician, or health department.

### **Organization of the Dissertation**

This dissertation consists of five chapters. Chapter I provided an overview of the problem, purpose, need, and rationale for this study. It captures the importance of this study, provides definitions, and introduces the dissertation research question. Chapter II is a literature review of historical views of health and well-being, including the mind/body connection of psychosocial stressors and health outcomes in research that have led to the development of integrated care. Theories and models of the Biosychosocial Model (Engle, 1977), wellness, and Social Cognitive Theory (Bandura, 1986) are examined in relation to integrated primary care. Chapter III provides an outline of research design, methodology, description of participants, data collection, and interpretative analysis. Chapter IV reports on results and findings of this study. Finally, Chapter V is an analysis and summary of this research and its implication for the literature on integrated care.

## **CHAPTER TWO: LITERATURE REVIEW**

This chapter provides an overview of literature that is relevant to behavioral health clinicians working in integrated primary care settings. The chapter is organized with the following sections: (a) an overview of integrated primary care; (b), historical perspectives on mind, body, and health, (c) the biopsychosocial model, (d), biopsychosocial leading to integrated care, (e) psychosocial stress and health outcomes, (f) health and behavior change: social cognitive theory, (g) behavioral health clinicians role in integrated primary care; (h) the influence of wellness on professional counselors, and (i) mental health providers' attitudes and perceptions toward IPC. The chapter concludes with a summary and rationale for the study.

### **Overview of Integrated Primary Care**

Integrated primary care is a way of addressing health from a mind and body biosychosocial approach (Blount, 2003). It has gained support nationally and globally (WHO, 2008). Integrated care primary (IPC) began over 30 years ago as a grassroots effort to bring together mental health providers and primary care physicians to focus on holistic treatment of a person's health (Blount, 2003). Integrated primary care places a behavioral health clinician in the primary care setting so that treatment is targeted and coordinated with the physician (Peek, 2009; Tew et al., 2010). Blount (2003) suggests that together physicians and counselors can "more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place" (p. 1).

As mental health providers are beginning to adapt to the role of behavioral health clinicians and work on-site in integrated primary care practices, there is concern that they have not received the training necessary (Blount & Miller, 2009). This is a valid concern. In addition, consideration of mental health counselor's attitudes is important in adapting to new organizational policies (Arrons, 2004). A challenge in implementation of integrated primary care is that the treatment of health care historically has separated the mind from the body. This has influenced the professional culture of mental health providers and physicians in training and theories that have divided mental health and medical care into different ways to address healing for individuals who are suffering.

### **Historical Perspectives on Mind, Body, and Health**

Health historically has been separated into mind or body, and the implementation has been influenced by social and political shifts in ideology. Individuals have been in pursuit of health and wellness for centuries. As early as 55 AD, the Roman poet, Juvenal, proclaimed "a healthy mind in a healthy body." Throughout history, numerous models have been developed, and the definitions of wellness and health have changed. The first writings about wellness are credited to Aristotle, the Greek 5<sup>th</sup> Century B.C philosopher, who wrote about illness and good health being "nothing in excess." The next model is credited to Descartes in the 17<sup>th</sup> Century, who proposed the fragmented duality of mind and body. The outcome of this ideology has led to separation of teaching and training in academics in mind and or body, but not both together.

The Diagnostic and Statistical Manual (DSM) was first published by psychiatrists in

1952 and is a distinctly independent classification system for mental health illnesses (Cummings & O'Donohue, 2011). It has since gone through five revisions with the most recent DSM-5 edition released in 2013. The DSM contains diagnoses codes and descriptions of mental and emotional illnesses. It began as a means to catalogue and provide diagnosis categories and became the means for which to receive insurance reimbursement for mental health conditions (Cummings & O'Donohue, 2011). This categorization has also impacted labeling and further stigma regarding mental health conditions.

A shift began in the mid to late 20<sup>th</sup> century challenging ideologies in the treatment of health. The most significant for integrated care was behavioral medicine reorganization, when the World Health Organization defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948). Then came a challenge to the medical community in 1977 with Engle's challenge to physicians to adopt a biopsychosocial approach. This was followed by research that has linked psychosocial stressors and coping to health outcomes (Keicolt-Glasser, 1999) By 2012, it has become recognized that mental health and behavioral lifestyle has a significant impact on health, and yet, a stigma continues to persist for seeking mental health services (Curtis & Christian, 2012).

According to the Centers for Disease Control and Prevention (CDC), 25% of all Americans suffer from a chronic mental illness with 50% of adults being impacted by mental illness at least once during their lifetime (CDC, 2011). The most commonly reported mental health diagnoses for adults are depression, anxiety, and mood disorders (CDC, 2011). Rather

than seek out mental health services in the community, patients have reported they prefer to receive services at the primary care physicians' offices (Nour, Elhai, Ford, & Frech, 2009). In addition, adults with a mental health conditions are reported to have a 68% higher rate of having at least one comorbidity of a co-occurring chronic medical condition (Goodell, Druss, & Walker, 2011). When adults are diagnosed with a chronic medical condition, for example diabetes, or chronic pain, migraines, they are more vulnerable to develop depression (Goodell et al., 2011; Narajo, Arean, Hessler, & Mullan, 2011). Depression is now understood to be a risk factor for developing cardiovascular disease (Frasure-Smith, Lesperance, & Talajic, 1993). Finding ways to meet the needs of this group of individuals is important.

The October 2006 report issued by the National Association of State Mental Health Program Directors indicated that individuals with serious mental illness are dying 25 years earlier than the general public due to the high occurrence of comorbidity with chronic medical conditions and lifestyle behaviors (Parks et al., 2006). Many of these mental health and medical conditions such as smoking, obesity, substance abuse, and suicide prevention and are preventable and treatable with early intervention and behavioral lifestyle changes, (Parks et al., 2006). Recommendations and solutions based on this 2006 report have been to educate the community, implement wellness approaches in recovery, as well as “establish standards of care for prevention, screening, assessment, and treatment through and improved access and integration with physical health care services” (Parks et al., 2006, p. 7).

## **The Biopsychosocial Model**

In 1977, George Engel, a psychiatrist, published in *Science*, “The Need for a New Medical Model: A Challenge for Biomedicine.” Engel’s opinion paper aimed to bridge a historical divide between mind and body by recommending six changes for physicians to follow in moving from a biomedical perspective to incorporating and understanding the relationships between biological, psychosocial, and social as a way to explain the connection between health and illness (Engel, 1977; Ghaemi, 2010; Sperry, 2006). The recommendations based on his thoughts and opinions were referred to as the Biopsychosocial Model.

The Biopsychosocial Model resulted in a shift in ideology and in interpersonal interactions with patients. Engel challenged the dominant model, the biomedical model, that takes a reductionist approach and attributes health issues only to biological causes (Wood, 2012). Engel suggested that psychological variables, demands on life, social, and cultural conditions, impact the course of any disease progression (physical or mental). It is the psychosocial aspects that will influence how an individual will respond to treatment both successfully and/or unsuccessfully in healing. Engel also suggested that the physician relationship itself influences medical outcomes for the patient, for better and for worse.

The Biopsychosocial Model has impacted multidisciplinary care during the past 36 years. This model has set a new direction in healing for mind and body health, and for this reason alone counselors need to understand the shift that has been occurring within the medical field, a shift that has more recently begun to open the doors to an awareness of how

an individual's culture and the therapeutic relationship shapes well-being. The model captures the professional and cultural divide between mental health professions and traditional medical orientations.

To understand the impact of the Biopsychosocial Model is to capture the historical essence of the movement. It began as a crusade attacking the Biomedical Model for a reductionist approach in which health is a product only of a biological agent. It is understandable that adopters of the Biopsychosocial Model adopted a different perspective by embracing a different philosophy of care. Moreover, the Biopsychosocial Model (Engle, 1977) has had significant influence in redefining views on health and healing within the medical community and in training in medical schools (Shorter, 2005). It created a significant change in thinking as a departure from puristic biological or psychosocial factors, resulting in a system of complex interactions inclusive of understanding the whole person (Shorter, 2005; Sperry, 2006).

No one definition captures the Biopsychosocial Model. At best, the Biopsychosocial Model at its core assumptions attempts to explain that health is interrelated and interconnected, encompassing multiple variables of biological, social, psychological, and cultural aspects with human relationships and individuality (Wood, 2012). Historically, the term *bio-psycho-social* is first credited to Roy Grinker, a patient of Freud's, who trained in neurology and who later became a psychiatrist, head of the Michael Resse Hospital, and editor of the Archives of General Psychiatry Journal (Ghaemi, 2010). He is considered to have provided the original definition of biopsychosocial in his writings as follows:

The broad term, bio-psycho-social encompasses all aspects of the living organism. It indicates the inseparability of the environment from organic life and the relationship between human existence and its social and cultural products. The term is not easy to grasp theoretically, and it is difficult to implement operationally. With its holistic concepts, it is often used to deny the significance of particular frames of reference and the importance of one or another variable in health or illness. ... It is indeed a comprehensive approach to the totality of an integrated process of transactions among the somatic, psychic, and cultural systems (Ghaemi, 2010, pp. 34)

Engel (1977) recommended that physicians make six changes in how they conceptualize health. These changes were a shift in ideology and in interpersonal interactions with patients. The medical model attributes health issues only to biological causes, and Engel challenged this notion. The first recommendation was that illness or disease needs to be considered from multiple perspectives, including the individual's experience of psychological, social, cultural, and concurrent biological factors. This recommendation is useful not only for physicians, but also for counselors as a way to conceptualize the spectrum of health. It allows for a range in individual responses.

Engle's second recommendation was that physicians develop highly skilled abilities in interpreting patient meanings. He argued that the ability to synthesize and analyze how a patient verbally communicates his or her symptoms is considered essential to understanding the patient. A patient's use of verbal and non-verbal language may result in ambiguity. It is

assumed that in order to be skilled in this ability the physician would need to develop good counseling and reflective listening skills as well as have a sufficient knowledge of mental health symptoms (Engle, 1977).

The remainder of the recommendations made by Engel focused on the point that when discussing disease broadly this included physical and mental health and how both impact a person's life. He suggested that psychological variables, demands on life, social, and cultural conditions impact the course of any disease progression (physical or mental). Though Engel never mentioned the terms stressors or coping in his recommendation, it appears that this is to what he was referring. Also, psychosocial variables influence the onset, severity, and course of illness. It is also an individual's personality characteristics that lead to adopting the role of being sick or ill, not necessarily the result of a biological test or diagnosis. As a result, health is not necessarily achieved even when test results indicate a biological recovery (Engle, 1977). It is the psychosocial aspects that will influence how an individual will respond to treatment successfully or unsuccessfully. His final recommendation was that the patient-physician therapeutic relationship is powerful. Engel suggested that the relationship itself influences medical outcomes for the patient, for better and for worse.

### **Biopsychosocial Leading to Integrated Care**

A main criticism of the Biopsychosocial Model is the debate that it is not a model and offers no practical application or guide for how physicians independently can implement this new approach into daily practice (Borrell-Carrio, Suchman, & Epstein, 2004; Herman, 2005). Rather, the Biopsychosocial Model is a clinical approach (Wood, 2012) that offers a

theoretical grounding practice. As such, this is a clinical approach that can be interpreted to place a considerable responsibility on a physician's approach with each encounter with a patient "to be biopsychosocial" (Hepworth & Cushman, 2005; Herman, 2005). Herman (2005) shared his own struggles as a family physician in attempting to be biopsychosocial and the potential risks within medicine. He wrote, " I often end the day with a feeling that all the people who needed a broader diagnosis received amoxicillin or a non steroidal anti-inflammatory drug, and those who got a bit more of my time walked out of the room feeling understood but, possibly, with undiagnosed hypothyroidism" (Herman, 2005, p. 373).

The Biopsychosocial Model offers a way of conceptualizing health as well as a bridge between disciplines requiring both physicians and mental health providers to recognize the interconnectedness of social, psychological, cultural, and biological conditions. In collaborative partnerships, each discipline brings their own specializations and skill sets to assist an individual's health complexities. How this is implemented continues to be addressed through various models of ways to coordinate care. As such, a collaborative model, such as integrated primary care, where a physician partners with the patient, as well as with mental health providers to provide comprehensive care, is a solution in how to be biopsychosocial (Hepworth & Cushman, 2005; Herman, 2005). In fact, Engle concluded his thoughts on the course of action by suggesting that to be biopsychosocial may, include "referral to another helping profession. Hence the physician's basic professional knowledge and skills must span the social, psychological, and biological, for his decisions and actions on the patient's behalf involve all three" (Engle, 1977, p. 133). Mental health providers collaborating with primary

care physicians will provide services to patients with a wide range of health concerns.

Therefore, understanding the research supporting the Biopsychosocial Model is significant so that the prevention techniques and treatment interventions can be developed to support optimal health outcomes.

### **Psychosocial Stressors and Health Outcomes**

In the past 20 years, the positive psychology movement and stress and coping research have strengthened both the medical and the social science understanding of the complex interaction between mind and body. This adds more credibility to the Biopsychosocial Model in connecting psychosocial stressors to health outcomes. Moreover, as behavioral health clinicians are working in primary care settings, it is a reasonable assumption that they will need a theoretical knowledge base of how psychosocial and personality stressors impacts physical health and vice-versa and what coping skills can be utilized to improve well-being.

The term “stress” has been used since the 18<sup>th</sup> century and has become so commonplace in casual conversation that it has been overused, developed multiple meanings, and creates misunderstandings (Aldwin, 2007; Wheaton, 1999). Individuals and the media refer to stress lightly and in such general terms as a catch all with the implication that “stress” is the same for everyone. In reality, stress is a physiological biological response, and typically what individuals are referring to in his or her conversations are stressors (Aldwin, 2007).

In research, stress is defined as “a biological state of the body - a generalized physiological alert, if you will - in response to a threatening agent” (Wheaton, 1999, p. 177). Aldwin (2007) attempted to capture a broader definition to be used in academic research: “stress refers to that quality of experience, produced through a person-environment transaction, that, through either overarousal or underarousal, results in psychological or physiological distress” (p.24). To limit confusion in terminology, Wheaton (1999) believed that focus needs to be placed on defining stressors within the context of various models of stress.

Wheaton defined stressor as “conditions of threat, demands, or structural constraints that, by their very occurrence or existence, call into question the operation integrity of the organism” (Wheaton, 1999, p. 177). His three categories of psychological stressors are: (a) threats that include personal harm or challenges; (b) demand placed by expectations or personally or for filling expectations and responsibilities, and (c) structural constraints that can be placed upon individuals by society or self imposed that result in limitations in social and economic status (Wheaton, 1999). Psychological stressors reactivity can occur as a result of any of the following: chronic stressors, discrete life events, daily hassles, societal stressors, nonevents in an individual’s life, and trauma (Wheaton, 1999). These stressors, depending on how a person copes and their personality disposition, can lead to physiological changes in the body.

Similar to the evolution of health, early models of stress have led to more advanced understanding of psychological stressors and physiological reactivity. The Biological Stress

Model developed by Selye in 1956 was based on the general adaptation syndrome of reaction, physical alarm, and exhaustion. He proposed that a threat on an organism led to a condition creating an adaptive syndrome and the body will respond. Similarly, the engineering stress model, developed by Smith (1987) was based in understanding external force in building bridges with metal. When external forces or a threat reaches too much external demand, it will collapse (Wheaton, 1999). Wheaton argued that “the psychological implication is that, at some point an individuals’ ability to respond with adjustments that enhance strength will no longer be possible” (p. 181).

When an individual experiences an overload of too many psychological stressors and is not able to cope with the demands, the body, in turn, can react with physiological demands and these cumulative demands for adaptation are called allostatic load (McEwen, 2000). Reactivity to stressors begins the activation of the sympathetic nervous system which leads to anxiety (negative affect), with increased blood pressure and the activation of the hypothalamic-pituitary adrenal (HPA) axis, which creates changes in corticosteroid (McEwen, 2000; Taylor & Stanton, 2007). This reaction is commonly known as fight-or-flight and is capable of becoming activated without a real biological stress threat but in response to a psychological stressor (McEwen, 2000).

Long-term exposure to psychosocial stressors results in changes in physiological homeostasis (McEwen, 2000), and a decrease in immune functioning (Kiecolt-Glaser, 1999). Results from the CARDIA, a 10 year longitudinal study, revealed that adults who reported low childhood socioeconomic status (SES) and harsh early family environments had higher

levels of depression, anxiousness, hostility, and, in addition, had increased blood pressure (Lehman, Kiefe, Taylor, & Seeman, 2009). High blood pressure is a risk factor for developing hypertension that leads to coronary heart disease, and depression is common in the first six months after a heart attack (Frasure-Smith, Leperance, & Talajic, 1993). It is important for behavioral health clinicians who are working in IPC to be aware of how psychological stressors impact physical health symptoms and that reactivity can occur not only from chronic stressors but also from daily stressors.

Daily stressors can accumulate, and depending on how an individual perceives these stressors they can be seen as a threat activating the allostatic load (Almedia, 2005). Daily stressors are defined by Almeida (2005) as:

the routine challenges of day-to-day living, such as the everyday concerns of work, caring for other people, and coming between work and home. They may also refer to more unexpected small occurrences -such as arguments with children, unexpected work deadlines, and malfunctioning computers-that disrupt daily life. (p. 64)

Almedia (2005) believed that when daily stressors accumulate over multiple days they have an immediate effect on emotional and physical functioning further impacting daily well-being.

Almedia, Wetheington, and Kessler (2002) researched the prevalence of daily stressors among adults in the United States and the relationship of those stressors to physical health symptoms. Using the Daily Inventory of Stressful Events (DISE), adults (n=1031) were contacted by phone over eight consecutive days and asked questions pertaining to their daily

stress, mood, and physical health symptoms. Results from this study demonstrated that over the course of 8 days adults reported at least one stressor in 40% of the days. The most common daily stressor were interpersonal arguments and tension. Gender differences were found in types of stressors reports. Men reported job related stressors as primary and financial stressors as secondary whereas women reported home and network stressor that involved their relationships with close friends and/or relatives. The researchers demonstrated that 17 of psychosocial stressors correlated with physical health, with 16 of the stressors correlated with negative mood (Almedia et al, 2002).

Almeida et al.'s (2002) research is significant for behavioral health clinicians working in IPC because the research demonstrates the prevalence of how daily stressors overlap with physical health symptoms and mood. Alemida et al.'s (2002) research may help to explain why so many primary care offices are treating mental health conditions. In their study, participants were asked to rate their physical health symptoms, daily negative mood, and daily stressors. Daily physical symptoms were categorized into five areas: "aches (headaches, backaches, and muscle soreness), gastrointestinal symptoms (poor appetite, nausea/upset stomach, constipation/diarrhea), upper respiratory symptoms (sore throat, runny nose), and other physical symptoms or discomforts" (Alemida et al., 2002, p. 44). These symptoms, when persisting daily, are the ones that initially may lead individuals to a primary care office seeking relief and healing. If daily stressors or more chronic stressors are what is underlying the physiological response, a BHC can assist in working with the patients on coping skills.

Almedia (2005) developed a model of resilience and vulnerability to daily stressors. He

believed that resilience/vulnerability factors interact with stress exposure and reactivity in the daily stress process, influencing daily well-being and resulting in a continuous feedback loop of stressors and well-being. In the model, Almedia identified three reliance/vulnerability factors that interact with each other: (a) socioeconomics (e.g. age, gender, education, income, marital status, and parental status), (b) psychological make up (e.g. personality traits, mastery, chronic stress, and life goals), and (c) general health status (e.g. chronic health problems, acute disease, and mental health). These resilience/vulnerability factors interact with daily stress process that he breaks into two categories: (a) stressor characteristics (e.g. frequency, content, focus of involvement, objective severity), and (b) subjective appraisal (e.g. goal relevance and commitment, severity of loss, threat or challenge). These two categories, the resilience and vulnerability factors and daily stress process, are influenced by stressor exposure and stressor reactivity that influence daily well-being (e.g. psychological distress and physical symptoms).

As previously stated researchers are discovering that personality disposition, coping styles, and context are an important mediator in the physiological adaptation responses. For example, individuals with an optimistic disposition report positive affect and better health and well-being (Aspinwall & Taylor, 1997; Taylor & Stanton, 2007; Sergerstron, Taylor, Keeny, & Fahey, 1998). This is in contrast to individuals with negative affect. The personality trait of hostility is a risk factor in coronary heart disease (Shekelle, Gale, Ostefeld, & Paul, 1983). In addition, depression and lack of close social support is a predictor of mortality after myocardial infarction (Frasure-Smith et al, 1993).

Lazarus (1999) identified coping as “the emotion process. Emotion is a superordinate system that includes motivation (an individual’s goals), appraisal, stress, emotion, and coping as component parts” (p. 101). An individual’s appraisal is part of the emotional process in coping that prepares an individual to consider options and how they will adapt (Lazarus, 1999). More specifically, personal control or mastery (Thomson, 1981) refers to an individual’s ability to control outcomes (Taylor & Stanton, 2007).

The coping skill of mastery can buffer health reactivity. Neupert, Almedia, and Charles (2007) conducted a multi-level modeling study of reactivity to daily stressors and the coping skill of mastery in adults ( $N=1031$ ) for eight consecutive days. Results from this study found that age and control buffer physical effects to daily stressors. Older adults who implemented personal control coping of mastery reported this skill buffered physical effects related to work stressors. Likewise, middle aged adults with the coping skill of mastery buffered the emotional reactivity to network stressors. These results are significant for behavioral health clinicians in understanding the importance of the coping skills of mastery and belief systems that impact physical health symptoms. Additionally, mastery may be linked to personality disposition (Neupert et al., 2007). And, individuals that have more optimal self-regulation and the ability to make choices that lead to a sense of mastery. The perceived ability to control one’s outcomes is associated with positive well-being (Lazarus, 1999; Taylor & Stanton, 2007). When confronted with a stressor, or in anticipation of a stressor, an optimist because of their disposition and out look, may be more likely to try and

implement multiple coping strategies until they find one that works well for their current stressor (Segerstrom, Taylor Kemeny, & Fahey, 1998).

Individuals seeking care in primary care offices can benefit from coping skills that focus on outlook of a situation and planning to improve health. Proactive coping (Aspinwall & Taylor, 1997) is an active precursor to a stressful event. It is the ability to predict and plan how to decrease the currently nebulous and nonexistent stressor. When utilized, these coping skills help individuals decrease exposure to chronic stressors (Aspinwall & Taylor, 1997). A component of proactive coping may involve avoidant coping or the ability to avoid a situation or develop a plan. Proactive coping may include a discussion with a patient around the risks and benefits of taking daily medications and/or exercise as part of their treatment plan. When following these recommendations are a challenge, proactive coping could be utilized to help an individual anticipate the challenges and different life strategies that may need to occur, for example, placing medication in a location that is seen daily or adjusting workout times that help an individual establish exercise as part of a daily routine. BHCs have skills in listening and helping individuals and families cope with stressors. In turn, the same skills can be used for prevention efforts and in addressing behaviors in changing health.

### **Health and Behavior Change: Social Cognitive Theory**

Social Cognitive Theory (SCT), developed by Albert Bandura (1986), is a broad theory originating from the social sciences that attempts to explain the questions of how and why people make health behavior changes. Since 1986, SCT has been one of the most commonly used theories of addressing health behavior (Glanz et al., 2008). Other leading

health theories are the Health Belief Model and The Transtheoretical Model/ Stages of Change; both incorporate the SCT construct of self-efficacy.

The main assumption of SCT is based on reciprocal determinism: the interaction between people and environment. Bandura (1986) argues that from a “ social cognitive view people are neither driven by inner forces nor automatically shaped and controlled by external stimuli. Rather, human functioning is explained in terms of a model of triadic reciprocity in which behavior, cognitive and other personal factors, and environmental events all operate as interacting determinants of each other” (p. 18). This assumption holds that a change in either personal abilities, environment, or behavioral factors will produce a dynamic change in each of the other categories.

In research on stress linked to physical illness, researchers are beginning to explore prevention, lifestyle, and wellness. This leads to the question, what is health and wellness? If wellness is having a healthy mind, then professional counselors, given their holistic training, are in a prime position to answer the call for wellness interventions (Myers & Sweeny, 2008). How then do professional counselors incorporate assessment wellness, as part of their comprehensive intervention and treatment planning working with primary care physicians? Moreover, what are professional counselors taught about wellness, and will these foundations impact their attitudes towards IPC? More specifically, what is the role of mental health provider as they work in integrated primary care settings as a behavioral health clinicians?

### **Behavioral Health Clinicians Role in IPC**

As integrated primary care is still developing, to date, there remains limited understanding of the specific clinical role of behavioral health clinicians as to what they are actually doing in primary care settings (Funderburk, et al., 2011) or agreement on what to call these professionals once they are working in a medical setting. The behavioral health clinicians that are filling the roles working in integrated primary care settings are licensed and credentialed in various mental health specialty disciplines and include Licensed Professional Counselors (LPC), Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Psychologists (LP). At present, there is no graduate training program specifically for IPC for BHC (Barrett & Warren, 2012). The distinction of a change in professional name suggests that when a mental health provider engages in integrated primary care their role is different and they are making a career change (Blount, 2003; Curtis & Christian, 2012).

A review of the literature found multiple terms for the role of mental health providers working in an integrated primary care setting which further indicates that there is something distinctly different about IPC for the mental health provider and that it demands a professional identity name change as they become part of a medical team (Blount, 2003; Curtis & Christian, 2012; Hunter et al., 2009; & Patterson et al., 2002). The terms that have been used are behavioral health professional (Hegel, Imming, Cry-Provost, Noel, Arian, & Unutzer, 2002); behavioral health provider (BHP) (Curtis & Christian, 2012); behavioral

health consultant (Hunter et al., 2009; Ray-Sannerud, et al., 2012) and behavioral health clinicians (Blount & Miller, 2009).

The term behavioral health clinicians (BHCs), was selected for this dissertation research because it is the term used in one of the only United States certificate training programs that is focused on re-training psychologists, social workers, and counselors to work in primary care settings. This 36 hour training program was developed by the Department of Family Medicine and Community Health at the University of Massachusetts Medical School specifically with the goals of training mental health providers from various clinical backgrounds to be successful as behavioral health clinicians in a primary care setting (Blount & Miller, 2009). This training curriculum is comprised of seven full day workshops that address the following topics: (a) Primary Care Culture, Behavioral Health Needs and Working with Physicians, (b) Evidence-based Therapies and Substance Abuse in Primary Care, (c) Child Development and Collaborative Pediatric Practice, (d) Integrating Care for People with Serious and Persistent Mental Illness, (e) Behavioral Health Care for Chronic Illnesses, Care Management and An Overview of Psychotropic Medications in Primary Care, (f) Behavioral Medicine Interventions: Health Behavior Change and Relaxation Response Techniques, (g) Families and Culture in Primary Care, Advice on Implementation.

Anecdotal reports from mental health providers who have worked in integrated care pilot projects suggest there is a change in mindset and a difference from working in a 50-minute therapy hour as an outpatient mental health counselor and in working in an integrated primary care setting (Pomerantz, Corson, & Detzer, 2009; Robinson & Strosah, 2009). These

lessons learned from the field suggest that mental health providers have been trained to provide therapy that involves lengthy psychosocial assessments and treatment plans that typically do not include consultation with primary care. The reality is that primary care offices require brief, fast paced screening and interventions, along with the ability to provide consultation to physicians (Pomerantz, Corson, & Detzer, 2009; Robinson & Strosah, 2009). A mental health provider working in integrated primary care as a behavioral health clinician requires a shift in mindset in a theoretical shift in how they were and in adapting to the fast pace of a primary care culture. As IPC is in its development, it remains based on a biopsychosocial model attitudes and theoretical influences in training are important for exploration in order to know what mental health providers' from all disciplines think about working in an integrated primary care setting. Even the change in terminology of referring to a client as a patient becomes a culture shift as does adapting to working in a medical setting (Paterson et al., 2002).

### **Influence of Wellness on Professional Counselors**

Historically, the field of counselor education has evolved from a humanistic perspective that is in opposition to a reductionist medical model that treats individuals based on symptoms (Hansen, 2012). What has evolved within the counseling field is a separation from early psychologist philosophies of reductionism in place of humanistic and strength based approaches (Hansen, 2012). Roscoe (2009) stated that wellness is “the central paradigm for counseling and development” (p. 216). Wellness within counseling provides emphasis on optimal well-being and prevention (Witmer & Sweeney, 1992). The Wheel of

Wellness (Myers, Sweeney, & Witmer, 2002) is a counseling based theoretical depiction of health, quality of life, and longevity with spirituality at the core, defining wellness as,

A way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving (2000, p. 252).

This model is grounded in the theoretical foundation in the conceptualization that humans are more than the sum of their parts from Adlerian theory (Adler, 1964). At the center of The Indivisible Self is holism at the core of wellness and five factors of self (creative, coping, social, essential, and physical); a change in one factor results in a causal effect with another factor (Myers & Sweeney, 2008).

Within the counseling field, there are mixed attitudes toward the medical model. Myers and Sweeney (2008) stated that the wheel of wellness is contrary to the medical model of illness and treatment. This suggests a position that views the counseling field as distinctly different from, or apart from, working within primary care offices. A further debate has been about whether counselors should consider being a part of the medical model of health care (Hansen, 2007).

According to Pistole (2004), “mental health counselors have the ability to understand professional health systems and be flexible in adapting to the political and social *zeitgeist* of healthcare” (p. 4). If this is the case, then counselors will be adapting to healthcare reform by incorporating integrated primary care. Not commenting specifically on integrated primary

care models, Fetter and Koch (2009) have urged professional counselors to promote wellness to address the health crisis in America. They have stated that with chronic conditions rooted in behavioral lifestyles, professional counselors are well equipped to provide intervention for promoting health.

Counselor education training is governed by the Counseling & Related Educational Programs (CACREP) the accrediting body governed by the American Counseling Association (ACA) which credentials counselor education training programs to promote excellence in the knowledge, skills, and program development that incorporate best practices of the counseling profession (Urofsky, 2013). These standards for counseling training programs have evolved over the last 30 years include that guides best practices and the professional identify of counselor education (Urofsky, 2013). These standards influence the education and training of the profession. Similar other mental health professional training programs are have accreditation, for example the American Psychological Association (Urofsky, 2013). Within counselor education, clinical mental health counseling is one of the CACREP programs that leads to professional licensure (Urofsky, 2013) and the professional practice of counseling.

Hansen (2012) argued that counselor education programs are moving away from their humanistic vision toward a scientific based approach, and in doing this, the profession is moving away from its early foundations. Hansen (2012) reported the increase of counselors participating in a medical model training with the use of diagnosis and symptomology of human experiences for third party insurance billing. Hansen (2012) suggested, “ whether a

counselor decides to participate in the medical model is a personal ethical decision. However, counselor education programs should prepare students to think critically about this model so that it is not uncritically accepted once students become practitioners” (p.139). While these types of statements are being presented within the field of counselor education, CACREP standards have progressively incorporated stronger emphasis on understanding a biopsychosocial perspective for clinical mental health counselors (Lies, & Wagner, 2010).

### **Mental Health Provider: Attitudes and Perceptions toward IPC**

*Attitude* is defined by the Oxford Dictionary as a way of thinking or feeling about something (OxfordDictionary.com). According to Aarons (2004), mental health providers’ attitudes can guide decisions about starting a new type of practice, training, and affect procedures in real-life settings that impact organizational changes. According to Derksen (2009), who developed an integrated primary care psychology training program in the Netherlands, attitudes influence how mental health providers will adapt to working in primary care settings and in adopting a theoretical biopsychosocial model to multidisciplinary team based care.

A need exists for mental health providers to begin to work as behavioral health clinicians in integrated primary care settings, there is a significant gap in the research that examines behavioral health clinicians’ roles, attitudes, and training preparation to fill positions in IPC. Only in the past five years, with the anticipated growth of integrated primary care (IPC) has there been concern about a workforce shortage of mental health providers from various licensed credentials of Licensed Professional Counselors (LPC),

Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Psychologists (LP) that are filling positions as behavioral health clinicians working in integrated primary care settings (Barrett & Warren, 2012). These clinicians are coming from different training backgrounds that may have influenced their attitudes toward IPC in theory and skills in preparation for these positions. Therefore, the collective voice and contribution from these behavioral health clinicians who are working in integrated primary care settings has not yet been heard.

A challenge noted in previous research that has examined mental health or physicians' perceptions and attitudes toward working together is that the level of collaboration has not been clearly operationalized. Recognizing a need for additional research, as well as problems with operationalizing levels of collaboration in previous research, Miller et al., (2009) developed a research framework. This was done because of the terminology and confusion between the terms of *collaborative*, *coordinated*, *co-location*, and *integrated* (Miller et al., 2009). Specifically, these terms have been used interchangeably in previous research while they may have different meanings. Miller et al., (2009) set forth guidelines recommending clearly operationalizing and standardizing terminology differentiating between minimal collaboration, co-location, and integrated care in future research and has been followed in this present study.

Limited research exists that has explored physicians' and or mental health providers' attitudes toward collaboration (Gavin, Wagner, Leslie, Price, Thorland & deGroot, 1998; Miller et al., 2004; Todahl et al., 2006). Only one study was found specific to behavioral

health clinicians in integrated primary care, and the focus was on licensed professional counselor professional identity, not the roles or training needs (Gersh, 2008). There is a clear gap in research that explores the roles, attitudes, and training experiences of behavioral health clinicians working in integrated primary care. The previous research that focuses on other levels of collaboration is useful in gaining insight and in designing research study. Early studies began using survey research when capturing attitudes regarding working with the other discipline (Leareau & Nelson, 1994; Miller et al., 2004) and as the terminology of collaborative care levels have become more complex, researchers have moved toward qualitative designs to capture rich in-depth information (Gavin et al., 1998; Gersh, 2008; Todhal et al., 2006). Despite these challenges, these studies do provide insight into physicians' and mental health providers' attitudes.

Lareau and Nelson (1994) explored physicians' ( $N=108$ ) attitudes in regard to a liaison practice with a mental health counselor. The physicians were located in rural Virginia. Of the physicians who responded to the surveys, 57% were in favor of liaison collaboration with mental health. At the time of this study, only six of the physicians reported having a mental health provider working in their office setting. The level of collaboration was not clearly defined but most likely, the liaison collaboration referred to a close collaboration, not integrated primary care. Regardless of the level of collaboration that was assessed in this study, 62% of the physicians indicated that it would be important for mental health providers to have some medical training if they would be working in a medical practice. Therefore, future studies with BHC need to incorporate clear language regarding the level of

collaboration (e.g. integrated primary care) as well as explore training and knowledge needed for working in integrated primary care settings.

Miller, Hunley, and Hall (2004) specifically focused on a sample of professional counselors and primary care physicians to examine the value perceptions of working together. Miller et al. (2004) examined the following three questions: 1) Is there a significant difference between counselors' and physicians' perceptions of the value of mental health counseling which is integrated with the practices of primary care physicians? 2) Is there a significant difference between counselors' and physicians' perceptions of the skills that they possess for identifying mental health issues? and 3) To what degree do counselors and physicians agree regarding the best approaches to integrate mental health and primary care? The results of the Miller et al. (2004) study suggested that physicians support the value of collaborating with mental health counselors, with 53.8% of the physicians supporting a model that would place a counselor in the same office space. The professional counselors in this study were licensed and also reportedly perceived a benefit for working within the same office space with a physician (Miller et al., 2004). It is not known if this level of collaboration was close collaboration or integrated primary care.

The Miller et al. (2004) study incorporated a qualitative component. Within this qualitative section physicians reported that patients would benefit from seeking therapy in a place which patients are already familiar. Barriers that physicians face with patients is limited time to address mental health issues that are not reimbursed by insurance companies. Concerns were addressed by these professional counselors were related to practicalities of

how to develop relationships with physicians and professional conceptualization in the use of a medical model as well as overcoming language barriers that occur between the disciplines.

This study had multiple limitations that make generalizing results a challenge. Miller et al. (2004) failed to provide a consistent definition of integrated care and switched between terms such as '*integrative*,' '*integration*,' and '*collaboration*' throughout the study. From the descriptions provided, it appeared that the professional counselors and physicians were located in separate practices when they were surveyed. Therefore, the findings provide some insight into professional counselors as well as physicians' attitudes regarding minimal or close collaboration but not specifically regarding their attitudes based on experiences of working in an integrated primary care setting. Another limitation of this study was that the response rate from the professional clinical counselors survey was relatively low (26%). Additionally, the qualitative component of this study was not clearly described for analysis in addition to the previously mentioned concerns stated this study did not focus on professional counselors who were working on-site in a primary care office providing integrated primary care. Findings from this study do support that professional counselor may perceive that working with a physician in the same office setting is a good idea but that there are concerns related to the theoretical orientations. Additional research is needed that clearly defines the level of collaboration as integrated primary care and that focuses more emphasis on in-depth qualitative study that would capture the rich in-depth information regarding the experiences of behavioral health clinicians regarding their attitudes about IPC and theoretical training.

From a training and theoretical standpoint, Gaven et al. (1998) found that belief in a biopsychosocial approach, organizational expectations, years of experience, and previous training all influence mental health providers' attitudes toward collaboration with primary care providers (Gavin et al, 1998). Gavin et al. (1998) conducted a study of medical and mental health providers to examine beliefs and attitudes about collaboration. Gavin et al. (1998) stated that they left the term collaboration open for participants to self define. The majority of the mental health providers ( $N=37$ ) were psychologists and social workers, with a third of the sample being comprised of psychiatrists and mental health nurses with previous medical training. Professional counselors were not identified as being part of the population sampled in this study (Gavin et al., 1998). Therefore, the results may not be relevant to professional counselors but are important to consider in context of the theoretical orientation toward a biopsychosocial approach.

Gavin et al. (1998) used The Physicians Belief Scale adapted for mental health providers to examine four subscales: (a) ease and usefulness of collaboration, (b) comfort addressing patients health issues, (c) perceived burden to practice, and (d) the belief in mind-body approach (Gavin et al., 1998). The study revealed that for mental health providers, training and years in practice influenced their attitudes towards collaboration. Mental health providers reporting that their training emphasized collaboration found collaboration easier ( $F=4.97, p<.05$ ), and they reported that they collaborated with physicians more frequently ( $F=3.41, p<.10$ ) than mental health providers who did not have training. Over 95% of the mental health providers in this study reported a 4 or above on a 5-point scale for belief in the

biopsychosocial approach scale (Gavin, et al., 1998). Mental health providers who had been practicing longer reported more comfort in addressing medical and mental health care of patients even when they did not report as strong of a belief in the biopsychosocial approach as newer mental health providers. Therefore, it is important to explore both the length of time a mental health provider has been in practice as well as their theoretical training. Gavin et al. (1998) recommended that future research use a different methodology, such as focus groups, or individual interviews, rather than surveys, to capture mental health providers' attitudes. This recommendation was based on the need to gather more in-depth details to learn more about collaborative practices (Gavin et al., 1998). This current study used a semi-structured individual interviews to capture behavioral health clinicians' attitudes of their experiences working in integrated primary care settings.

A qualitative study was conducted to examine physicians', therapist', and patients' providers' perceptions of collaborative care at one community clinic (Todahl et al., 2006). The level of collaboration was described as close collaboration in which a mental health provider is operating in the role of a traditional psychotherapist located at the primary care site. Todhal et al. conducted 40 qualitative interviews over 18 months at one primary care clinic. Participants providing co-located collaborative care were physicians ( $n=2$ ), psychotherapists ( $n=5$ ), nurses ( $n=1$ ), office manager ( $n=1$ ), and patients ( $n=5$ ). All of the therapist participants were licensed. Two held degrees in family therapy; two reported they held degrees in masters in counseling, and one self identified as a mental health therapist. All participants agreed with the conceptual idea that there are benefits in collaboration. Results

indicated that physicians preferred working with a therapist trained in family therapy, due to the family systems orientation. Physicians and psychotherapists reported that colocation is beneficial by improving access for patients and providing early intervention. However, this study cannot be generalized to behavioral health clinicians, as Todhal et al. (2006) did not specifically examine behavioral health clinicians' perceptions in working in integrated primary care settings. Todhal et al. (2006) does recommended future researchers continue to use qualitative methods to gain a rich in-depth understanding of qualitative settings. This current study used qualitative methodology to gain a rich and in-depth understanding of behavioral health clinicians' experiences working in integrated primary care settings.

Gersh (2008) conducted a qualitative phenomenological dissertation study exploring the impact of working in IPC on professional counselors ( $N=6$ ) professional identity. The participants were all licensed professional counselors who had worked on-site in integrated primary care for at least one year. The findings suggested that counselors overall described positive and rewarding experiences collaborating with physicians and patients. Gersh (2008) revealed that despite the benefits, these professional counselors also reported challenges in adapting to working in a medical model and modifying their counseling skills to fit brief medical treatment approaches, as well as challenges with communication, lack of respect given to counselors in a medical setting, and a feeling of isolation. Regarding professional identity, the counselors in this study reported that the experience of working in an integrated behavioral health setting helped them grow as a professional by broadening their professional identity that resulted in their becoming more clinically effective. Gersh (2008) recommended

further research and the need to continue examining counselors' experiences working in integrated primary care and to incorporate training needs for a career in integrated behavioral health. In order to capture training needs, it is important to obtain first hand accounts from behavioral health clinicians as to what roles they are providing. Are they providing mental health and chronic disease behavioral health interventions as has been suggested by the national needs?

In efforts to inform this current dissertation, Glueck (2012) conducted an unpublished masters thesis pilot study titled, *Mental Health Counselors' Attitudes Toward Integrated Primary Care*, that was conducted in the summer of 2012 in compliance with all requirements of the North Carolina State Internal Review Board. The purpose of this mixed-methods study was to provide a preliminary critical analysis examining attitudes of mental health counselors who currently are working in integrated primary care settings. A structured interview was developed for the focus group based on a review of the literature. This thesis then was used to pilot focus group test questions with a group of mental health counselors working in integrated primary care settings to better inform the methodology for dissertation.

This masters thesis differs from the dissertation research in sample characteristics of participants as well as methodology. The participants ( $N=6$ ) of the masters thesis held the following credentials as licensed mental health counselors in North Carolina: Licensed Professional Counselors ( $n=1$ ), Licensed Clinical Social Workers ( $n=4$ ), and Psychologists ( $n=1$ ) and all self reported they currently were working on-site in a primary care office providing integrated primary care. Because the sample size had only one Licensed

Professional Counselor, the results cannot be applied to the counseling field. Therefore, a significant difference in this thesis and the dissertation is the sample of the participants. The dissertation study placed emphasis in recruiting more Licensed Professional Counselors within the sample. In addition, the experience of conducting the thesis study further informed this researcher as to viewing this group of mental health clinicians as separate from and different from traditional mental health providers. Therefore, the dissertation distinctly captures this difference by referring to this group as behavioral health clinicians rather than mental health counselors.

Another significant difference between this masters thesis and the doctoral dissertation study is the methodology. The thesis utilized a mixed-methods approach using both a focus group and brief survey to test preliminary questions among a group of mental health counselors who were working in an integrated primary care setting with a focus on attitudes. The dissertation used a interpretative phenomenological analysis to capture the experiences of behavioral health clinicians across North Carolina. The thesis study helped better inform the semi-structured interview questions developed based on the literature for use in the dissertation. Questions were tested with the focus group and/or adapted from either the focus group interview questions or survey to be used in individual interviews with behavioral health clinicians for the dissertation. For example, two questions about confidence level in providing mental health and or chronic disease behavioral interventions were asked in demographic questions as “Yes/No” question on the thesis survey. Upon analysis, this yes/ no or even a Likert scale response would not provide the detail of a behavioral health

clinician's experiences. This is also a significant difference. This researcher made a decision to use a phenomenological interpretative approach for the dissertation to gather more in-depth understanding of the experiences of behavioral health clinicians working in integrated primary care settings. In addition, the participants of the focus group were from the same region of North Carolina, three of whom from the same primary care practice. In the dissertation, a focus was made to capture individually the experiences of behavioral health clinicians across North Carolina in a variety of different primary care practices. This was done because the results from the thesis group may have been biased by group think as a result of the focus group but also because of the culture and influences of the practice.

The thesis provided insight into a select group of mental health counselors' attitudes working in integrated primary care. The 90-minute focus group was recorded and data were transcribed verbatim. Thematic analysis was used to examine the focus group data. A coding team consisted of the main researcher and two doctoral students from the Counselor Education Program at North Carolina State University and used an inductive approach allowing themes to emerge. The transcription individually was analyzed by each member of the coding team prior to meeting as a group for achieving consensus of themes. Five main themes emerged in response to the main research question of "What are mental health counselors' attitudes toward integrated primary care?" : (a) counselors have multiple roles in IPC, (b) counselors in IPC have a philosophy in holistic biopsychosocial team based care, (c) barriers exist for implementation of IPC, (d) multiple ethical considerations exist, and (e) there is a need for training for counselors working in IPC. In addition to the focus group, a 9-

item demographic and background was used to gather data on gender, race, licensure, degree achieved, years in the mental health profession, training, attitudes regarding mental health in primary care as a specialty area of training, and confidence in abilities to provide mental health and chronic disease behavioral interventions.

The majority of the mental health counselors had a Master's level of education (83%), as opposed to a doctorate (17%). The range of years in practice was from two to five years to over 15 years in practice. Over 83% reported above 10 years in practice, with over 50% reporting over 15 years in practice. Participants reported a range of locations where they are providing integrated primary care. Over 50% of the participants reported providing integrated primary care in family medicine practices, with the other 50% reporting working in either a health department, OB/GYN, or primary cancer center for patients.

Consistent with previous literature, this study revealed that mental health counselors reported a lack of training in IPC. Mental health counselors primarily reported receiving training in integrated primary care through continuing education. The following is a categorization of where mental health counselors have received training in IPC: graduate school (0%), internship (16%), certificate course in integrated primary care (0%), continuing education in IPC (66%), and other, fellowship, (16%). All of the mental health counselors (100%) indicated a yes response to the question, "Do you consider providing mental health services in primary care to be a specialty area of training?" From the focus group, the participants stressed a need for counselors to understand basic medical knowledge as well as

understanding the complexities of the overlap between medical and mental health conditions. A recommendation was for clinical internships in IPC locations.

The Glueck (2012) focus group study had multiple limitations. The results reflected only this group of mental health counselors that participated in this focus group. Krueger and Casey (1994) recommend that it take at least three focus groups or more until saturation of themes occurs from the data. The participants represented a homogeneous sample with all participants being Caucasian females. This sample did not capture attitudes toward integrated primary care that may have emerged from differences in gender and/or race. There was diversity among mental health disciplines ranging from LPC, LP, to LCSW. However, due to the limited sample size, these differences were not individually examined.

Another limitation was that the participants represented a group of individuals who are invested in integrated primary care. This was evident in their monthly peer supervision group meetings and work in a location that is invested in developing residency and counseling internships. Finally, these participants all provided integrated primary care within a region of North Carolina that has supported the infrastructure of IPC, offering internships for medical and mental health students. A potential barrier for focus groups is the potential for 'group think' and has to be given consideration in evaluating these results.

Time also was a limitation for participation in the focus group. This study originally was planned for a focus group in Raleigh/Durham/Chapel Hill area of North Carolina. Participants who initially responded with interest in the focus group were located in rural areas within at least one or two hours from Raleigh, NC and they expressed that participation

would incur a hardship of time. It became evident to this researcher that bringing together multiple groups of mental health counselors for multiple focus groups when these clinicians are predominately working in rural communities in primary care offices would be asking too much of the participants. Moreover, individual semi-structured interviews using a phenomenological approach would capture more in-depth the lived experiences of these behavioral health clinicians, along with lessening the burden of time on the participants by offering to meet on-site at the integrated primary care site.

### **Self-efficacy**

Bandura (1986) developed self-efficacy as one of the theoretical constructs of Social Cognitive Theory (SCT). As a learning theory, self-efficacy is defined as the “belief about personal ability to perform behaviors that bring desired outcomes” (Glanz et al., 2008, p. 171). The extent to which persons believe they are able to succeed or reach a goal determines significantly how he or she will think, feel, and act in ways that support this belief system. Four themes influence self-efficacy, and they are as follow: mastery, social modeling, social persuasion, and psychological response.

Behavioral health clinicians working in integrated primary care currently are the first group of mental health professionals to make this transition to this new work setting. With limited training in IPC, there likely is a lack of social modeling in the capacity to observe and learn from other behavioral health clinicians working in IPC as a means of developing mastery. If a mental health counselor happens to work in an IPC location that has more than one counselor, then social modeling may occur between and amongst the counselors.

As behavioral health clinicians begin to work in IPC settings, it is important to examine self-efficacy. Questions such as, “Do counselors feel confident in their abilities to work with mental health?” are different from the question of confidence in assisting primary care patients with behavioral lifestyle and coping strategies around chronic disease management. For example, have counselors been trained in assisting medical patients in proactive coping strategies for diabetes management or hypertension? Are behavioral health clinicians confident in their abilities to develop treatment plans that address mental health and substance abuse and how these conditions impact chronic disease management? Questions such as these broadly reveal the importance of examining a behavioral health clinician’s self-efficacy in how they perceive their confidence about roles in IPC, previous training, and their belief in their abilities to successfully provider clinical services as part of the medical team. Bandura (1986) stated that self-doubters have difficulty with the perseverance required for developing self-efficacy. This is why individuals with similar skills may respond differently in their level of competency.

### **Chapter Summary**

In summary, integrated primary care (IPC) is designed to increase access of services by having a mental health counselor on-site in the primary care office (Blount, 2003; Dickinson & Miller, 2011; Patterson et.al., 2002). IPC also is designed to improve patients’ health using a biopsychosocial model (Engle, 1977). This change represents not only a shift in work location for mental health providers but also a new role for as behavioral health clinicians working in a medical setting that involves a broader conceptualization of treatment

of health than only focusing on mental health. In IPC the behavioral health clinicians become members of a health care team.

The IPC idea is challenging a long-standing separation between mind and body and is different from providing traditional therapy located inside a primary care office. Changes are occurring in health care reform to support IPC. With these changes, there will be a need for mental health providers to respond to the workforce in integrated primary care settings (Blount & Miller, 2009). Currently, national leaders in collaborative care have expressed concern that mental health counselors as a collective group (i.e., counselors, social workers, marriage & family therapists, and psychologists) are not prepared with the knowledge and training to work in a primary care office setting (Blount & Miller, 2009; O'Donohue, Cummings, & Cummings, 2009).

In a review of the literature, previous studies have not explored the experiences of behavioral health clinicians who are currently working in integrated primary care settings to better understand their actual roles in IPC or training needs. It is important to gain this knowledge first hand from these BHC who currently are working in IPC to ascertain what are the roles of a BHC across various primary care settings, what are their attitudes about IPC, and what training is needed. This information can best be captured using qualitative methodology. Creswell (1998) states that qualitative inquiry is used to learn more about research questions that ask the question of “what,” for topics that need to be explored, and in which an in-depth understanding in a natural setting is needed.

### **CHAPTER THREE: METHODOLOGY**

This chapter will include the purpose of the study, the research questions, description of the research design, participants, procedures, data collections, and analysis. Each of these methodological considerations will be discussed in detail.

#### **Purpose of the Study**

The purpose of this current qualitative phenomenological study was to explore the shared experiences of behavioral health clinicians' working in integrated primary care offices in North Carolina in order to gain understanding about their roles in IPC, attitudes toward IPC, and training needs. This study also was conducted in partial fulfillment of the educational requirements for the Doctor of Philosophy degree in the Counselor Education Program at North Carolina State University. Results from this study will expand the knowledge base on behavioral health clinicians' working in integrated primary care, provide insight into their roles, attitudes toward IPC, and shed light on educational training needed to prepare counselors for this new clinical setting as part of a medical treatment team.

For the purpose of this current study, a behavioral health clinician was defined as a mental health provider who holds a license in North Carolina and is working in an integrated primary care setting. This definition is broad in order to include Licensed Professional Counselors (LPC), Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Psychologists (LP), as these are the disciplines that are currently working in an integrated primary care setting. The rationale for being licensed provides a standardized basis of competency achieved within each discipline of mental health within North Carolina. The

term, integrated primary care, was defined as a primary care location in which a behavioral health clinician is located on-site and provides same day or joint appointments with the primary care providers as part of a medical team. For this study, the term primary care was used as a collective term to identify a medical facility that serves the general population for health. This definition included a family practice, pediatrician office, or a health department. For the purposes of this study an integrated primary care clinic does not include a specialty medical clinic in which a primary diagnosis of a chronic illness or disease is made and which the clinic exclusively treats that subspecialty.

### **Research Questions**

The primary research questions that guide this qualitative research are the following:

1. How do behavioral health clinicians view their role in integrated primary care?
2. What are behavioral health clinicians' attitudes toward integrated primary care?
3. What training is needed for behavioral health clinicians to work in an integrated primary care setting?

### **Research Design**

This study used interpretative phenomenological analysis to discover the shared meaning for behavioral health clinicians working in integrated primary care settings.

Creswell (1998) stated that qualitative inquiry is used to learn more about research questions that ask the questions of “what,” for topics that need to be explored, and in which there is a need to acquire an in-depth understanding in a natural setting. Patton (2002) described qualitative analysis as the use of in-depth open-ended interview questions that provide “direct

quotations from people about their experiences, opinions, feelings, and knowledge” (pp. 44). Qualitative research is best utilized when inquiry is broad and further issues need to be examined in more detail (Patton, 2002). The use of open-ended interview questions provides a way to obtain rich detailed information from participants, expressing their own world-view in a conversational format. For this reason, qualitative inquiry requires purposeful sampling methods of the participants to gain a better understanding of their experiences (Patton, 2002).

Interpretive phenomenological qualitative inquiry is designed to capture the process and is concerned with making sense of the meaning and experiences for the study under investigation and the participants’ real-world experiences. This is in contrast to a positivistic approach to knowledge, which abandons political influence and aims to accumulate facts through precision and order (Rubin & Rubin, 1995). Instead, the Interpretive Phenomenological Approach (IPA), having a foundation in philosophy, is designed to gather descriptions and meanings from the participants then to be interpreted regarding how they relate to the human experience and social cognition (Lopez & Willis, 2004). An interpretive phenomenological research approach acknowledges that there is more than one way to interpret data and is designed to use these interpretations to find “meanings for practice, education, research, and policy to create informed and culturally sensitive health care knowledge” (Lopez & Willis, 2004, p. 730). In addition to descriptive data, IPA can be used to develop models and theories around a phenomenon under study (Fade, 2004). In IPA, data that are gathered are thick with rich descriptions of detail because the researcher aims to

capture the participants' meaning of the experiences (Rubin & Rubin, 1995; Smith, Flowers, & Larkin, 2009).

Because of the depth involved in the interview and analysis, sample size is generally homogeneous and small (Smith et al., 2009). The homogeneous sample is in reference to having a participant group in which the research question is meaningful and can vary from study to study. Smith et al., (2009) suggested that when considering a homogeneous sample researchers need to consider the practicalities of how many people and how easily these participants can be contacted to be part of the study. When a topic under study is rare or may have a limited sample this narrows the sample size and leads to a homogeneous sample (Smith et al., 2009). The rationale for a small sample size is that, “ the issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases (Smith et al., 2009, p.51)” Smith et al. (2009) recommend between three and six participants or four participants interviewed twice. The small sample size is due to the rigor involved in IPA analysis, the amount of data that is generated, and the analysis that examines meaningful points on an individual case as well as similarities and comparisons between participants. Smith, Flower, and Larkin (2009) acknowledged that this small sample size may be a challenge for doctoral students conducting IPA for a dissertation who need committee approval and caution new researchers that “ In effect, it is more problematic to try to meet IPA's commitments with a sample which is ‘too large’, than one that is ‘too small’ (p.51). However, sample size also needs to be considered from departmental requirements and what is standard within the profession.

Therefore, this study has taken Smith et al.'s (2009) considerations into account, along with requirements for a dissertation as well as what is standard within the professional literature, and a decision was made by the researcher to select eight to ten participants. Because the participants are professionals who are working in busy medical practices and giving up their time during lunch, the decision was made not to conduct multiple interviews as this would have been an undue burden for the participants as well as for the researcher who was traveling across North Carolina to meet at their practice sites.

In qualitative inquiry, the researcher needs to plan for the design and then be flexible and iterative for continuous design (Rubin & Rubin, 1995). The qualitative design may adapt and change as interviews begin and the researcher analyzes the data. This concept of a flexible design is a normal process in qualitative research. Because qualitative inquiry begins in an exploratory place, as data are collected and as questions are asked during a semi-structured interview, there is a built in process that requires ongoing continuous questioning and redesigning throughout the study. This provides an opportunity to explore new topics that may emerge during the data collection based on responses from participants.

### **Participants**

Purposeful criterion sampling was used to recruit eight to ten behavioral health clinicians who were licensed in North Carolina and at the time of the interviews were working on-site in a primary care office providing integrated primary care. Participants met criteria for this study if they held one of the following credentials: Licensed Professional Counselors (LPC), Licensed Clinical Social Workers (LCSW), Licensed Marriage and

Family Therapists (LMFT), or Licensed Psychologists (LP) and who currently self-reported working on-site in a primary care office providing integrated primary care located in North Carolina. Exclusion criteria were behavioral health clinicians who are not fully licensed to provide mental health counseling services by state licensure boards in North Carolina and who were not currently working on-site in a family practice, pediatric practice, or health department primary care office. Participants were offered an incentive of a meal up to \$10 in exchange for their participation time. This incentive was offered with an awareness that the participants may be giving up their lunch to meet for the interview.

### **Procedure**

This study followed all requirements to comply with the Institutional Review Board at North Carolina State University. Participants were recruited through an e-mail invitation (see Appendix B) that was sent directly to behavioral health clinicians known to be working in integrated primary care that had been identified through the Kate B. Reynolds Foundation that provides grants to primary care practices across North Carolina to support efforts for integrated care, in addition to behavioral health coordinators for the Community Care of North Carolina (CCNC), Mountain Area Health Education Center, and leaders in integrated care in North Carolina to help identify participants for this study, as well as through an integrated care listserv. This method of using purposeful sampling was meant to target participants who met the study requirements for a homogeneous sample. Participants who responded to the initial e-mail request were asked the following screening questions (see Appendix C) to determine eligibility for this study: 1) “Are you a licensed mental health

counselor North Carolina? What is your licensure (LPC, LMFT, LCSW, LP) and 2) “Are you currently providing services on-site in a primary care office (primary care, pediatrics, health department) as part of a medical team in which you provide same day or joint appointments with the primary care provider?” A response of “yes” to question #2 was used to identify that the practice the behavioral health clinician was working at is an integrated primary care practice.

Individual interviews were set with each of the participants who met the screening criteria. In order to capture diversity of BHC across North Carolina, no more than two participant interviews were conducted at sites that had multiple BHC’s. This was to capture diversity in experiences that may exist across various integrated primary care sites within North Carolina. In recruitment, efforts were made to interview participants in different geographical locations and settings across North Carolina, and LPCs were given priority for participation in this study. Arrangements were made individually to coordinate a time and convenient meeting location, and this researcher offered to conduct the interviews at the integrated care location. Participants were reminded of the incentive for lunch to be provided up to \$10, and arrangements were made for the researcher to bring take-out from a selected restaurant to their office location or to meet the participant at a local restaurant for the interview. All but one interview was conducted at the primary care integrated site.

Participants received two courtesy reminder e-mails prior to the scheduled interview. The first reminder was sent one-week prior and the second two days prior. Both e-mails included a confirmation of the date, time, and location of the interview along with a PDF

copy of the informed consent. The semi-structured guide was not sent to participant prior to the interview. The rationale for this decision was to decrease participants approaching this research as an assignment and to allow for naturalistic flow, emotions, and responses to the questions during the interview. A hard copy of the semi-structured interview questions was presented to the participants at the time of the interview along with the informed consent to sign. The purpose of providing the questions before starting the interview was to decrease any anxiety or worry that participants may have been feeling and decrease anticipation by wondering what questions the researcher would ask during the interview session.

At the time of the semi-structured interview, participants were asked to complete a brief demographic questionnaire and sign the informed consent. To protect confidentiality, participants were asked to select a pseudonym. If one was not chosen, the researcher selected a name.

The semi-structured interview was audio-recorded on two recorders. The researcher transcribed each recording within two days of the interview and then reviewed each transcript against the recording twice for accuracy. Then within a week of the interview a copy of the transcription was sent to each participant for the purpose of member checking, a procedure that adds credibility and reliability to qualitative research. If participants had comments or wanted to make changes to the transcript, only minor changes were made that clarified meaning or added to the readability, for example, placing quotation marks around statements to increase readability or making editorial changes on acronyms. These changes were checked against the original transcription and the audio recording and re-sent to the

participant for a final member validity check. All participants responded to the member check. After completion of the interview and member checking, each participant was sent a final e-mail thanking him or her for their participation.

### **Instruments**

For this study, a semi-structured interview (Appendix E) was developed based on a review of the literature. The initial questions were tested in a focus group with mental health counselors currently working in integrated primary care. Qualitative questions are focused on meanings and experiences of the participants (Patton, 2002). Rubin and Rubin (1995) identify that qualitative interviewing is a way of “finding out what others feel and think about their worlds” (p. 1).

#### **Semi-structured Interview**

Semi-structured interviews were used to capture specific information from the participants. The researcher uses a guide of prepared questions that allows the participants’ thoughts and ideas to emerge. The interview is similar to a conversation but with a guide and focused purpose. However, the interview differs from conversation in that the researcher is intensely listening for the context and meaning of what was being said, to understand the world view of the participant (Rubin & Rubin, 1995). The interviews were recorded and then transcribed.

#### **Interview Question Development**

The interview questions were developed based on literature and tested in a focus group. A focus group is “a carefully planned series of discussions designed to obtain

perceptions on a defined area of interest in a permissive, nonthreatening environment” (Krueger & Casey, pp. 2). Krueger and Casey (1994) stated that the purpose of a focus group, “is a way to better understand how people feel or think about an issue” (p. 2). When relaxed and comfortable, the belief is that participants can self-disclose their opinions about a topic without judgment (Krueger & Casey, 1994). In-depth individual and group consensus attitudes are revealed using carefully constructed open-ended interview questions (Krueger & Casey, 1994; Stewart & Shamdassani, 1990). Moreover, results generated from a focus group can lead to development of surveys for future quantitative research (Stewart & Shamdassani, 1990, Krueger & Casey, 1994). Slight changes were made from the questions used in the focus group and demographic questions to strengthen the development of the questions for this present study. In the focus group, the term, mental health counselor, was used. This term was changed to behavioral health clinician for this study upon recommendation and further review of the literature that it more accurately captures the professional title of the participants. The following is a description of question development, and when appropriate, provides explanation of changes made from the focus group.

**Question 1.** *How would you describe your role as a behavioral health clinician working in an integrated primary care setting?* This question was open-ended to capture the view that BHCs have of their role. Creswell (1998) states that qualitative inquiry is used to learn more questions that ask the question of “what,” and “how” for topics that need to be explored, and in which there is limited information and need to understand an in-depth understanding in a natural setting.

**Question 2.** *What are your attitudes and beliefs about providing behavioral health services in integrated primary care?* This question was also open-ended to capture in-depth understanding and meaning of the participants' experiences (Creswell, 1998). This question was modified as a broader open-ended question to capture attitudes and beliefs and to reduce leading or bias responses. The following was the pilot tested focus group questions: *What do you think about mental health counselor providing service in integrate primary care? What do you think are the advantages of integrated primary care? What do you think are the barriers of integrated primary care? Do you think there are ethical considerations for mental health counselors providing integrated primary care?*

**Questions 3 and 4.** *What theoretical training did you receive prior to your work in integrated primary care? Prompt: Has this been helpful to you in your work in integrated primary care? And, Where have you received training in how to provide mental health services in an integrated primary care setting? What about in your graduate program?*

Previous researchers have expressed the concern that IPC requires a different skills set than traditional mental health settings and that training is limited (Blount & Miller, 2009; Hunter et al, 2009). In the focus group, questions were not asked about theoretical training.

Participants in the focus group completed a demographic questionnaire and were asked to respond with a yes/no response to the question. *Have you received training in how to provide mental health services in an integrated primary care setting?* If the response was "yes", participants were asked to check all the places they received integrated primary care training that applied that included: graduate program, internships working in primary care,

certification course, continuing education, and other. In keeping with open-ended qualitative inquiry, these questions were taken out of the demographic questionnaire, and open-ended questions were asked to gather deeper in-depth information about training.

**Question 5.** *To what degree do you feel confident in your abilities to provide services in integrated primary care? For mental health? For chronic disease behavioral interventions?* This present study did not specifically seek to examine self-efficacy. However, obtaining attitudes and beliefs about the behavioral health clinicians' confidence was important based on responses from the focus group. In the focus group, participants completed the following yes/no question of: *“Do you feel confident in your abilities to provide mental health and chronic disease behavioral interventions as a mental health counselor in an integrated primary care?”* This question was adapted to be an open-ended question of “what” and a decision was made to ask for the distinction on mental health and then separately for chronic disease behavioral interventions, rather than making assumptions that the participants would respond similarly to both categories.

**Question 6.** *What kind of training and knowledge do you think is needed for behavioral health clinicians providing integrated primary care?* This final question was intentionally left broad to capture the participants' attitudes and recommendations. The only change made from the questions for the focus group pilot tested and the above question was the change in terminology from mental health counselors to behavioral health clinicians.

### **Researcher as an Instrument**

In qualitative research the quality and credibility of the research depends on the researcher (Patton, 2002). The researcher in IPA withholds bias, but uses knowledge in constructing interview questions and in the analysis of the data (Lopez & Willis, 2004). The researcher's knowledge of a subject and, in addition, understanding of the literature is what leads to the research study (Lopez & Willis, 2004). Theory is used to guide the research inquiry and questions to be asked, and the theoretical orientation becomes a lens for interpretation of results (Lopez & Willis, 2004).

Rubin and Rubin (1995) identify that the researcher is forming a relationship with the participant. The researcher's approach toward the participant, such as warmth and empathy, or being closed off and impersonal, will reflect the quality of the participant's openness in disclosure. Therefore, researchers need to understand clearly how their own presentation may influence the quality of the data. This researcher's skill in interviewing and conducting focus groups is an instrument of methodology. The principal investigator is a doctoral student at North Carolina State University. She has taken doctoral level courses in research and is also a Licensed Professional Counselor in North Carolina with over 12 years of experience providing individual counseling. As a counselor, this researcher has developed clinical skills to develop empathic and neutral rapport with individuals, creating a safe environment for the sharing of thoughts and feelings. In addition, her counseling training has provided the ability to listen intently for meaning from the spoken word, the omitted statement, pauses, and non-verbal behaviors that are observed.

The researcher is both an insider and outsider to the participants. The researcher is licensed professional counselor but is an outsider to this group because she has never worked as a behavioral health clinician in an integrated care setting. Previously she has worked in medical settings as a co-located counselor. The researcher previously had providing training assistance for assisting medical practices in developing integrated care practices and has developed working relationships with mental health counselors who are working on-site in IPCs. Being an insider within the integrated care community of North Carolina has provided familiarity with agencies that are supporting integrated primary care efforts in North Carolina and access to participants for this study. This familiarity could pose a problem in participants' responses to the researcher with pre-conceived ideas or expectations on how they think they should respond to the interview questions. On the other hand, not having this insider access may result in lack of trust by participants not engaging in research. The researcher will keep a journal during the process of data collection and data analysis to reduce biases so that these do not influence the results. This journal was shared with the coding team.

### **Data Analysis Framework**

Phenomenological inquiry is grounded in philosophy, in which knowledge is truth (Patton, 2002). This study is designed to capture participant's truths of their own experiences. To the extent possible, the validity of this research is through creating a research design that is followed and can be replicated (Patton, 2002). This study used an Interpretative Phenomenological Analysis (IPA) to capture themes and meanings of behavioral health

clinicians' experiences working in an integrated primary care setting. "IPA does not include a single step of data analysis, but must include the following characteristics: (a) movement from what is unique to a participant to what is shared by the participants, (b) description of the experience which moves to an interpretation of the experience, (c) commitment to understanding the participant's point of view, and (d) psychological focus on personal meaning-making within a particular context (Smith et al., 2009) in (Cooper, Fleischer, & Fatima, 2012, p. 5)."

### **Interpretive Phenomenological Analysis**

Interpretative phenomenological analysis is a reflexive continuous process that utilizes both thematic analysis and interpretative meaning of the participants. Thematic analysis was the primary analysis for this research. Thematic analysis of the transcripts was achieved using a coding team that consisted of this researchers, a Ph.D. level counselor educator, and a doctoral candidate also in counselor education. IPA does not typically use a coding team for analysis. A coding team was used to decrease the researcher's bias and add credibility to the results. The two other members of the coding team had no connection to the integrated care community in North Carolina and had never worked as mental health counselors in a co-located or integrated primary care setting. The coding team members all had previously been trained in thematic coding in a doctoral level qualitative course as well as in previous qualitative research experiences. The researcher extended this training by meeting with the coding team as a group and providing training for this study. Each member of the team completed a journaling bias prior to coding. Next, each coder individually coded

using a method of reviewing line-by-line but coding to capture meaning and themes (Chenail, 2012). This process required that coders review the transcript line-by-line but analyze for the meaning rather than literal line-by-line codes (Chenail, 2012). Upon completion of this first level of analysis, the coding team met as a group to achieve consensus of these codes. Next, the researcher calculated the Kappa coefficient ( $k$ ) to measure the degree of inter-rater reliability among the themes by the researcher and two members of the coding team. The final analysis is consistent with IPA in that the researcher examined the thematic coding achieved by the group on the content and meaning that captured the experiences of the BHC's.

**Coding meaningful themes.** Analysis of the data included multiple steps. IPA is inductive and requires immersing oneself in the data for noting descriptive comments, emergent themes, building connections among themes, and making meaning of these themes to capture the participants experiences. The first step of analysis included each transcript being coded individual by each member of the coding team for descriptive comments, key phrases, and emergent themes. The coding team was comprised of this researcher, a doctoral candidate, and a Ph.D. level professional, all of whom have training in counselor education. The coding team met as a group, and were provided training on coding the transcripts reading line-by-line to capture themes and meaning (Chenail, 2012). This process of analysis was utilized to capture the meaningful experiences of the participants. Chenail (2012) suggested that when coding line-by-line important contextual information can be lost that captures the

essence of participants' experiences that is valuable in qualitative inquiry. All coding was individually completed in Microsoft Word Track Changes.

**Coding subsumption.** Following this step, the analysis was comparing and contrasting themes for each individual transcript as a case study developing subsumptions, a process that leads to the IPA development of super-ordinate themes. Each of the three coder's individual responses for each individual transcript were merged into one document. This allowed greater depth of analysis in examining the three coding team responses within one document. The researcher then began IPA analysis by examining each individual transcript as its own case study, as well as contextually exploring the coding teams noted descriptive comments and themes. For each transcript, broad themes were generated. This process of examining the transcripts individually allowed for greater depth in the IPA process for examining polarization, differences and similarities, context, and numeration (Smith et al., 2009). Numeration is the frequency in which a theme occurs (Smith et al., 2009).

**Super-ordinate themes.** Utilizing IPA methods the researcher then began to search for connections among the themes that emerged, and charting the process of movement from the meaning-making in the transcript to looking for patterns in the development of a super-ordinate theme. Smith et al., (2009) describe the super-ordinate theme as a "basic form of identifying patterns between emergent themes...It involves putting it all together like with like and developing a new name for the cluster" (p. 96). This step of analysis allowed the researcher to utilize the IPA method of assimilating the descriptions, key phrases, and themes

from the coding team for each individual transcript to generate broader meaningful themes that captured the collective experiences for the group of behavioral health clinicians.

**Interpretative analysis.** In the next step of analysis, the coding team met as a group to review the themes that originated from the data that were captured in the individual transcript and the IPA grouping of subsumption, the patterns across cases, that lead to the super-ordinate themes. The coding team then achieved consensus of the super-ordinate themes and interpretations of meaningful experiences for the participants. This researcher then utilized these agreed upon themes in the process of interpretation of the data in the results.

### **Credibility and Trustworthiness**

The researcher used data collected as a way of understanding the participants' experiences in answering the question, what is the narrative meaning for interpretation (Patton, 2002). A systemic process was followed to meet the rigors of credibility for qualitative research (Patton, 2002). In this study, the researcher sought credibility by open disclosure and a stance of neutrality toward the lived experiences of behavioral health clinicians working in IPC. This researcher did not seek to prove a hypothesis or to develop a theory; instead, the purpose is to understand the worldview experiences of the participants. Patton (2002) suggests that achieving neutrality is a challenge and suggests that qualitative researchers take steps to achieve credible research that is as free from bias as possible. To achieve neutrality and credibility in this research, the researcher used the following techniques to produce rigorous data that are credible and trustworthy: (a) use systemic data

collection procedures, (b) memo after each semi-structured interview, (c) establish reflexivity during the data collection and analysis, (d) worked with a coding team to reduce personal bias, and (e) conducted an external audit.

This researcher followed a transparent systemic rigorous data collection method to add credibility and trustworthiness to the qualitative research method. This transparency will allow others to replicate the research methods. All participants were asked the same set of interview questions. The researcher conducted the interviews, transcription, and journaling in the same manner for each participant. A member check was used to validate the transcriptions before beginning analysis. For the member check, each participant reviewed his or her transcribed interview for accuracy and e-mailed this researcher that the transcription was accurate. To ensure that the researcher was not inadvertently or unconsciously attempting to shape the research findings, the approach of looking for data that supports alternative explanations was used (Patton, 2002). Consequently, the researcher attempted to find negative cases and exceptions to the rule. This attempt to include exceptions provides an opportunity to challenge themes that emerge (Patton, 2002).

### **Memo-writing**

In keeping with rigorous data collection and analysis protocols, the researcher completed a memo after each interview. The memo included key information noted during the interview that may not have been captured during the semi-structured interviews. These observational data were used as a means of triangulation in order to make comparisons between what was said in the interview and what was observed and enrich the contextual

meaning in the analysis. The journal was kept during the analysis that contained the researcher's thoughts, beliefs, and biases. Both the memo and journal were shared with the coding team during analysis for the purposes of challenging bias and context for interpretation of the findings (Patton, 2002).

To strengthen the quality and credibility of the analysis, the researcher requested each member of the coding team to disclose his or her personal biases toward behavioral health clinicians working in integrated primary care. To lend to the credibility of the researcher she was reflexive and reported biases before, during, and after the analysis, giving full disclosure of her biases on the topic of mental health counselors working in integrated primary care.

### **Reflexivity**

The researcher understands the importance of self-awareness in qualitative methods and utilized reflexivity throughout this research process (Patton, 2002). This researcher believes that IPC is a model that can increase access to care for clients that may otherwise not receive any help due to rural location, culture, or stigma. This researcher does not believe that IPC replaces the need for traditional mental health counseling but rather that it complements the needs for a community and for some individuals seeking care at their primary physician's office as a first point of service and place of identification. Throughout the analysis and interpretation for meaning, this researcher sought to balance her perspectives of interpretation of meaning with the voice of the participants (Patton, 2002). The use of a coding team and auditor served to decrease this researcher's personal biases to allow the voices and meaning of the participants to be heard.

### Coding Team and Inter-Rater Agreement

The use of a coding team is not mentioned by Smith et.al. (2009). Typically, the IPA researcher conducts the analysis independently. This researcher selected to incorporate the assistance of a coding team as a means to strengthen the credibility and trustworthiness of the study. In addition, Cohen's Kappa coefficient ( $K$ ) was calculated to measure the degree of inter-rater agreement among the emergent patterns for each case transcript and as a collective group of ten participants. Below is a chart of the kappa scores that reflect the strength of inter-rater agreement ( $K= 0.79$ ). Kappa ranges between .061-.80 demonstrate a strong agreement, with kappa scores closer to .80 as excellent.

Table 1

#### *Cohen's Kappa Score Results*

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	Total
R1	20	27	21	16	19	19	15	20	21	18	196
R2	17	25	17	13	14	15	12	18	18	17	166
R3	19	24	20	15	17	17	13	17	20	16	178
Total codes											540
Agree	15	20	17	12	11	14	10	15	15	14	
Total agree: 143 Total Agreements (143 *3) = 429 / 540=0.79											

**Auditor**

Smith et al., (2009) suggest that an independent audit can be used to assess the validity and quality of qualitative research. An audit consists of a paper trail that demonstrates a logical or credibly step-by-step path that leads from the initial raw data of transcripts and coding to the final analysis (Smith et al., 2009). In qualitative research, an audit is not the same as inter-rater reliability used in quantitative research. Rather, an audit is an attempt to “ensure that the account produced is a credible one, not that it is the only credible one (Smith et al., 2009, p. 183).” An audit can be independent, performed by the researchers, or completed by a researcher who is not connected to the study. To strengthen the validity and credibility of this dissertation, the researcher enlisted the services of an Assistant Professor in Counselor Education who serve as the auditor. The auditor was not compensated for the time as this was done as a personal favor. Because the auditor resides out of the state of North Carolina, documents were sent electronically for this process.

**External Audit.** Smith et al., (2009) recommend conducting an individual audit or an external audit. An external auditor was selected to verify the results. The auditor was sent all transcripts and original codes generated by the coding team, memos from the interviews, along with data analysis documents that documented the iterative analysis of data reduction and meaning assimilation from the themes, along with the final themes from this interpretative approach. The auditor reported finding no discrepancies with the codes, bias, or Cohen’s Kappa scores. The use of a coding team and auditor increases the credibility and trustworthiness of these results.

## **CHAPTER FOUR: RESULTS**

The purpose of the study was to explore the experiences of behavioral health clinicians (BHC) working in integrated primary care settings. The qualitative questions that guided this study are as follows:

1. How do behavioral health clinicians view their role in integrated primary care?
2. What are behavioral health clinicians' attitudes toward integrated primary care?
3. What training is needed for behavioral health clinicians to work in an integrated primary care setting?

This study used Interpretative Phenomenological Analysis (IPA) to capture themes and meanings of behavioral health clinicians' experiences working in an integrated primary care setting. The findings from this study are reported in this chapter. Participant characteristics are reported using descriptive statistics. The results of the ten qualitative individual interviews are reported based on research questions by themes and supported by participant verbatim statements. The quotations have been kept in the original language of the participants' verbatim responses taken from the transcripts. This researcher did not change or alter the transcriptions to reflect proper grammar. Results are also reported utilizing tables and graphs when appropriate.

### **Participants Profiles**

Ten behavioral health clinicians individually were interviewed for this study. The ten participants were working in eight different integrated primary care settings that spanned the regions of eastern, central, piedmont, and western North Carolina. Over 50% of the

participants requested to use their real names for this study. However, in compliance with IRB guidelines proposed, a pseudonym was selected for all participants in this study. In the following section a description of the participants captures the information that was self-reported on the demographic form. The below descriptions include additional descriptions that that were captured by this researcher and noted in memo after each interview.

### ***Anna***

Anna self reported as a white female who completed a master's degree and is a Licensed Professional Counselor (LPC) in North Carolina. She reported working in the profession of mental health for six years and working in an integrated primary care setting for one year and two months. The interview was conducted in a medical exam room at one of the three urban safety net primary care settings that she rotates between for services. Anna reported that in one of the IPC settings there is a full time LCSW. In the other two of the IPC settings where she works, she is the only BHC, and at her location her title is an Screening, Brief Intervention, and Referral to Treatment (SBIRT) Specialist. *Participant check.* After the interview was transcribed it was sent to Anna within a week for a member validity check. Anna had no changes to make to the transcript and confirmed that the information was accurate.

### ***Kim***

Kim self reported as a white female who has completed a master's degree and is a Licensed Professional Counselor (LPC) in North Carolina. She reported that she has worked in the field of mental health as a counselor for 16 years and worked in an integrated primary

care setting for four years. The interview was conducted at a pediatrician's office in a rural location of North Carolina. She stated that there was initially confusion within the medical practice as to what would be her title that would capture her role. Her title is Behavioral Health Counselor. She is the only BHC at this IPC setting. Kim shared she does not know any other LPCs who are BHCs and would like the opportunity to connect with others.

*Participant check.* After the interview was transcribed, it was sent to Kim within a week for a member validity check. Kim had no changes to make to the transcript and she confirmed that the information was accurate.

### ***Liz***

Liz self reported as a white female who completed a master's degree and a dual license as a Licensed Professional Counselor (LPC) and Licensed Psychological Associate (LPA) in North Carolina. She reported that she has been in the profession of mental health for 20 years and has worked in integrated primary care for six years. The interview was conducted at a family medical residency program in an urban location. She is one of three BHC's in her clinic and her title is Behavioral Health Provider (BHP)/ Faculty. Liz reported that she has assisted in the development of an integrated primary care internship for master's level counseling students and is a site supervisor for this program. *Participant check.* After the interview was transcribed, it was sent to Liz within a week for a member validity check. Liz had no changes to make to the transcript and confirmed that the information was accurate.

***Earl***

Earl self reported as a white male who has completed a master's degree and is a Licensed Professional Counselor (LPC) in North Carolina. He reported he has been in the profession of mental health for 12 years, and he worked in an integrated primary care setting for four years in a pediatric practice. The interview was conducted in his therapy office in a rural location in North Carolina. Earl was selected for this study as a disconfirming case study for this qualitative study because he led the efforts to start the IPC arrangement with the pediatric practice. Within the past few months, he moved out of the IPC setting and is renting space next door to the primary care setting. He cites policy changes within Medicaid in North Carolina impacting IPC that have led to his to his renting space next door. He continues to walk over to the pediatric practice for consultations and provides therapy at his office location.

*Participant check.* After the interview was transcribed, it was sent to Earl within a week for a member validity check. Earl had no changes to make to the transcript and confirmed that the information was accurate.

***Nisha***

Nisha self reported as an Asian female who completed a master's degree and is a Licensed Professional Counselor (LPC) and Licensed Clinical Addiction Specialist (LCAS) in North Carolina. She reported she has been in the profession of mental health for 16 years and has worked in an integrated primary care setting for five years. The interview was conducted at a local restaurant at her request during her lunch break. She reported working in

an urban safety net primary care setting that serves as a health department. She reported her title is the Director of Behavioral Health and that she helped develop the integrated care program and has expanded these services now supervises three licensed mental health professionals who are behavioral health clinicians at this clinic. *Participant check.* After the interview was transcribed, it was sent to Nisha within a week for a member validity check. Nisha had no changes to make to the transcript and confirmed that the information was accurate.

### ***Lena***

Lena self reported as a white female who completed a doctorate degree and is a Licensed Psychologist (LP) in North Carolina. Lena has been in the profession of mental health for 12 years and has worked in an integrated primary care setting for three and half years. The interview was conducted in her therapy office that was located on a medical hallway in a pediatric practice in piedmont NC. Lena is the only BHC at her office setting, and she is employed by the pediatric practice as a psychologist. She stated that she does not know any other mental health providers who are working on-site in a primary care office. *Participant check.* After the interview was transcribed, it was sent to Lena within a week for a member validity check. Lena had previous experience working on a research project for qualitative studies and had done transcription. Lena recommended use of quotations in specific areas to convey clarity of the meaning. These changes were made, and the transcript was returned to Lena who validated the accuracy.

***Jane***

Jane self reported as a white female who completed a doctorate degree and is a Licensed Psychologist (LP) in North Carolina. She also reported during the interview that she was certified in 2008, as an Integrated Care Behavioral Specialist, through the only training conducted in North Carolina. Jane reported that she has been in the profession of mental health for 36 years and providing integrated primary care for five years. The interview was conducted in the morning prior to her starting work for the day at a rural medical clinic where she is employed as a Director of Behavioral Health Provider. She helped develop the behavioral health provider model at her site, and she has since expanded the services, hiring and providing clinical supervision to three additional BHP's. *Participant check.* After the interview was transcribed, it was sent to Jane within a week for a member validity check. Jane had no changes to make to the transcript and confirmed that the information was accurate.

***Martha***

Martha self reported as a white female who completed a master's degree and is Licensed Clinical Social Worker (LCSW) in North Carolina. Martha reported that she has been in the profession of mental health for 30 years and has been working in an integrated primary care setting for 2 and a half years. The interview was conducted in a rural location in the afternoon at one of the sites where she is working as a behavioral health provider. She is one of three BHCs, and she reported that she receives clinical supervision in applying her skills from mental health settings to integrated primary care. *Participant check.* After the

interview was transcribed, it was sent to Martha within a week for a member validity check. Martha identified one change in an acronym correction. This correction was made to the transcription and was sent back to Martha who then confirmed that the information was accurate.

### ***Chris***

Chris self reported as a white male who completed a master's degree and is a Licensed Clinical Social Worker (LCSW) in North Carolina. Chris has 14 years of mental health experience. He has been at his current location for three years. He reported that he previously worked in community mental health and in a school based services where he had interactions with nurses. In retrospect he now considers those years of experience as integrated care. The interview was conducted at the family medical clinic in a rural location in western NC where he is the only BHC at the practice. His position is grant funded, and he has helped develop the integrated care model. *Participant check.* After the interview was transcribed, it was sent to Chris within a week for a member validity check. Chris identified one change to correct an acronym. This change was made and sent back to Chris who then confirmed that the information was accurate. Chris added a response to his statement on e-mail and gave permission for this brief statement be used as an addendum to his transcript for his reflections on of the importance and need for training.

### ***Ella***

Ella self reported as a white female who completed a master degree in social work and public health and she is Licensed Clinical Social Worker (LCSW) in North Carolina.

Ella has 13 years experience in mental health, and she reported that all of these years have been in an integrated care setting. The interview was conducted at the family medical residency program in an urban location. She is the Director of Behavioral Health Providers/Faculty at this location. Ella works with two other BHCs at this practice. *Participant check.* After the interview was transcribed, it was sent to Ella within a week for a member validity check. Ella had no changes to make to the transcript and confirmed that the information was accurate.

### **Descriptive Statistics of Participants**

As shown in Table 2, the participants consisted of 10 individuals ( $N=10$ ). The majority, 80%, of participants reported their sex/ gender as being female and 20% as male. The majority of participants, 90%, self reported a their race/ethnicity as white and one participant, 10% reported being Asian. Over half of the participants self reported that they held a license as a Licensed Professional Counselor (LPC) in North Carolina: LPC ( $n=5$ ) 50%; LCSW ( $n=3$ ), 30%; and LP ( $n=2$ ), 20%. The majority of the participants, 80% ( $n=8$ ) reported holding a master's degree. Of the participants who reported holding a doctorate level education ( $n=2$ ) 20% both held licensure in North Carolina as a psychologist (LP).

Table 2

*Demographics of Participants*

Participant	Gender	Race	Education	License
Anna	Female	White	Master	LPC
Kim	Female	White	Master	LPC
Liz	Female	White	Master	LPA/LPC
Earl	Male	White	Master	LPC
Nisha	Female	Asian	Master	LPC
Lena	Female	White	Doctorate	LP
Jane	Female	White	Doctorate	LP
Martha	Female	White	Master	LCSW
Chris	Male	White	Master	LCSW
Ella	Female	White	Master	LCSW

*Note.* License is certification participants reported based on the North Carolina State Licensure Boards. Licensed Professional Counselor (LPC), Licensed Psychologist (LP), Licensed Clinical Social Worker (LCSW).

As part of the demographics, participants were asked the following two questions to capture participant years in practice (Table 3): (a) How long have you been in the profession of mental health? and (b) How long have you been working in an integrated primary care setting? In response to the first question, participants reported a mean of 17.5 years in the profession of mental health, with a range of 6-36 years. In response to length of time working in an integrated primary care setting, the participants reported a mean of 5.75 years, with a range of one year to 13 years. The median number of years in an integrated primary care setting was 4.5 years with a mode of 4 and 5 each occurring twice.

Table 3

*Participants Number of Years in Practice*

Participant	Years in Mental Health Profession	Years in IPC
Anna, LPC	6 years	1 year 2 months
Kim, LPC	16 years	4 years
Liz, LPC/LPA	20 years	6.5 years
Earl, LPC	12 years	4 years
Nisha, LPC	16 years	5 years
Lena, LP	12 years	3.5 years
Jane, LP	36 years	5 years
Martha, LCSW	30 years	2.5 years
Chris, LCSW	14 years	13.5 years
Ella, LCSW	13 years	13 years

Note. Years in practice in the mental health profession and in Integrated Primary Care (IPC) settings were self-reported.

The term, Behavioral Health Clinician (BHC), was used in this study to identify licensed mental health providers working on site in integrated primary care settings. As seen in Table 4, the participants in this study reported six different titles corresponding to their work position titles. This information was captured from memo kept by this researcher and was not part of the demographic form. The term Behavioral Health Provider was used most frequently ( $n=4$ ; 40%) followed by Behavioral Health Clinician ( $n=2$ ; 20%), SBIRT Specialist ( $n=1$ ; 1%); Behavioral Health Counselor ( $n=1$ ; 1%), Psychologist ( $n=1$ ; 1%), and

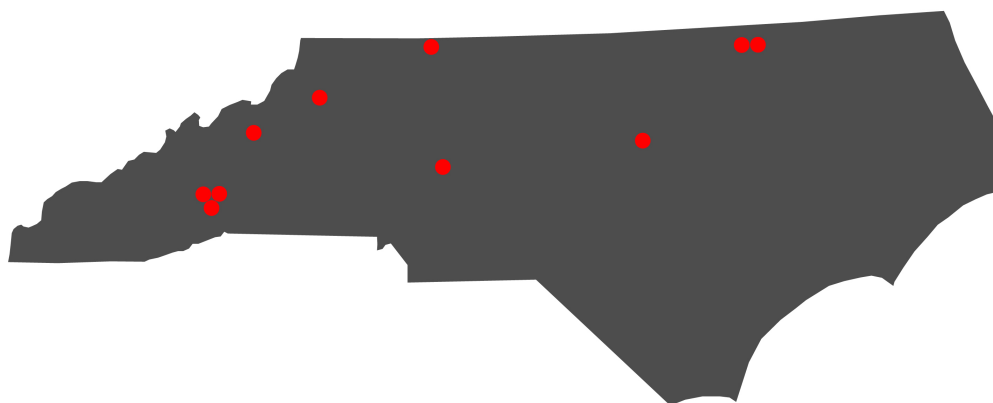
Director of Mental Health Services (n=1; 1%). Table 5 is a map of North Carolina and represents the locations of the BHCs across the state.

Table 4

*Title and IPC Location*

Participant	Position Title	Location
Anna, LPC	SBIRT Specialist	Public Health
Kim, LPC	Behavioral Health Counselor	Pediatrics
Liz, LPC/LPA	Behavioral Health Provider	Family Medicine
Earl, LPC	Director of Mental Health Services	Pediatrics
Nisha, LPC	Behavioral Health Clinician	Public Health
Lena, LP	Psychologist	Pediatrics
Jane, LP	Director Behavioral Health Provider	Public Health
Martha, LCSW	Behavioral Health Provider	Public Health
Chris, LCSW	Behavioral Health Clinician	Public Health
Ella, LCSW	Behavioral Health Provider	Family Medicine

*Note:* Position titles were captured in how BHCs referred to their title.



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Figure 1. Map of integrated primary care sites across North Carolina and location of behavioral health clinicians that participated in this study.

### **Research Question One**

Research question one explored the following: “How do behavioral health clinicians view their role in integrated primary care?” This IPA analysis consisted of examining how participants responded to the semi-structured interview question to capture research question one in addition to the themes and meanings that emerged from the transcripts. With regard to their roles all of the participants reported that they hold multiple roles located on-site as part of an integrated primary care team. Five roles emerged from the participants experiences as behavioral health clinicians that included the following: (a) Program Administration / Program Development; (b) Mental Health Brief Screening / Interventions; (c) Consultation / Teaching; (d) Referral Coordinator; and (e) Chronic Disease Behavioral Interventions. These roles vary to some degree depending on the needs of the primary care setting, if the practice is located in an urban or rural setting, and the number of BHCs at the location.

### **How would you describe your role as a behavioral health clinician working in an Integrated Primary Care Setting?**

**Multiple Roles.** The participants initially reported that the role of a Behavioral Health Clinician is complex and best described as broadly encompassing multiple roles. For example, Kim, an LPC, stated, “ I have a couple of different roles.” She shared, “That’s been a learning process for me, is learning what my roles are here and what integrated care looks like.” Chris stated, “ I wear a number of hats. I have a number of different roles.” This statement was also made by Lena, “ I wear many hats here... you know, in terms of the whole picture. It um, so with that there is excitement there are some challenges too as we are trying to figure out roles. And, how to make this happen.”

Interwoven in the roles was a commonality shared by participants that they are part of a larger system of change and a member of a team influencing the primary care culture. Ella stated, “ I would describe my role as somebody who partners with the clinical, um, the primary care providers.” Nisha reported, “ I feel that as the behavioral health professionals who are working in an integrated care setting that we can definitely focus some of our energies looking into specific ways that not only are we going to support the patients with their mental health and substance abuse needs as they come in, that we can also create that awareness within that integrated care setting with the providers, nurses, even the front desk staff about a couple of things.”

**Program Administration / Program Development.** Based on participants’ responses, integrated primary care is an early developing model for implementation in

practice. Eight of the participants had leading roles in the program administration and program development of the behavioral health integration into the primary care practices in their settings, beginning as early as 2007 in North Carolina. For some, this role has been something they pursued. For example, Jane, an LP stated in response to her role, “It feels multi-faceted because I also have almost equal administrative role in the program that we have developed. So, my role has changed over time because there was no program here in 2007, which is when I started and now we have four clinicians, three of whom are full-time.” She stated that IPC was “Something I had actually proposed to some practices in this area. I mean I am talking twenty or twenty-five years ago, just because it made sense to me. At least, the co-located with a primary care practice, but I could never get any interest in it.” Kim, who was recruited for her position and was the first BHC in her practice, described the time commitment that goes into developing a program and the importance of considering the needs of the community and practice. She stated, “ I came here in February of 2009. It was really just finding out what our agency, what our pediatrician’s office needed, And then we go from there. I did help identify what this practice needed and what this community needed. That meant a lot of meetings with a lot of different people.” Chris stated, “In addition to being a provider, I am also sort of my own administrator and program director and everything wrapped into one”

In some practices, there is more emphasis placed on a split between clinical rotations of a BHC, in addition to an emphasis of educating and training physicians. This requires the BHCs to see the gaps and needs within the practice and be able to make administrative

changes as the practice is developing IPC. Ella works in a location with three other BHCs at an IPC site that also serves as a medical residency program. She was able to be influential in changing the previous model of how BHCs were utilized at that site and expanding the roles to incorporate consultation and education of family physician residents. At this site, BHCs rotate time between providing clinical services to patients while another BHC is present with family medicine residents to provide consultation/education about behavioral health. The BHC program administration / program development role required careful observation of the current model, while taking program administrative steps that would result in change. She stated, “Before I started, they had behavioral health providers but they didn’t have them in that, we call it the consulting room. They call it precepting in other residency programs. But it would be like being in the office where all the physicians are in a clinical that wasn’t a residency program. And so, before I started they were in their offices and they were covering at certain times so they could be paged to go in and see somebody or they would come and get them. Not a lot of time. They were actually doing patient care at the same time so they were being pulled out of patient care. And so they didn’t get first of all they only came to get the behavioral health provider when it was something that they identified that was needed and they probably limited it to really you know high need cases, not just come meet this patient. Because you know they were interrupting, there was an extra step, anyway. So when I came I really just happened, because they told me as part of my training that I should sit in and see what the residents are doing in the consulting room. And I basically never left.”

**Mental Health Brief Screenings/ Interventions.** The primary clinical role reported among the participants' was reported as that of providing brief mental health services, screenings, and counseling for the patients in the medical practice. Regardless of the type of IPC setting (e.g. primary care, pediatric, or public health) all participants reported the need for strong generalist mental health clinical skills and the ability to work with a broad range of ages, populations, and diversity that matches patient population of the IPC setting for individual or family. BHC reported that types of issues addressed in IPC span clinical areas. Chris shared, "So probably the biggest things have to do with depression, anxiety, grief, kids with behavioral issues, um, but smoking cessation a little bit of substance abuse." Lena, shared she primarily works with ADHD, and family parenting. For Nisha, she notices domestic violence, PTSD, and trauma. Crisis assessment and substance abuse were also mentioned as important for BHCs to provide.

The mental health brief screenings / intervention clinical role differed based on the IPC setting. The roles include brief screening and assessment that occur at the same day and same time of the medical visit and brief therapy sessions. Anna rotates between three clinics and primarily provides screening and assessment at the time of the patient's medical appointment. She stated, "My role is now is to do the SBIRT program, which is the Screening, Brief Intervention, and Referral to Treatment." She expanded on this stating, that in her role, physicians will come to her when they have concerns about a patient, requesting substance abuse and mental health assessments during the time of the patient's medical appointment. Anna stated that she relies on her clinical interview skills, in addition to brief

screenings that have been developed for use in the primary care offices. She states, “I do find that the providers will come to me if they have a client, or a patient, that is anxious or has depressive symptoms or they just have a lot going on. They will come in and say, ‘I don’t really have time to talk to this patient today. Can you spend some time with them and do a PH-Q9 and tell me what you think?’” And so, I will do an interview. I’ll do a PH-Q9 I’ll do some other anxiety scales or things like that if I need too. And then, if I’ll always, I still do, the AUDIT and The DASKS just to make sure, there are not substance issues going on.”

After completing a screening, she stated that she has the option to make a referral within the community or continue to provide brief services within the integrated primary care setting depending on the situation. She stated, “I can refer them to that person if I feel that they may need to have ongoing help. If it’s not, if the doctor can provide an antidepressant and they can monitor that, if that is needed, and then just some therapy then I’ll do just the referral onsite.”

Nisha describes how her clinic role of providing mental health brief screenings/ interventions fits into the broader clinic goals of meeting Patient Centered Medical Home (PCMH) standards and coordination of care. She states, “We have kind of rearranged all the services in the clinic to reflect the Patient-Centered Medical Home system of care.” As a component of this process, she describes the BHC roles in saying, “We do the assessment depending on what we get we typically would discuss with the patient what the recommendations would be. If we see that we can support the patient with the services we have in the clinic, with the basic benefit services, then we go ahead and share that with the

patient, review with them all the options that we have available, the different therapist, the different groups, all of that can be pull together.” As a BHC working in an integrated primary care setting, there is an emphasis on the ability to provide brief assessment and interventions at the time of the patient’s medial appointment. Jane reported that if this is a first time appointment in which a primary care physician has asked her to meet with a patient she draws on her clinical years of experience, “If it is a first visit I am doing, what I consider a really brief but thorough um intake assessment.” She captures her role stating, “ I am assessing what’s going on, I am giving some advice about what I think might work. I might help arrange some things to happen, all that kind of stuff. It’s very practical.”

In some IPC settings, BHCs provide brief therapy in addition to same day assessments and crisis interventions. Earl, an LPC, shared, “Primarily I saw patients within the office and did therapy, family therapy, individual therapy.” In addition, he provided crisis same day evaluation, “I was on-call for the doctors should they need something. There were multiple times when they would have a patient that was suicidal in one of the exam rooms and they would come and get me and I would walk around the corner and assist that patient and make sure they were safe and stabilized and come up with a plan.” Liz described that her clinical role is split between brief same day appointments and therapy appointments to meet the needs in her IPC setting. In describing her role she stated, “It’s more brief, um sometimes it’s just meeting the patient, or you know 5-10 minute interactions with the patient. Sometimes it evolves into a 30-45 minutes long interaction depending on what is going on. Sometimes it could be a crisis intervention that leads to us helping with hospitalization or

something like that. And then, so that is different than the traditional, well the times when we have scheduled appointment that are a bit more like a traditional counseling session. So one is kind of more spontaneous as needed by the doctors and one is more scheduled for follow-up and on-going therapy for the doctor's patients."

**Consulting / Teaching.** Behavioral health clinicians reported a role of Consulting / Teaching to physicians, staff, and patients about behavioral health. This role was reported by 90% of the participants. The ability to provide consultation and teaching is dependent on the model of IPC and the number of behavioral health clinicians. Ella expressed, "We do educating the physicians...you know because they are not always necessarily experience in working with behavioral health nor are they always aware of all the different kinds of things that we can be involve in. Its not just you know people with mental health diagnosis but people with behavioral issues that affect their health. How they are taking their meds or what their disease process is, smoking cessation, and just the subclinical issues that really affect people that don't get teased out as much because they are not as obvious."

Liz works in an IPC location having three BHCs who are allowed to rotate between roles. At her location, there is a strong emphasis on training medical family residents. She describes that one of her roles is providing consultation/ teaching in context by stating "We are stationed right in the precepting area with the other faculty physicians listening as the residents review their patient care plan and their cases and we are offering input whenever a behavioral issues is apparent. The residents learn to ask for our input when they know there is a behavioral issues but we also listen out to offer if there is something behavioral that they

might not have noticed originally.” Jane provides consultation/ teaching to the physician and the patient at the same time while in the exam rooms. She states, “If I can go in with the primary care doc which I like to do, we do some dialogue in front of them. Of if they come in while I am in there, then I stop basically, but I will turn and say, here is what we have been talking about. Here is some of the stressors have been, here is what we are thinking about in addition to the biomedical stuff that needs to be discussed. Some good conversations in front of the patient with the medical provider.” Nisha describes the consultation/ teaching role as more spontaneous and bi-directional of education between BHCs and providers. She states regarding her role “ We have what’s called the huddle time with providers. Definitely anything that comes up that would be pertinent to that care we do try to work in out in a team environment.”

**Referral Coordinator.** BHCs reported taking on the role of being a referral coordinator and providing linkages and access to care for patients gaining access to community mental health. Martha indicated, “A plan might include resources outside of our agency.” When she needs to make referrals, knowing community resources is important. She states, “As a resource person, just having knowledge of what is available what is in the community. If I don’t have that knowledge knowing where to get it and how to look it up.” Kim stated, “It’s more that we know the resources out there so that we can refer. Um, you know if they need longer-term therapy.” In addition to the need for mental health therapy, referrals are be made to increase access of care based on culture and language. Anna stated, “Where I work, no one speaks Spanish. We don’t have a Latino counselor. And so if they are

a Latino, if they are a Spanish speaking client then I will always refer them.” In addition to making referrals outside the agency, Chris stated, “I coordinate a telepsychiatry contract” for psychiatrist to meet with the medical patients.

**Chronic Disease Behavioral Health Interventions.** The type of IPC setting influences how a BHC will be utilized. For example, the three BHCs who are working within a pediatric practice were in agreement that they were not providing chronic disease behavioral interventions. Whereas within a family practice or public health center that serves adults there has been more need and emphasis for BHCs to address chronic disease management and behavioral health interventions.

Anna captures the role of a BHC’s providing chronic disease behavioral health interventions saying, “The other thing that we do, that I do is disease management. Kind of talking about chronic issues. Hypertension, diabetes, and how it affects people’s lives. Um. Encouraging them with good habits, exercise. We talk about their food. We talk about their diet. We talk about how, um, use a lot of CBT in relation to that with changing the way they think about things, the way they feel about things in order to change their behaviors.” Jane expressed, “We have some very basic chronic conditions that I have gotten more familiar with. But, most of it still focuses on behavior. So, I am still intervening from a behavioral standpoint. What’s going on that is preventing you. A lot of times it’s where can you put your medicine in the morning that you will see it at the same place everyday and so you won’t forget that it’s there to take it. I mean it is something that simple. And, I’ve, but I’ve familiarized myself more with medical medication so that when I read a list I can get a quick

diagnostic idea about people. But, it is still relaxation training and it's still change your behavior or what can you substitute if you are trying not to smoke. Can you stick a straw in your mouth? Can you put in sugar free gum? I mean it is a behavioral intervention. Obesity, hypertension, diabetes, COPD, those are all probably top of the line stuff, um, cardiovascular disease.”

Other BHCs are beginning to work with the IPC model to provide groups for chronic disease management. Chris describes that he is seeing “More chronic pain management and diabetes management. Those are kind of, we are starting to work on groups with those folks so the doctors who don't do the groups are starting to bring me in because they realize that oh maybe Chris could offer this person something.” Nisha stated, “We are finding out with the chronic diseases, say diabetes, or hypertension it's sustained work. It's ongoing work. I mean to get the levels, the diabetes to a more stable level, or the blood pressure you know working with the stress level. You know, introducing a lot of lifestyle changes has been an ongoing effort and I think that success can be measured in different ways. I feel that the more inclined the patients are to engaged in behavioral health care overall we are seeing the changes but those changes have been more gradual than I would have liked. We are definitely targeting that this year. We are definitely offering more chronic disease management groups.”

### **Research Question Two**

Research question two explored participants' attitudes. Attitudes, was previously defined as a way of thinking or feeling about something (OxfordDictionary.com). Attitudes were important to explore based on previous literature that suggested that how mental health

providers adapt to a new practice, or setting in real-life situation influences organizational implementation (Aarons, 2004), and that attitudes influence how mental health providers will adapt to working in primary care settings and (Derksen, 2009; Gavin et al., 1998).

The results for research question two are reported using a combination of direct responses from specific questions asked during the semi-structured interview and themes generated from IPA analysis. The findings are presented by reporting the participants initial response to the three semi-structured interview question about attitudes followed by the emergent themes. Three themes emerged from the data regarding participants' attitude toward IPC are as follows: (a) Holistic Mind/Body Approach; (b) Culture of IPC influencing Attitudes; (c) Barriers in IPC. Each theme has sub-themes that are reported within the main theme heading.

### **What are your attitudes and beliefs about providing behavioral health services in integrated primary care?**

Regardless of their setting and across all licensure disciplines, all participants expressed a positive attitude toward integrated primary care. In addition, all of the participants' shared in a attitude that having BHCs working on-site in an integrated primary care setting is positive and necessary, in that their presence leads to an improvement of care offered in the health care system. Within the group of LPCs, Nisha, stated, "I personally really like the whole idea of the patient getting behavioral health care when they come to their appointments because clearly what I have seen in the past few years of work in this setting is that the patients respond really well when they come to one place to get most of

their care, most of their needs met.” Nisha later stated, “I feel very strongly about the integrated care services for the patient.” Kim stated, “I think as far as integrated care, it is the absolute best thing that a doctor’s office or a medical facility could do.” Jane, an LP responded that her beliefs and attitudes toward integrated care “are all very positive. I can’t even imagine. I can’t imagine why this hasn’t happened sooner.” Similarly, positive sentiments were expressed by Licensed Clinical Social Workers. Chris stated, “I think it’s a good idea.” Ella, expressed, “I think if that if you’re not providing it your not doing it, it’s not good care.”

Earl, an LPC, was selected for this study as a disconfirming participant. After four years of contracting and being located on-site in a pediatric practice he recently moved out of the IPC practice as a result of challenges with reimbursements and policies. He is now renting space next door to the clinic and he continues to work with the clinic. Despite this recent change, Earl’s response did not differ from the collective group in his attitudes toward integrated primary care. He stated, “I think it’s absolutely beautiful. I think it’s an incredible idea.” He reflected later in the interview by stating, “I wish that we could have been able to continue the model.”

**To what degree do you feel confident in your abilities to provide mental health services in integrated primary care specifically for mental health?**

In response to this question, all of the participants reported that they felt confident in their abilities to provide mental health services in the IPC setting. However, this attitude of confidence was reported with explanation about their IPC setting. Jane, who has been in

practice for 36 years stated, “I am kind of at the top of my game. You know, I have done it for a long, long, time. I love it.” Liz stated, “I feel pretty confident overall for the bulk of the presenting problems. I think I feel confident about that. Every now and then there is some kind of more atypical issue or really clinical issues that comes up that is out of my area. We might have to make a referral to another agency or sometimes just the severity of something is just beyond what seems appropriate for primary.” Anna stated, “I feel very confident.” Nisha expressed, “I feel very confident now. I will say that in the first year that I started I had a steep learning curve because so much of the learning comes when you are actually with the patient in the exam rooms and you’re with the provider. Often what I found was the provider needed as much education as the patients.” Lena shared, “I would say, um, pretty confident in terms of diagnosis and assessment, um, less confident in terms of communicating effectively with physicians and prescribers.” Ella shared, “I definitely have people on my patient load that I don’t feel incredibly confident about treating but will not go somewhere else. It is either me or nothing.” She further expressed, “I definitely, I do feel confident that I can walk into any situation in this clinic and know at least what to do in the moment. Like do we need to call crisis intervention? Do we need to send this person to the hospital right away? Can we start a medication with this person? If I don’t, I’ve always said I don’t have to know what I am doing before I walk in, we will be able to figure it out.... I feel like I have enough support even with just the physicians. Even if it’s not their specialty, they are just trained to handle things so we can all put our heads together.”

**To what degree do you feel confident in your abilities to provide services in integrated primary care for chronic disease behavioral health interventions?**

The majority of the participants responded with some level of hesitation in their responses and stated that even if they are providing these services expressed that they are still learning in this area. Jane shared, “Well that’s always a growing edge for me.” Liz, shared, “I’ve and the rest of us have had to learn more about how to make those more specific interventions for medical issues and we continue to work with the physicians pretty closely so that we can um keep improving on that.” Anna, stated, “I think I’m pretty good at that.” Chris shared, “At this point, you know about a 7 or 8 on a 1-10 scale. I have done a lot of it so it has become much more a routine part of what I do. There are certainly are times when I feel that I don’t have all the answers or all the information that I need to step in and do something right away. But the resource are available to me to find out what I need. Generally if one of the doctors is bringing me in to a situation they will brief me and let me know what it is they are hoping for.”

For those BHC working in pediatric setting they reported providing less chronic disease behavioral interventions. Earl stated, “Less so” when compared to his confidence level with providing mental health services. He shared, “There were some kids that I mentioned that have diabetes. I have one or two, there, um but, for the most part those weren’t the kids I was seeing.”

**Attitude Themes**

**Holistic Mind/Body Approach.** One of the three main themes that emerged from the data regarding attitudes toward was in the philosophy of BHCs providing services in IPC. The broad attitude of the BHCs was having a philosophy of care based in a holistic mind/body approach. Three sub-themes emerged in BHCs attitudes that are as follows: (a) IPC provides access to care; (b) IPC reduces stigma of mental health; and (c) IPC provides prevention. The BHC attitudes of the broad theme and following three sub-themes are presented in the following section.

All of the participants reflected an attitude toward providing a holistic mind/body approach as a core foundation in an integrated primary care setting. Jane explained this in stating, “We are working as holistically as we can; bio medically and psychosocial.” Another way this foundation belief was described was by Anna, “You can’t separate what people are feeling physically from what they are feeling emotionally. Because what they feel mentally and emotionally are going to affect them physically. And so, if you empower people from an emotional perspective, they are going to feel more empowered to take control of their physical health.” Kim shared in her role as a BHC, “We want to look at the whole person, not just their physical symptoms, but how their physical symptoms affect their mental health as well as their nutritional health.”

Specifically, through this Holistic Mind/Body Approach to care, BHCs expressed their attitude and belief about how IPC influences the healthcare system. Three sub-themes emerged in the attitudes of BHCs in their impact on the health care system being on-site in a

primary care practice. These sub-themes of the BHCs attitudes toward IPC are as follows: (a) Access to Care; and (b) Reduce Stigma of Mental Health; and (c) Provides Prevention.

*Access to Care.* A belief in social justice and equity was expressed by the participants in their roles of providing services in the community. The concept of improving access to care was apparent in their attitudes toward providing integrated primary care specific to location and ease of services for patients. For example, Martha describes that in a rural location “There is nowhere else for them to go, no other resources to pull in. We are kind of for a lot of people the only game in town that they can rely on for any kind of help that is beyond medical.” Transportation issues and the ease of coming to one place for one appointment was viewed as important for patients. Liz expressed, “It seems to make things a lot easier as far as access to behavioral health services. Um, most of the physicians talk about how helpful it is, especially when they work in places that didn’t have it. They’re amazed at how much easier it is to link their patients up with behavioral health services.” She further expressed that, “The patients’ also report enjoying having the easy access and feeling comfortable about having a provider that is stationed in their doctor’s office, making it easy to be in one place but also that they trust their doctor’s opinion and referral so they feel um, a little bit better about following through with it. It also makes it easy as a provider doing counseling, if there is a medication issue, to be able to just walk down the hall and get input on something that could be taken care of that day or if something can’t wait. So it is very helpful on both sides of the relationship benefit. Most patients really report enjoying the model and being pleasantly surprised when they see that it is available.”

Jane described that being located in the primary care office reduced a barrier to seeking services and increased access for individuals. She said, “I love being in a public setting where people who wouldn’t ordinarily would not have access to somebody like me, with the training that I’ve had, and my background and so on. Even, if they were referred to me and I could see them, if I were still in private practice at least 50% if not closer to 70% don’t make it to the referral source.” Earl said that “The experience that I have is that people immediately felt comfortable coming into a physician’s office...I think that just the comfort level over all and anonymity as well because when patients would come and sit, and families would come and sit in the waiting area you didn’t know if they were there for a check-up or to see a behavioral therapist.” Another theme that emerged was that providing access to care helped decrease stigma around seeking services.

***Reduce Stigma of Mental Health.*** BHCs reported an attitude of decreasing the stigma of mental health services. The BHCs are also aware that when the physician requests a consult they may be the first behavioral health clinician ever to have met with this patient, and there remains a barrier around individuals seeking out mental health and behavioral health services. Nisha expressed, “There is a certain level of stigma attached to mental health care, which is still a problem today unfortunately, and when they know that they come to the doctor’s office they are able to get the mental health care somehow it enables them to go ahead and access the care versus seeking out the mental health care elsewhere.” Chris stated, “I’m pretty clear that there is an awful lot of people who come through the clinic who aren’t interested in the services that I provide.” For those who agree to meet with him Chris shared

that this is an opportunity, “Well they are getting a few minutes, 15 minutes, a half an hour, or maybe a few additional sessions with somebody who is trained to deal with these sorts of things and maybe that is helping them to sort of normalize the idea that they might in the future actually pursue something that I feel like might really help them get past stuff that is really holding them back.” Liz attributed being able to provide services in the primary care settings where patients are already coming as helping to decrease stigma. She said, “I think to me it is just a really neat thing to be involved in. I think that a lot of clients really appreciate the idea of you know the fact that it takes some of the negative stigma away of mental health services they are already comfortable here. They know where the office is.”

Jane shared that one way her clinic has addressed stigma is through normalizing seeing a BHC. This is done through specific use of language and a team effort within the clinic in how her services are introduced to patients. She reported that at her IPC setting, “We believe strongly in the idea that, every patient has a behaviorist on their treatment team. It isn’t oh, my PCP has singled me out because he thinks I am crazy, or she thinks I am falling apart... that is how I introduce myself every time if I haven’t met anybody, I am a member of your treatment team.”

***Provides Prevention.*** BHCs expressed that the opportunity exists to offer help to patients by being proactive and providing prevention services for their health. This occurs through providing consultation to physicians and providing brief screenings. These opportunities help to provide early interventions. Ella stated that in her work she takes a broad perspective in working with primary care patients. She reported “So people that are I

don't know, for instance, that have a lot of stress, chronic stress and they don't necessarily meet full criteria for, like, major depression or some kind of depressive disorder, but you see that they're being affected by their stress, by their circumstances, and rather than waiting until they, you know score a whatever a 10 or 12 on their PHQ-9, even if they are at a 6 or 7 or so to go ahead and get them either some kind of intervention, maybe it is just that we go in and talk to them about how to use behavioral activation to help regulate mood. So not just again the people that are already full blown but also the people that are headed that way, so we can have prevention capacity as well." Nisha shared that in providing holistic care there is a need for "A lot of prevention, a lot of monitoring and care including groups, putting in place the groups and contracts, controlled medication contracts, and those kinds of things."

### **Attitude in the Culture of IPC**

BHCs reported a culture shift in working in an IPC setting that was meaningful to report as an attitude. This culture encompassed BHCs comparing their experience in IPC to previous work settings in community mental health or private practice. Three sub-themes emerged in BHCs attitudes that are as follows: (a) IPC is different from community mental health / private practice; (b) frequency of appointments; and (c) brief interventions. The BHC attitudes of the culture of IPC is reported with the three sub-themes and are presented in the following section.

**IPC is Different from Community Mental Health or Private Practice.** A meaningful theme that emerged from these behavioral health clinicians' experiences was the

comparison of working in an IPC setting and working in either community mental health or private practice. The semi-structured interview questions did not inquire about these differences. However, 90% of the participants used this comparison throughout the transcripts when they expressed their views about the role of a BHC and attitudes toward IPC. Capturing these insights of the participants was significant because they have worked in both settings. In adapting to the culture of IPC the researcher noted that 90% of the BHCs used the word “patient” rather than “client.” However, this is not the only difference in terminology. Earl captured this saying, “Working in a collaborative setting with a physician, there is a totally different lingo that they speak. Yeah, they speak in a different way about a lot of things. They are working from; you wouldn’t think that the ICD-9 and the DSM would be that far apart. Sometimes it seems like they are.” Additionally, the ability to communicate with the physician about a patient’s care on the same day was viewed as different, and more helpful.

Martha shared that the shift to working in primary care takes time, “It has gotten better because I have been here two and a half years. But to begin with it was so hard not to think of it as the same kind of thing as being in a mental health clinic and, just trying to have to keep going back to no this is within primary care, this is a whole different thing,” Kim, an LPC stated “Coming from private practice to integrated care is completely different, um, in a lot of aspects.” She shared, “when I was in private practice in Charlotte, I mean, we were, it was me and a couple of other therapist and a psychologist in a practice together and we didn’t have communication with their doctor. Like, I can just go outside my door and go and

talk to the doctor if there is a concern. Um, patients get what they need more here than they did in the outpatient therapy places that I worked before.” Jane stated of her prior experiences, “There was always a disconnect in private practice. I would address chronic illness, and I worked with a lot of people who were chronically medically ill. But, and I totally own it, I wasn’t like trying to call the primary care doc (laughter). I wasn’t saying oh, let’s work more closely together, but neither were they calling me. Now most medical providers in private practice, their primary complaint about psychiatry or psychology is that they never talk to us, they won’t give us their notes. And, from our end, it would be, oh, what a drag that I’ve got to get ahold of this primary care doc because I am really not addressing any of that stuff.”

Ella shared that there is an importance of being a generalist and part of the primary care team rather than being a mental health specialist. “Before I was here they had people who said, “Oh, I don’t do that.” Which was really off putting to the providers and created a little bit of a culture where they were not sure if they could trust the behavioral health providers. I got that message loud and clear when I got here. So I have never have said, “ I can’t do that.” Liz’s perspective was that teamwork and variety within the work is essential for her, “I personally like it because it has a team kind of feel to it which is a good fit for me verse private, sole private practice. I like having, you know, folks from different areas working together to help patients.”

***Frequency of Appointments.*** One of the differences BHC reported as different between their work in community mental health / private practice settings and working in

IPC is the frequency of appointments. The culture of working in an office setting in which BHC's are providing services as needed by a physician is different than providing regularly scheduled therapy appointments. In IPC the scheduling of patients and frequency of follow-up appointments is different in primary care than in community mental health / private practice. The role of a BHC in IPC is not to provide on-going therapy, which is different than the roles previously held by these BHC who had prior work experiences with regular scheduled therapy appointments. Jane states, "What is different of course from traditional practice is those are one of the biggest swings for people who have been like me in traditional practice and are considering this kind of work. It's a big shift and I am late stage career and mid stage and early stage career people would need to think about this. But, the increment, what, I can't get somebody back in here even certainly not a week that is unrealistic, and even two-weeks unless we have started them on meds. We have them back in a month." Lena stated, "Each day is kind of different in terms of what I am doing." She expanded that "one of the things that's been new to me in this setting is not having much control over my schedule." Chris's described, "My training the modality that I was originally trained in and that I have gravitated towards as a clinician prior to working here you know were much more insight oriented and in depth longer term modalities and I've had to adapt to the possibility that I might spend 5 or 10, or 15 minutes with a person and never see them again, or not see them again for 6 months or whatever and just work with that."

Jane meets patient during regularly schedule medical appointments, in the exam room. She stated, "We try to do mostly same day same time appointments with the primary

care doc so that for the benefit of the patient.” She explained that as a BHC, she needs to remain flexible sharing. “Sometimes I go in before the primary care doc, sometimes I go in with the primary care doc, sometimes I go in after. I accommodate my schedule pretty much to the medical provider’s schedule because, the point there to me, is not to slow down their flow.”

**Brief Pace.** The participants emphasized that working in IPC requires adapting to the brief pace of providing services in a primary care setting. This brief pace includes brief screening, brief therapy, and brief interventions. All of which are different than working in community mental health and private practice. This pace has required BHCs to adapt. Additionally, the theoretical framework such as Cognitive Behavioral Therapy (CBT) was stated as useful in IPC settings. Kim shared, “Instead of doing like doing a full blown out trauma focused CBT which I was trying to integrate that in six session and that doesn’t work, you know refer that. Don’t try to take that on yourself.” Chris shared, “I do much more brief intervention than I have in other places. So, a lot of cognitive behavioral, a lot of sort of basic problem solving.”

In IPC settings in which the BHC offers limited therapy the number of session is also brief. Kim provides limited family therapy sessions and stated, “Here we do brief therapy, primarily, and there are a few cases that I will take on, here and there, depending on the relationship that I have with the patient. That I might have for a longer than say 10 sessions. But mostly they come in for just a few sessions and do brief therapy.” However, this model of providing brief therapy is not standard in all practices and highlights the broad range of

experiences across IPC settings and how BHCs are utilized to meet the need of the practice and the community.

Lena shared that challenges in adapting her expectations as a psychologist doing testing to working in IPC with the brief pace. “I think one of the biggest things that I’ve had to adjust to here, is the rapid pace with which medical professionals are making decisions. And so, seeing clients every 10-15 minutes, um, you know, I think we are coming to a better understanding. But, especially my first year here like the idea that I might spend two hours with a child administering psychological test that seemed like. “Well you are going to spend two hours with them?” You know, to me I am thinking, yeah ‘I could spend six hours with them and still have some questions about how they learn, what their strengths and weaknesses are.’ But, um, but, needing to be able to provide information rapidly and answer questions that will be helpful.”

### **Attitudes of Barriers in IPC**

Although not specifically asked in the semi-structured interview questions, the participants expressed barriers in regard to insurance and healthcare policy that create challenges for behavioral health clinicians in providing integrated primary care. BHCs reported attitudes regarding barriers to working in an IPC setting. These barriers encompassed the following: (a) Billing and Policy; (b) Administrative Support; and (c) Training. BHCs shared attitudes in barriers for implementation of IPC, and these are reported in the following section.

**Policy.** Liz expressed, “Sometimes the system has just becomes so complicated in general in the United States. Healthcare systems have become so large and there are so many steps in a referral. I have trouble keeping up with it myself, what patient is allowed to go where based on diagnosis, age, um, insurance coverage, um, what kind of provider they’re allowed to see based on their insurance coverage...every referral has to be individually examined to decide what their insurance policy will allow them to receive. It is very frustrating.” Chris, shared, “I am sure that everything I am talking about is highly contextualized. It all has to do with this location and this practice. But the sort of the climate what I can see if I look beyond these walls it seems like there are state organizations and I am sure national organizations that really want to promote integrated care. But the funders or at least the payers, the insurance companies, are way behind at figuring out how to make that really work and so, one of the real struggles here has been trying to figure out how to make my job pay for itself.”

For Jane, a challenge exists in providing integrated primary care and conforming to the state requirements for reimbursements. She shared “What CMS has done, on the one hand requiring this kind of merger in integrated care and say let’s do it they turn right around a bifurcate from a billing from a CPT code standpoint. If I am doing Health and Behavior Assessment codes I cannot mention anything about a psychiatric disorder and I can only address the diabetes and there has to be an ICD-9 diagnosis. I can’t reference depression, anxiety, or anything else. I have to be addressing only, in that note, in order for it to be reimbursed as a Health and Behavior Assessment code.”

Earl stated, “I am really curious to see how it plays out. You know, on the one hand with the LMEs you get this talk about they are going to be providing or at least supporting integrated care and they are really pushing for it. But, you look around and well I can’t say. I haven’t see a lot in our area of building integrated co-located programs. Um. But then private providers like myself kind of get wedged out because of the administrative overhead.”

**Administration Support.** Participants described the importance of having administrative support for the development of IPC influencing the role of the BHC. When the clinic administration is not in support of IPC this creates a barrier for the implementation and the roles of the BHCs. Chris stated, “ It’s been challenging. I initially did not have tremendous administrative support for my position. One of the doctors wrote a grant, which got the position created and got me started. I was, I think the former CEO saw me as a part-time therapist on staff and didn’t really have a lot of interest in developing and integrated care program. One of the doctors did. We moved forward the best that we could. About a year ago, a little more than a year ago, a new CEO was hired and he has been very interested in the program. Since then the medical director has really gotten on board so I am getting the support now that I need to move forward.” Ella shared, “Compared to where I was before where I was by myself as the only behavioral health provider, I didn’t have support from colleagues, but here I do. That has been really great.”

**Training.** The lack of trainings specific for IPC and having to learn on the job was described by participants as a challenge. A barrier has been finding training. Kim stated, “I think that definitely the one about the medical stuff. The doctors they deal with the symptoms

and that part and if they feel like there is mental health component in there, they refer to me. I don't really know what to say about that but that would be a really good training. I haven't located anything like that yet." Chris added to this this by sharing an addendum he added to his transcript during the member checking in saying, "I think training is one of the major keys. I had no idea what I was getting into and no one helped very much. I got a little support ... but, mostly I was left to my own devices and I was not well prepared." Since training was a specific research question the results regarding training are discussed in research question three.

### **Research Question Three**

Research question three explored participants' training in IPC to capture a better understanding of the training need for BHCs working in IPC settings. Three questions were asked in the semi-structured interview, and the results from each question are reported. Two themes emerged as recommendations regarding training needed for BHCs to work in IPC, as the following: (a) Medical Training; and (b) Graduate-level track/ Internships. Each of the themes will be reported later in this chapter after results of the three specific semi-structured interview questions are reported.

#### **What theoretical training did you receive prior to your work in integrated primary care?**

The BHCs reported no theoretical training that was focused specifically for integrated primary care settings. Jane, who reported that she has a focus on utilizing Stages of Change, behavioral therapy, and relationship models, stated, "I guess, I would say I didn't have any

theoretical training in it, per se.” I came out of a very eclectic master’s program, and my doctoral degree program might have had a little more psychoanalytic bend at the time, but I continued to have exposure to lots of different theoretical ways of doing therapy.” Martha shared, “I have a master’s degree in social work, so we base things on family systems, motivational interviewing, but back then I don’t think it was called that, there was Rogerian. Because, when you have a situation and you are trying to deal with it at that moment in time you just go with the flow and go with what has to be done right then and so that is maybe more solution-focused based therapy. But, so, I don’t always know exactly what I am drawing on until after the fact, and I think that is just because of the pace and the immediate need that we see in the clinic.”

Prior experiences in Cognitive Behavioral Therapy (CBT) approaches were reported to be useful for BHC’s theoretical work in IPC. Lena stated, “Primarily, CBT and behavioral stuff, that is where I pull from, and I think that is the most helpful in terms of the work do here.” Chris stated, “Early on a lot of training in cognitive behavioral therapy. ” Nisha stated, “I personally espouse to CBT, DBT, cognitive behavior trauma counseling, reality based, gestalt. I also have received Seeking Safety training. So a variety of therapeutic modalities, and I do a lot of hands on trauma based grounding skills to assist. I have also trained in EMDR, basic EMDR.” Earl stated, “I do some CBT; I do family systems therapy.” Liz shared that her theoretical training began in “your usual classes about CBT, and um, Humanistic approach and basic counseling approaches.” She further stated, “Although many of those work well in traditional scheduled appointment times when you are doing the more

immediate quick consults, brief interventions in the integrated care setting, most of those have to be abbreviated significantly and pared down, and I don't, I didn't have any formal training in that; how to make them extremely brief back then. So that has been developed on the way."

Theoretical approaches have been explored by some BHCs because of their interest in holistic mind/body and their own pursuits of seeking out additional theoretical training. Ella shared, "I am trained in body/mind modalities, and so I understand that connection." She shared, "I did some CBT training, and of course that was helpful. But I ended up at a conference where there was one of the people that was presenting names was Peter Levine and he has written several books, and one of his first or seminal works was called, *Waking The Tiger*, and it is all about our biological, how we are biological programmed to respond to stress and threat and how sometime we don't really come out of that response in a way that puts us back into a healthy place." Chris reported a similar experience, as he shared that his theoretical training was "well mostly cognitive behavioral stuff for specifically targeting childhood stuff. As I got, sort of, as I progressed, I started studying psychomotor therapy. I took a little detour somewhere in the middle and studied a hands on modality called the Feldenkrais Method, which is not therapy and it is about learning how to be more aware of how we use our bodies and the connection between our body functioning and our mental and emotional functioning."

**Where have you received training in how to provide mental health services in an integrated primary care setting?**

All of the participants reported that their training in IPC was on the job, and that their strong clinical work experiences provided a foundation. Most of the participants have sought out additional continuing education to find ways to adapt the content to fit for the needs of IPC. Jane is the only participant who has completed a formalized certification course, and yet, she stated, “Most of it is self-taught. I’ve been reading online a lot and so on. Then, we were fortunate enough to be around when MAHEC [Mountain Area Health Education Center] did the one and only six day training to certify practitioners in integrated primary care. And that was, it started in July of 2008, and it was once a month for a six-hour day at MAHEC in Asheville.”

Other participants stated that their previous work experiences helped provide a foundation. Lena stated, “Primarily, on the job... I think my prior work experiences.” Nisha stated, “I really did not have prior training specific to integrated care services. Coming from a behavioral health standpoint, I learned as I went. What was very valuable was my supervisor.” Nisha added, “So, initially, I would say that lots of hands on education from the providers I worked with and shadowing them,” Liz stated, “I think over the years figuring out how to fine tune that and what to do.” Kim reported that she was provided a manual that was used for her training in addition to learning on the job, “This is the co-location manual. It’s the integration of mental health professional into the primary care setting. You can see this was April 2009. I came here in February of 2009.”

Earl stated, “Let’s see I went to a couple different integrated care trainings.” “There were a couple different ones. One was the psychopharmacological training treatment in

children that was in Chapel Hill. I think both of them were at the Friday Center in Chapel Hill, so those two. And then I am trying to think if I had any other specific training. I probably did, but I don't recall off the top of my head." He expressed, "I had had eight years of pretty much nothing but child and adolescent therapy prior to that."

Anna stated, "Just the last year of working in the primary care clinic." In addition, she reported, "I've gone above and beyond on the training that is required by looking at just different things that I know; especially, to the population that we work in. If you are working in substance abuse, it's going to be trauma related issues that are involved in them. So, I have done a lot of training with trauma. The EMDR. Anything to do with substance abuse. So, I would say also what has prepared me to work in the integrated care is also all of these additional trainings that I have taken along the way."

### **What about your graduate program?**

Regardless of clinical licensure, none of the participants reported having received training in integrated primary care in their graduate program. Ella stated, "Not that I know of. There was definitely nothing specifically called that." Martha reported, "No. Because, I don't think in my graduate program, I graduated in 1996 or 1997, it wasn't even heard of then." Nisha shared, "None at all. It was the last thing. Now, I graduated, it's been back then, um, 2003 Masters. Back then, there was no discussion at all about mental health setting having a happy marriage with medical care. It was as separate as it could be. Even substance abuse was considered very separate from mental health." Earl also stated, "No. No. Not that I recall. There was not anything like that. There was no overlap... between medicine and

behavioral health. I can't recall having any classes that touched on that. Well, well not in my graduate program." Liz stated, "Well again, it was, I started my program in 1988. It was, that phrase was not used, and I don't remember any mention of working in a medical setting although somebody might have had an internship working in a medical setting, maybe. But, I don't recall any focus being on it back then." Kim stated, "Oh no. That was '97. That was a long time ago. I graduated in '97, that was basically '95, yeah, yeah, (laughing). That was a long time ago. They weren't even thinking about co-location at that time, so, yeah." Jane stated, "Nothing particularly. At the time there would have been. I know there was coursework in community mental health and sort of community involvement and commitment. But, nothing that I recall that had anything specifically to do with integrated care." Chris shared, "I never heard the word integrated care until, probably until, well I came here really." Lena stated, "I never really. In terms of talking about integrated primary care, I don't think that we ever discussed that. I don't even recall, you know, thinking about that as a work option"

**What kind of training and knowledge do you think is needed for behavioral health clinicians providing integrated primary care?**

The participants reported the importance of a philosophy in holistic care, strong clinical skills, and brief interventions. Liz shared, "The family practice, it is quite broad, and you have to be comfortable working with a young child to geriatric patient." Martha shared, "I think there needs to be a working knowledge of, you know, the basic holistic medicine and looking at the whole person." Anna stated, "I would definitely say, they need to be good at

diagnosis. They don't have to do a diagnosis, but they need to be able to spot things. They need to know what depression is. They need to know what substance addiction issues are. They need to know the difference between how do I tell whether it's bipolar or and not to the degree that they would need to diagnosis, but to be able to say this person needs more care than what we can give them." She also reported, "I think they definitely need to have a background in substance use." In addition, Ella stated, "Lots, nice intervention skills, all the CBT is good and easy to go in and teach somebody a set of skills or a skill set that they can use right away. Definitely need to know how to handle patients that are suicidal, and then documentation is important in understanding how to document in a medical chart and how to protect your patient's information, also explaining to patients what the model is, and having an understanding that we share information with their physicians."

Chris stated, "It is interesting. I think that people need a strong background in some sort of fast moving modality. So I think motivational interviewing is ideal. There may be other things that I am not aware of, but, I think that is ideal. I think having some real basic cognitive behavioral intervention." Kim stated, "I would say anybody that's going into integrated care should really step it up on the brief therapy." Martha also expressed the importance of knowing the culture of the clinic and the community in saying, "I think any kind of integrated care, I mean, you would have to know the clinic, know the medical providers, and know the community, and know how to get things done quickly. Liz expressed, "But I think seeing how a model works and experience, for any form of training,

it's a good thing to have, even if you go into a regular counseling job its good to have in person visual of what it is like on a day-to-day basis of how the interactions work.

### **Training Themes**

Two main themes emerged in the participant's report as recommendation for training BHCs to work in integrated primary care settings. These are (a) Medical Training and (b) Graduate Level Course / Internship. Results for both themes are reported below.

**Medical Training.** Participants provided specific training recommendations that they believe would be helpful for one beginning to work in IPC; and these recommendations would continue to be helpful for ongoing continuing education. The training recommendation encompass a broad understanding of the connections between physical and mental health, chronic disease progress, adapting the theories and techniques to a brief pace for mental health interventions as well as chronic disease management behavioral interventions, an understanding of psychopharmacology, and, finally, understanding what it means to be a member of a medical team.

These recommendations were captured in Ella's responses as follows: "I really think that you should have an understanding of how your physical health affects your mental health and, vice-versa, that interplay. A little bit of understanding about disease process, chronic disease." Kim expressed, "Chronic medical illnesses and how it affects their mental health, and the mental health of the family." Earl stated, "Definitely some experience in, you know, co-occurring illness, and when I say that, I don't mean substance abuse, but, like, you know, medical conditions impacting behavioral health or causing behavioral health problems. I've

had some. I mean I've had some training and, but, it hasn't been as much as I would like. I would have liked to have, and still would like to have, much more knowledge and training in that area."

Chris stated, "I think it is important to either know or learn kind of the basics of what are the standard behavioral interventions for things like people with diabetes, people with COPD, kind of the big things that the docs are seeing over and over again. So that is kind of like the therapy skills side but then the other thing people need is how the medical side works." Earl shared "Psychopharmacology." He expressed, "I felt like I had a pretty good understanding of psychopharmacology before I got there, but it certainly, that my level of understanding, grew quite a bit while I was there and I think that is something that is lacking. Not that we are going to prescribe medications, of course, but I think if you are a therapist and don't educate yourself as far as potential side effects so that you can spot those." Liz also agreed for the need for "general psychiatric medication classes." She reported that she has offered a few lectures in her community to provide this kind of education.

The participants expressed the importance of working as a member of a medical team. Being a medical team member was identified as a need for mental health professionals transitioning to work BHCs in IPC. Ella shared in her reflections about what is needed for training and knowledge saying, "I guess understanding the medical model and how physicians work or how primary care providers work. I don't like to be exclusive toward physicians; there are other levels as well. But what model and how they are different from us behavioral health or mental health providers. And just how to be able to work within that

system.” This was also expressed by Jane, who stated, “I think just the whole concept of this is a team. This is integrated. I mean these are basic words, but we all have our own definition of what that means.” Jane said “I think the idea of being team members. Working on a team. Probably not being the head of the team. Being a part of the team and um. I have them do on occasion respectfully disagree with the medical provider, but the buck stops with the medical provider, not with me.” The need for training and knowledge was expressed as well by Earl, who stated, “Working in a collaborative setting with a physician” and by Lena, who shared, “Being able to collaborate, being part of a team.”

Jane stressed the importance of the BHC’s role within IPC, as part of medical training and working as a team. She expressed that the team training needs to incorporate the culture shift around how BHCs are utilized within a medical practice for reducing stigma for services and increasing access to care. That medical training is not only for a BHC who is working within the medical clinic but also for the medical practice in adopting a new culture in the roles of a BHC. Jane captured this in stating, “Probably one of the biggest culture changes we had around here has been ‘We don’t just use them for behavioral health or ‘crazy people’ or ‘depressed people’ we use them for any patient.’ Any patient has the right to have that kind of attention and care.” In addition, the BHCs expressed the importance of obtaining and participating in mutual learning as part of on-going growth in learning from the primary care providers. Earl stated his need, “to educate myself as much as I could. To ask physician’s questions as much as I could.”

**Graduate Level Course / Internship.** Participants expressed that as IPC evolves there is a need for focused training that begins at the graduate level and continues through continuing education. Liz shared, “Well, I think, I guess if it was to become more of a mainstream thing and there could be a track at graduate programs, that would be helpful.” Nisha stated, “I feel that definitely, especially in the graduate programs, they should be able to offer programs that specifically focus on the behavioral health issues presented by a lot of the medical concerns that typically patients present when they come in. Especially, the chronic long- term medical issues. I feel that is definitely something that needs to be taken into account and looking at different options of care. ‘Cause, often with the integrated care setting, it is not the traditional psychotherapy format that is presented. You know, the meet and greet can be shorter, and it could be more solution focused.” Jane stated, “I think a good graduate program for clinicians that actually wants to be in public services and there are very few that are being trained that way. I think there are doctoral level programs that are health education that are health intervention which are probably, is addressing this more is a whole semester on what it is like to be integrated into a setting, what are the ranges of possibilities from co-location to collaboration to integration to reverse co-location, what all that means and what your style might be.”

Another training option that was presented was internships. Anna did not complete an internship in IPC but did work in a substance abuse facility that was focused on a team based environment. From this experience beyond graduate courses she shared, “Probably where you learn, most of it is in your internship. When you go to the internship, because that is

where it is hands on.” Liz stated, “So, I think having the internship is the ideal form of training.” Liz is at an IPC that has begun to develop a partnership with a master’s degree program in counseling. She stated, “The universities where we get our counseling interns from, we have collaboration with them; they are sort of trying to develop an integrated care track.” She stated that for the master’s degree in counseling student, “I feel like when they leave the internship here they are a great candidate to go into integrated care practice. Even though they only had a semester with us, they have seen what the model looks like up close, which I think is the most important thing, and getting comfortable working with physicians, and having unexpected things, kind of, referred to you, and being comfortable dealing with a variety of things and ages.”

Training beyond graduate school and internships were presented as needs in continuing education. Liz stated, “Or you know that you have some occasional programs in the community, like, I mentioned earlier, that offer integrated care certificate where they talk about various aspects of the billing and the interaction with the physicians and how to tailor interventions to be more brief.” Nisha presented the idea that IPC training expands beyond BHCs working in IPC, and continuing education is needed for mental health providers to understand integrated care. She said, “So, I feel that this would be a good, definitely areas that the graduate school could focus on and subsequent workshops that are offered. Like, for instance, in my LPC or the LCAS, they could, for instance in my LCAS, I have to have addiction focused workshops. I have three hours of ethics. If they could start putting this in place, that you need to have three hours of integrated care related education.” She stated, “I

feel like if we really stick our head into it and this becomes a required curriculum then we are going to stick our head into it and gain more knowledge which really and truly, I feel, is going to be beneficial whether you work in an integrated care setting or in a regular outpatient setting.”

As a component of graduate internships and professional work participants mentioned the importance of seeing IPC in action. Shadowing and on-going clinical supervision was reported by some of the participants as needed for on-going training. Martha reported that she shadowed saying, “The person that I am working with for the first month and saw patients with her before I did anything on my own. And then, for two months after that every note that I wrote she reviewed. And I think we started out having weekly supervision and then that became every two weeks, so that is what we have stuck with.” A few BHCs reported having a peer integrated care group that they meet with regularly. However, some BHCs reported not knowing any other BHCs.

This chapter reported the results of this qualitative study that explored the experiences of ten behavioral health clinicians working in integrated primary care settings in North Carolina. Chapter five will examine the results from this study within the context of previous literature. Limitations of the study will be presented. In conclusion, implications for clinical practice and recommendations for future research will be discussed.

## CHAPTER FIVE: DISSCUSSION

The present study was the first of its kind to explore the collective experiences of mental health providers who were licensed in different clinical disciplines and working as behavioral health clinicians (BHCs) in a variety of integrated primary care (IPC) settings that span different regions in North Carolina. The purpose of this study was to gain insight from BHCs in order to better understand the roles, attitudes, and training needs for working as a BHC in IPC. The present study attempted to answer the following research questions:

- 1) How do behavioral health clinicians view their role in integrated primary care?
- 2) What are behavioral health clinicians' attitudes toward integrated primary care?
- 3) What training is needed for behavioral health clinicians to work in an integrated primary care setting?

An interpretative phenomenological approach was used to capture the experiences and meaning of the ten participants. In this chapter, the results that emerged from the semi-structured interviews are critically examined within the context of previous literature. Limitations of this study are discussed. Two conceptual models are introduced and implications for clinical practice and training are suggested. This chapter will conclude with recommendations for future research.

### **The Emerging Roles and Responsibilities of a BHC**

As with any new evolving system in change, the evolution from conceptual ideas to implementation takes time. This study specifically explored the emerging model of integrated primary care (IPC) in which a mental health provider is working onsite in a primary care

office, providing same day or joint visits with a primary care physician. Primary care was defined as the first point of services where an individual seeks health care, and this includes a family medicine, pediatrics, or health department. The BHC participants described a transformation that is occurring, and the results from this present study are placed within the context of previous literature.

It was evident in the responses from participants from this present study that the role of a BHC in integrated primary care is in a developmental stage. What emerged in the results across North Carolina settings are that participants reported that they have been providing services in IPC predominately since 2007 and primary care practices are evolving in their understanding of integrated care to best meet the needs of the communities. As anticipated, based on the literature (Blount & Miller, 2009; Curtis & Christian, 2012; Patterson et al., 2002), the participants were trained in a variety of mental health professions and are now working in IPC. Regardless of their profession, they reported that working in IPC is a professional transition. A review of the previous literature found limited information regarding the actual roles and responsibilities of a behavioral health clinician. As Funderburk et al. (2011) stated, “The existing literature focuses on what BHPs *should* do in primary care settings; however, little research exists specifying what BHPs are *actually* doing (p. 22).”

BHCs seeking knowledge about a job description for filling a position in IPC had limited resources that clarify the roles. A majority of the participants (80%) reported helping to establish the development of the integrated primary care at their setting. The participants reported that they were guided by the conceptual ideals of integrated care, experiences in

shadowing others on sites for learning, learning on the job, self-learning, and seeking assistance from other community members in their development of the implementation of integrated primary care at each of their sites. Only one of the participants had completed a certification training in integrated primary care. Consistent with previous literature (Blount & Miller, 2009) participants reported that IPC is different from working in mental health settings and private practice, and expressed there is a need for training specific to IPC. In addition, there was evidence from participants referring to primary care practices are attempting to keep up with changes in the Patient Centered Medical Home (PCMH) and are seeking to improve quality of care that impacting delivery systems in primary care offices with an emphasis on screenings and treatment for individuals for mental health and substance abuse, in addition to strengthening coordination of care and improving accesses to services for patients for chronic disease management (Tew et al., 2010).

The participants reported the increased pace of working in a primary care setting. They made the distinction that appointments are brief and not scheduled as frequently as they are in comparison to outpatient mental health agencies. This finding support previous literature in mental health providers' experiences adapting to working in primary care settings (Curtis & Christian, 2012; Hudson-Allez, 2000; Hunter et al., 2009; Pomerantz et al., 2009; Patterson et al., 2002). The model of integrated primary care is also emerging. The results from this present study do not support the VA model of integrated primary care base on what is occurring within the field in practices where the participants are working in North Carolina, none of which are part of the VA (Tew et al., 2010). Funderburk et al., 2009 found

that services provided in the VA integrated primary care were brief. The majority of patients (60%, n=109) attended one session, and the average length of each session ranged from 15-75 minutes. Similar to the VA, participants in this present study reported that some of their time is spent providing brief same day assessments and interventions, but, in addition, many of the participants reported that they also provided brief individual or family therapy. These sessions are limited from six to ten sessions a year, following a brief therapy model as a component of their integrated primary care.

Kim, a LPC who works in a rural area in a pediatric setting, provided an example of this split model. She shared, “We have six board certified pediatricians here, and so they will call me or come to my door and grab me, even if I am in with somebody else. They will, they can come and get me and I can either meet the patient or I can actually do like a 20 minute, 30 minute, session with them right then.” In explaining her roles, she also stated, “We do brief therapy, primarily. There are a few cases that I will take on, here and there, depending on the relationship that I have with the patient, um that I might have for a longer than say 10 sessions. But mostly they come in for just a few sessions and do brief therapy. Then, they are on their way.” While some may argue that Kim is not in a fully integrated primary care setting, she reported that she shares electronic medical records, is an employee of the practice, and reportedly works in sync with the physician at a level beyond what would be typical of co-location. Additionally, she reported that being in a more rural area of North Carolina she needs to extend her services beyond only provide brief intervention services. For some referrals, the closest location is 45 minutes each way.

Before delving further into these multiple roles identified by BHCs, it is important to consider professional titles. Consistent with the literature, the participants reported multiple and different titles referring to their positions working in integrated primary care. Only one psychologist continued to use her professional identify as a psychologist. The other BHCs continued to use their licensure credentials but took new professional titles for the integrated primary care setting. The title, Behavioral Health Provider (BHP), was reported most frequently. This is also consistent with terminology reported in recent literature (Curtis & Christian, 2012; Funderburk et al., 2011) as opposed to the term, Behavioral Health Clinician, used by Blount in 2007 training program (Blount & Miller, 2007). The use of the term, “provider”, after behavioral health, may be used, because it represents equal status within a primary care setting. For example, a behavioral health provider and a primary care provider are both providers within the practice. The reason that the professional name is important is that it captures the identity of the participant’s experiences. A change in name suggests a new transformation of professional identity, and the professional title should be considered in context of the roles that have emerged in this present study.

### **Multiple Roles of a BHC**

This study provided a framework of roles that emerged as themes across multiple different IPC sites from different regions in North Carolina. Participants revealed that they view their role within IPC as multifaceted and that they have multiple responsibilities. Regardless of the setting, be it a primary care office, pediatricians’ office, or health center, and across urban and rural areas, five themes emerged that consistently captured these

participants' views of their multiple roles incorporating the following responsibilities: (a) Program Administration/ Program Development; (b) Mental Health Brief Screening / Intervention; (c) Consulting / Teaching; (d) Referral Coordinator; and (d) Chronic Disease Behavioral Interventions. No previous study or literature has captured specifically these five main roles that emerged from this data that were defined by this broad group of participants. The focus group conducted by Glueck (2012) as a pilot for this present study with a different group of participants also found that the roles of a mental health counselor who is working in IPC, is multifaceted. Participants reported that within these roles they are providing services for individuals presenting to the primary care offices with mental health, substance abuse, and psychosocial stressors (Curtis & Christian, 2012; Gatchel & Oordt, 2003).

**Program Administrator / Program Development.** A new finding from this study was that currently in North Carolina, as IPC is being implemented in clinics in eight of the sites, the BHCs are serving as Program Administrator / Program Development, while also simultaneously providing all of the other four roles within IPC. Barrett and Warren (2012) made reference to the role of programming in their chapter, *Becoming The Behavioral Health Expert*. The concept of programming was described as a workflow that needs to occur within the practice to decrease obstacles for a streamlined operation, along with suggestions provided as to where to locate the offices, how to market services, and ways to inform new patients of the primary care office on the use of screening tools, and how to use electronic medical records to improve coordination of systems (Barrett & Warren, 2012).

Participants initially responded to questions about how they view their role as a BHC by describing their clinical duties. However, what emerged throughout the shared experiences of these participants were the added responsibilities of program development and administration of the IPC. These have been the areas that are missing from the literature. Participants described in their experiences as the first BHC at a primary care practice starting integrated primary care that they had the responsibility of taking on a role of helping to develop the IPC program. The BHCs are not finding that they are entering a system that already is established. As such, there have been expectations by the IPC practices that the new BHC will help create the integrated primary care system within their office. Often, very few resources or guides are available for any core competencies. No clear roles have been presented in the literature for the role of the BHC. Participants in this present study expressed how they are being influential in developing and creating IPCs all the while expressing that they are learning on the job, and, when possible that they are learning from each other. The present findings support research conducted by Bitar, Springer, Gee, Graff and Schydlower (2009) who reported a theme in barriers and facilitators of an adolescent primary care providers was clinic management and organization, in not spending enough time planning and communicating the program development.

**Mental Health Brief Screening / Intervention.** Consistent with previous literature and the goals of the Patient-Centered Medical Home, the primary clinical role participants reported was in providing brief screenings and interventions for mental health and/or substance abuse. The participants in this study expressed that it is important for a BHC to

have a broad clinical skill set and strong clinical generalist skills to work in a primary care setting. These findings are consistent and support previous literature. Barrett and Warren (2012) recommend that behavioral health providers need to be responsive to the needs of the primary care practice. In order to fit in as a member of the primary care team, the behavioral health provider needs to be adaptable and respond as a generalist. Barrett and Warren (2012) state that a behavioral health provider needs to be cautious in how they interact as a member of this team. “Responding to a request for help with comments like “I don’t treat that’ or ‘That is not my specialty’ will quickly disillusion providers. Just as the family practice physician is a ‘generalist’ and is knowledgeable about a broad spectrum of issues, the BHP must also be a mental health and /or substance abuse generalist in the primary care setting” (p. 23).

Participants reported that in their roles providing mental health brief screenings / interventions, some of them used standardized brief screening models and assessments developed for primary care offices. Not all of the participants in this study reported the use of these screening tools; however, no questions specifically were asked about if or what types of screening tools were used. For example, Anna, an LPC states, “I’ll do a PHQ-9, I’ll do some other anxiety scales or things like that if I need too. And then, if I’ll always, I still do, the AUDIT and the DASKS. Just to make sure, there are not substance use issues going on.” Jane shared, “Big SBIRT comes primarily from substance abuse, and that is what we first got ahold of as saying okay that’s a model of screening, brief interventions, referral to treatment. But, in terms of little SBIRT, what I say is that’s what we have been doing all the time. Every

time we walk in the room, I am screening, I am doing brief interventions whatever it may be, if it's a handout or talking with me. And, referral for treatment.”

The findings from the participants indicated that changes in policy are being implemented within North Carolina. As part of the Obama Administration's efforts to improve health care, in 2010, more emphasis was placed on early detection of substance abuse through a program called “SBIRT,” is an acronym for Screening, Brief Intervention, and Referral to Treatment (Humphreys & McLellan, 2010). The rationale for widespread implementation was that substance abuse is a public health concern and that by providing early detection and intervention more individuals could be screened, receive services, and, for more chronic high users, find recovery. On a policy level, Medicare and Medicaid codes were opened for the use of these screenings for reimbursement. Because training of substance abuse previously had been limited, a component of the health care efforts included expanding physician training in SBIRT for the implementation in primary care offices through the Substance Abuse and Mental Health Services Administration (SAMHSA) (Humphreys & McLellan, 2010). This present study supports that SBIRT screening is being provided in some settings specifically for the intended purpose of early intervention and detection of substance abuse and that the model itself is being applied in integrated primary care for other mental health and behavioral health interventions.

**Consulting / Teaching.** The behavioral health clinicians in this study also identified their roles as providing Consulting and Teaching. This role incorporates psycho-education but goes beyond this element of working with primary care patients to include educating

physicians. Participants viewed this role as important for educating physicians about mental health, substance abuse, domestic violence, grief, parenting, behavioral interventions, and psychosocial stressors for individuals and families. Within this role participants expressed a hope to shift the culture within the primary care offices to better understand behavioral health. This role is also supported in the literature by Barrett and Warren (2012), who stated, “The integrated model will thrive only if PCPs understand how to utilize BPHs and if they believe in the efficacy of collaboration. Just as it is important for the BHP to learn the medical culture, the PCP’s practice can benefit from learning aspects of behavioral health” (p. 25). Bitar et al., (2009) in a focus group of adolescent primary care physicians reported that training of physicians is limited in the areas of behavioral health, and physicians need to feel confident in their own skills to ask questions of patients so they can make appropriate referrals.

**Referral Coordinator.** The role of being a referral coordinator is organic to the brief screening and interventions triage in the primary care setting. This role also fits within the context of the needs of the Patient-Centered Medical Home (PCMH) in coordinating care. Because the services that they provide are brief in a primary care setting, all participants of this present study described that referral is a component of their role. Moreover, many of the BHCs extended themselves within their communities to develop relationships with their referral sources that included outpatient mental health agencies for referral for therapy, psychological testing services, substance abuse, crisis and hospitalization services, connecting for cultural and native speakers, coordinating for telepsychiatry in rural settings,

and even partnering with school systems. This points to the importance of mental health community agencies and /or private practice clinicians needing to be aware of how they fit into this larger system of integrated primary care within the community.

**Chronic Disease Behavioral Health Interventions.** The results from this present study support previous findings that mental health providers have been trained for working in traditional mental health rather than primary care to address behavioral health for chronic disease (Hunter et al., 2009; Patterson et al., 2002). This study found that BHCs are providing a role of providing chronic disease behavioral health interventions but that this skill is viewed differently from providing mental health brief screenings. Some of the participants did not identify this as a role until specifically asked in the semi-structured interviews regarding his or her level of confidence in providing chronic disease behavioral health interventions. Other BHCs shared that they viewed this component part of their responsibilities. All of the participants expressed that this is an area where additional training is needed in order to understand disease progression and behavioral health interventions. Even participants who expressed feeling confident expressed that this is an area for continued growth and mutual learning from physicians. This study specifically identified these as two separate and distinct roles because they require a different set of knowledge base. Participants working in pediatricians' offices reported not providing these types of service. Participants working with adults in family practice and health department settings reported that they are working with behavioral lifestyle changes. At least three BHC reported that they are now working with primary care providers at their IPC settings to develop groups for

chronic disease management. The participants who are providing these services described a culture shift that needs to occur within the primary care office staff so that they are used not only for mental health and substance abuse counseling but also for providing behavioral lifestyle interventions. To do this, BHCs expressed the need to be skilled in understanding chronic disease and know how to provide interventions for these services. Hunter et al. (2009) developed a step-by-step resource that provides a tool kit for a BHC for adapting to the new culture of working in IPC with common chronic disease, and behavioral health conditions, and recommendations for brief interventions. Increased emphasis on chronic disease management likely will mean that BHC who are working in IPC settings will begin to be utilized for these services and therefore will need to be prepared.

### **Attitudes Toward Integrated Primary Care**

Participants in this study reported positive attitudes regarding integrated primary care. As shown in Figure 1. at the core and central attitude reported was the concept of providing a holistic mind body approach that offers access to care, reduces stigma about mental health, and provides prevention. This attitude, or way in thinking, is broad and requires an ability to conceptualize and synthesize multiple perspectives. As seen in Figure 1, having a holistic mind/body approach is at the core of the attitudes for these participants.

Previous results indicated that BHCs may have difficulty adapting to a medical model. Specifically, for Licensed Professional Counselors (LPCs) the counseling profession historically has been separated from a medical model (Hansen, 2010), with more emphasis on a wellness approach (Myers, Sweeney, & Witmer, 2002). The historical base of

counseling in both humanistic person-centered approaches combined with the wellness philosophies were thought to create conflict. Miller et al., (2004) reported that professional counselors found challenges in collaboration with physicians with the concept of the medical model, in addition to language barriers between the professions. Similarly, Gersh (2008) reported that Licensed Professional Counselors reported challenges in adapting to the medical model. In this present study, the participants did not use the terminology of a medical model. Rather, they presented that their experiences were different than their previous work experiences in community mental health and/or private practice settings and that working in an IPC setting does require different skill sets and understanding of working in a medical practice. It is important to note that many of the participants, including the LPCs, expressed dissatisfaction with their prior work settings and expressed how positive they felt about working in the IPC setting, due to the collaboration. All of the participants in this study made a choice to work in an IPC setting. This choice may have contributed to their positive attitudes of IPC. Also, that this new setting has a different culture, set of norms, and way of doing things-including a language is to be expected based on previous literature (Patterson et al., 2002). However, a difference in culture is not the same as being for or against a medical model. Rather, the participants expressed that they were learning how to adapt to fit into being a part of the medical team. Fundamentally, IPC settings, because of the emphasis on a biopsychosocial approach are likely not functioning in the same way as traditional medical model primary care offices – because they are incorporating a more holistic approach. Additionally, the BHCs in this study provided examples in how they are

using their roles providing consulting / teaching to the physicians and in making changes in program administration and program development in ways that are having an influence on the model of care. In addition, they reported that the learning is reciprocal.

Integrated primary care requires that behavioral health clinicians have the ability to think conceptually about broad systems and integrate their skill set within the culture of a medical practice. BHCs need to consider alternative ways of healing as part of a multidisciplinary team, and this requires cognitive complexity. Cognitive complexity is defined as “the ability to absorb, integrate, and make use of multiple perspectives (Granello, 2010, p. 99).” Granello (2010) reported that cognitive complexity increases with more years in counseling practice as a developmental trajectory and that training needs to be tailored to the developmental stage. Nine of the participants in this present study reported that they had more than 10 years of experience in the profession of mental health. According to Granello (2010), this places these BHCs in the late multiplistic or early relativistic stages of development, indicating that these participants are in the developmental stages of questioning absolute truths and seeking knowledge.

All of the participants in this present study expressed having an approach that incorporated mind body that had developed throughout their years in practice. Length of time in the profession was found in previous studies to influence attitudes toward a holistic or biopsychosocial approach. Gavin et al. (1998) found that years of experience influenced mental health providers’ attitudes toward providing collaboration with primary care, and that

years practicing provided more comfort in the ability to provide services for medical and mental health, even if they did not have a strong belief in a biopsychosocial approach.

The culture of primary care as different from outpatient mental health agencies has been written about in lessons learned, articles and books (Curtis & Christian, 2012; Hunter et al., 2009; Paterson et al., 2002). The participants in this study further confirmed that the pace of primary care moves at a pace that requires brief interventions, and that frequency of sessions is based on a different model than their previous training (Bitar et al., 2009; Hunter et al., 2009; Pomerantz et al., 2009). Despite the difference, this study found that for these participants adapting their skill set has taken time, and they have needed to modify therapeutic interventions to implement within the brief pace of a primary care setting.

Access to care was a belief that emerged from the participant responses as well as reducing stigma. The participants agreed that being on-site in a primary care office offered services to individuals who may otherwise not seek out support. Being in IPC provides an opportunity to provide services to a more diverse multicultural population. Bitar et al. (2009) found that in adolescent primary care clinics both parents of adolescents as well as provider reported stigma as a barrier in accessing care and receiving care within the primary care office. A recent study conducted with Latinos found that they preferred receiving mental health services located in a primary care clinic rather than at a mental health agency; part of the reasons for wanting to remain at the primary care were cost and logistics of going to a different location (Kaltman, Hurtado deMendoza, & Gonzales, 2013). Participants in this current study expressed that even though the services they provide are brief they are needed

and may be the only services that some individuals will receive and is consistent with previous findings in barriers to receiving services (Bitar et al., 2009). Ruest, Thomlinson, and Lattie (1999) findings based on barriers for missing initial behavioral health appointments that originate from primary care to mental health providers in separate locations because of decreasing barriers regarding transportation, and keeping a referral at a new location. The participants in this present study viewed that being on-site in a primary care office assisted in decreasing barriers for individual receiving services.

In a pilot focus group conducted by Glueck (2012), ethics of providing integrated primary care was reported as a barrier. However, in this present study, one of the participants discussed ethics of IPC. Specifically, confidentiality and the differences within ethical codes have been written about as part of integrated care. Barrett and Warren (2012) identify the important of informed consent, obtaining releases of information, and having ongoing discussions with patients regarding information sharing between providers as a key component of IPC. Each discipline has different ethical codes, and the process of informed consent, confidentiality, and relationships with patients are different among different mental health providers working as BHCs and different from family practice physicians (Boice, 2012).

Participants reported one of the barriers in the implementation of integrated care as policy regarding insurance and billing. Participants in this present study expressed that the primary care administrators need to be in full support of this emerging model of incorporating a behavioral health clinician as part of the team. How the administrators view

the BHC will impact the level of collaboration that is ultimately implemented within the setting and how the BHC is utilized in the practice. Additionally, BHC reported barriers regarding funding and payment for the services they are providing. At present they reported some changes within North Carolina that have recognized their roles and providing reimbursement within this new setting. However, the consensus was that in order to support this emerging model of care policies should change to better reflect the biopsychosocial level of care that is unique in the IPC setting. Miller, Teevan, Phillips, Petterson, and Bazemore (2011) argued that as primary care is being redesigned there is an opportunity to strengthen mental health services and develop new policies for payments, suggesting that over time healthcare cost will decrease because of providing team based services for health.

### **Training and Knowledge Needed for BHC in IPC**

This present study supports the idea that there is a need for behavioral health training specific to integrated primary care. As previously addressed, Blount and Miller (2009) expressed the concern of a workforce crisis in integrated primary care and the avenues for providing training for mental health professionals. They presented two options for training that are being offered through the Department of Family Medicine and Community Health at the University of Massachusetts Medical School that include a primary care psychology fellowship and a certificate program. The Primary Care Behavioral Health was launched in 2007 and is “designed to facilitate the transition from specialty mental health settings to primary care for mental health clinicians of many disciplines (p 114).” Blount and Miller stated that there is a need for training that incorporates the clinical skills of mental health and

substance abuse, and in addition that utilizes the clinical skills to address the psychosocial and behavioral health interventions for chronic disease management.

The participants in this study reported having limited or no training specific to integrated primary care prior to working in this new setting. The majority of the participants graduated from their clinical programs over 10 + years ago. They reported at that time they had never heard of integrated primary care; it was not discussed in their graduate programs and was not considered as a possible career option. The participants in this study reported that they have attended only a few training sessions in North Carolina specific to integrated care. The majority of their training has been self-taught or on the job learning, and while shadowing other BHCs. One participant had attended the certificate training that was the program offered through the University of Massachusetts Medical School. Supporting the findings from Glueck (2012), the focus group participants reported viewing IPC as a specialization.

Self-efficacy is a person's belief in their abilities (Bandura, 1986). Participants were asked about their confidence levels in providing mental health services as well as chronic disease behavioral health interventions within the primary care setting. Despite having significant years of clinical experience in mental health, the participants expressed that it has taken time to adjust to the culture of how IPC is different from how they were trained and other settings in which they have worked. The majority of the participants reported that they still need to learn more about chronic disease behavioral interventions. This developmental trajectory of working and gaining mastery is an expected component of developing self-

efficacy (Bandura, 1986). Moreover, the participants expressed that shadowing other BHCs who were established was important in their learning process.

This research design was grounded in multiple theoretical mind/body theories that capture the broad understanding of mind and body health in the context of a historical movement toward integrated primary care. The theoretical underpinnings were the biopsychosocial model (Engle, 1979), wellness models in counselor education, health and behavior changes with social cognitive theory (Bandura, 1986), and stress and coping research. Participants reported a need for understanding a holistic mind body approach, although they did not mention specific theoretical approaches such as the biopsychosocial model. The theoretical approaches that were discussed were based on their previous training, which they reported did not incorporate integrated care. As previously stated in the literature, mental health providers are having to adapt their training to fit primary care settings (Patterson et al., 2002). Participants reported clinical approaches based in brief therapy as important with emphasis placed on cognitive behavioral therapy, family systems, and humanistic approaches.

Makinson and Young (2013) have reported a need for counselors-in-training to gain a better understanding of neurobiological and how counseling interventions impact the biological system. Specifically Trauma-Focused CBT (TF-CBT), EMDR, and Mindfulness-Based Cognitive Therapy (MBCT) impact neurological changes in individuals with post traumatic stress disorder (PTSD) (Makinson & Young, 2013). Gregg, Callaghan, Hayes, Glenn-Lawson (2007) researched Acceptance and Commitment Therapy (ATC) in diabetes

groups and found that helping individuals cope with acceptance of their chronic illness and mindfulness reframing skills improved diabetic control. Advances and recent attention in counselor education to theories that incorporate mind and body are needed to guide training and practice for clinicians working in integrated primary care.

**Medical Training.** Participants recommended training and knowledge for BHCs working in IPC that would incorporate medical training. Recommendations from this present study are presented to expand counselor education training to incorporate interdisciplinary opportunities. Consistent with recent literature (Blount & Miller, 2009; Cutis & Christian, 2012), participants expressed BHCs need to have a strong clinical foundation as a generalist with strong clinical, substance abuse, crisis intervention, and trauma experience. In addition, the participants expressed a need to have medical training. The medical training that was recommended by the participants included training in physician mental health co-occurrence, chronic disease progression, psychopharmacology, theories and techniques for behavioral health interventions, and working with an interdisciplinary medical team. The need for medical training is consistent with findings from Lareau and Nelson (1994) in which physicians reported that medical providers who are working in medical settings need some medical training. The findings from this present study for medical training are closely aligned with the curriculum being offered through the University of Massachusetts Medical School. Therefore, the curriculum offered through UMASS could be a beginning start for a counselor education program seeking to develop a curriculum. Additionally, efforts need to be made to bridge interdisciplinary studies within university campus programs and in community

education for cross discipline studies and to expand the comfort level in different disciplines working together.

**Graduate Track / Internship in IPC.** The final recommendation of the participants was a graduate level track and/or internships with a focus on integrated care. The licensed professional counselors in this study were especially vocal about this need within the counseling profession. At present counselor education does not recognize a specialty or concentration area in integrated primary care. This recommendation is consistent with findings from Gersh (2008), who focused exclusively on licensed professional counselors' experiences. Robinson and Strosahl (2009) argued that training programs need to help mental health providers learn about the primary care that include core competencies and a mentor-trainer model.

### **Limitations**

All research studies have limitations that can impact the credibility and trustworthiness of the results (Heppner & Wampold, 2008). This study utilized an interpretative phenomenological analysis (IPA) design to capture the experiences of behavioral health clinicians working in integrated primary care settings. The limitations of this study include the emerging model of integrated primary care and participant characteristics.

**Emerging Model of Integrated Primary Care.** Integrated Primary Care is not a standardized model of care. The definition of IPC was dependent upon the participants in eligibility reporting they are providing same day and joint services providing team based

integrated primary care. Therefore, as IPC is emerging in clinical practice, the model may be different and varied depending on the needs of the primary care setting. In defining integrated primary care for this study, this researcher selected key terms based in the literature to capture the highest level of collaborative care in an integrated primary care site. However, participants self interpreted the level of collaboration. It is possible that a participant may have responded that they are working on-site in a primary care office setting (primary care, pediatrics, health department) as part of a medical team in which they provide same day or joint appointments with the primary care providers. However, in reality, they may have been in a close collaboration model rather than working in an integrated primary care site. In this study, the researcher observed only one participant who responded that they were providing integrated primary care but a better description was close collaboration with a therapist and being co-located.

**Participants' Characteristics.** Other limitations of this study are that the participants self selected and were motivated to participate and were individuals who were working in integrated primary care settings. While these characteristics were needed to for conducting this study, consideration needs to be given to these dynamics. All participants completed a member check of his or her transcript. This was used to add credibility to this study. There is no way to assure how closely each participant reviewed the transcript or if the did review the transcript before confirming.

The results from this study are generalizable only to this specific group of participants who participated. However, it is possible that other BHCs who did not participate may have

had different experiences and views about IPC. These BHC were not organizationally mandated or forced to work in this setting. In fact, many of the BHCs described seeking out opportunities to work in an IPC. Therefore, it needs to be assumed that given how new integrated primary care is, this field currently is attracting mental health providers who are willing to take new risks, who are drawn to briefer models of therapy, and who are more open to working with primary care providers.

While the diversity in BHCs' backgrounds lends a collective voice to the broader understanding of BHCs' experiences working in IPC in North Carolina, the study did not capture the unique differences among and between groups of LPCs, LCSWs, and LPs. Further, the voices of LMFT were not heard, and their experiences may be different.

### **Implications for Practice**

The findings from this study have implications for clinical practice and training for counselor education and the field of behavioral health clinicians working in integrated primary care and are presented in Figure 1 and 2. When a system is a process in transformation, as is the case with integrated primary care professional practice will be advanced beyond training opportunities. Primarily, this study provides Licensed Professional Counselors who will be entering the field of integrated primary care as behavioral health clinicians a guide for the roles of working in this setting. As the role of a BHC is emerging, this current study provides a conceptual model of the roles and attitudes of BHCs working in IPC as well as an emerging model for training.

Figure 2. is representative of the results of the Roles and Attitudes of Behavioral Health Clinicians in IPC. At the core of this image is the participants' attitudes toward working in integrated primary care settings was a belief in a holistic mind/body approach. The first ring illustrates the reported barriers BHCs reported as impacting their roles that included: (a) primary care culture, (b) lack of training in IPC, and (c) barriers with policy. The second ring, in white represents the participants attitudes work in IPC provided access for services, decreased stigma regarding mental health, and provided prevention. Barriers and facilitators of providing these services were the culture of the IPC practice, training, and policies. The outer ring represents the synergy of the multiple roles the five themes that emerged in how behavioral health clinicians view their roles, each working together.

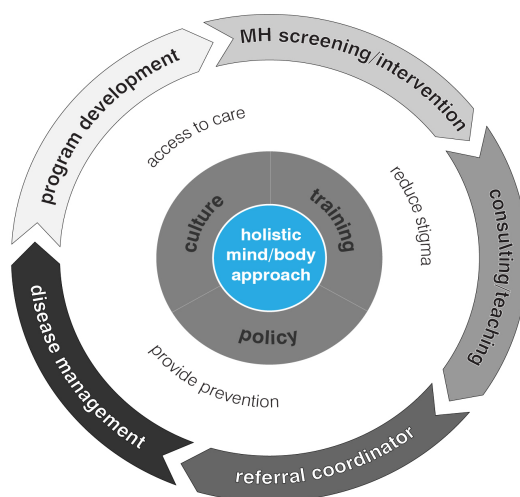


Figure 2. This figure represents the findings of the roles and attitudes reported by behavioral health clinicians' experiences working in integrated primary care settings.

This figure may be useful for BHCs who are currently in IPC settings to guide the development of their IPC program. It may also be useful in clinical supervision as a way to discuss strengths and weaknesses in the growth for the professional. Figure 1 may be used for future research as well as in the development and planning of integrated primary care offices and among BHCs in developing their roles. This figure may also be useful in conceptualizing the experiences of BHCs and useful in training programs for integrated primary care.

### **Training in IPC for Counselors**

Licensed Professional Counselors in North Carolina seeking to work in integrated primary care settings are adapting their skill set to work within the culture of a primary care office. Training specific for integrated care is limited. This poses a challenge for LPCs. The American Counseling Association (ACA) (2005) Code of Ethics encourages counselors to be active in changing systems to “promote change at the individual, group, institutional, and society levels that improves the quality of life for individuals and groups and remove potential barriers to the provision of access of appropriate services being offered “ (p. 9). Additionally, counselors are expected to base their practices on areas that have been researched and in which they have received training. The ethics regarding training are specified in Section C Professional Responsibility (C2.B New Specialty Areas of Practice) stating, “Counselors practice in specialty areas new to them only after approached education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm” (ACA, 2005, p. 9). When these LPCs venture toward promoting system

change, such as integrated primary care that reportedly decreases the stigma and reduces barriers for individuals and families, they are charting a new path and setting an example for the profession. Counselors are in need of training specific to meet the needs of the integrated primary care setting.

As the Counseling & Related Educational Programs (CACREP) are re-evaluating and implementing changes for the 2016 standards for clinical mental health training programs, the recommendations will be influential in guiding decisions in Counselor Education programs (Urofsky, 2013). Masters level courses, in the clinical mental health counseling programs can incorporate learning about integrated care. Additionally, graduate courses or tracks can be developed specific to prepare counselors for the needs for working in primary care offices. Internships can be developed to promote experience in interdisciplinary team building between counselors and physicians and develop internship opportunities.

Counselor education programs should expand coursework on stress and coping research that broadens students' understanding of immunity, health, and disease progression as well as expand exposure to methods of coping and impact on physiological health outcomes. Additional, academic course are needed to address behavioral lifestyle interventions for chronic disease management and how current counseling therapeutic interventions can be applied. Training can emphasize the levels of collaboration and define clearly the terminology of integrated care. Theoretical approaches such as the biopsychosocial approach and models that support community resources, self management

for chronic disease, and proactive coping that could be added to counselor education programs.

The results of this present study, coupled with a national focus on primary care needs, points to the need for more education and research in the area of integrated primary care. Currently there is a need to incorporate integrated primary care education in graduate, internships, and in continuing education. A significant component of IPC is educating counselors on the roles and skills counselors that can provide with healthy lifestyle behavioral health interventions. This includes an understanding of how stressors impact physiology and coping skills that improve health and well-being. It is likely that in the future IPC will require a counselor to have specialized training. Therefore, graduate programs and clinical supervisors will need to be ready to provide training.

### **Emerging Model: Counselor Training for Integrated Primary Care**

Figure 3 represents the Emerging Model of Counselor Training for Integrated Primary Care. In this model the training needs for a BHC are explored through the lense of counselor education. The assumption is that each multidisciplinary clinical group working towards integrated primary care will need to view their training needs from their own profession. The model is structured as a hexagon, a structure that appears in nature as efficient. The symboloisim of the use of a hexagon is important as the aim of integrated primary care is to strengthen services and provide holistic quality care for patients. Therefore, to do this a BHC and primary care team need to be working together in harmony in a way that is efficient.

In this model three large hexagonal structures are identified as counseling, medical training, and culture of primary care. The BHC in this study expressed training in these three areas for BHCs working in IPC. Within each of these main hexagon structures are components that have been reported by the participants as well as represented in the integrated primary care literature as competencies of knowledge.

The smaller hexagonal structures within each of the three categories represent training. For example, within counseling the 13 core knowledge areas are shown based on reports from participants and the need for a generalist broad approach to foundational counseling. Each category has a similar core knowledge structure based on what counselors will need to learn for working in IPC. Therefore, in order to apply counseling and clinical skills to an integrated primary care setting, this model represents the knowledge areas that counselors will need in the culture of primary care and have some basic understanding of medical training. Some of the smaller hexagonal structures intentionally overlap sections. This demonstrates a bridge of working on changes in disciplines. Areas of all three larger hexagonal structures have been left with empty spaces. This represents that the roles and training needs for working in IPC is emerging and there may be knowledge areas that need to be added in the future as additional research is conducted.

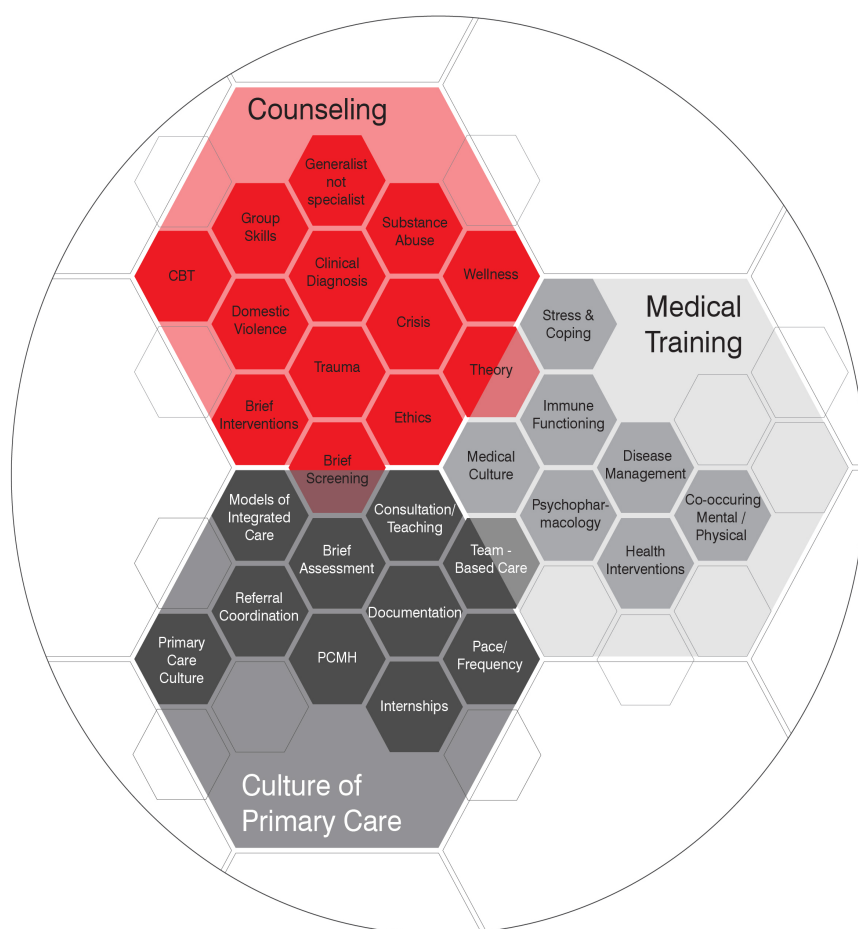


Figure 3. Emerging Model: Counselor Training for Integrated Primary Care. From the lens of Counselor Education needed training for preparing counselors for working in IPC.

### Recommendations for Future Research

The emergent increase of behavioral health clinicians in integrated primary care settings creates a shift in the need for interdisciplinary mind body techniques and trainings.

The role of the BHC will continue to develop. At present, no formal standardized measure exists for establishing core competencies. Future research should seek to develop a measure that evaluates the roles of a BHC compared to the needs of IPC. Such a measurement could then be used on a broader scale to capture when BHCs nationally are evaluating roles of BHCs and if they are provided needed training for services in IPC. This study can be used to develop a survey. Then, utilizing this survey, the roles of the BHCs can be tested on a broader scale for strength and frequency in a larger sample for the following roles: (a) Program Administration/ Program Development; (b) Mental Health Brief Screening / Intervention; (c) Consultation / Teaching; (d) Referral Coordinator; (d) Chronic Disease Behavioral Interventions. This type of study would be important to conduct prior to developing full programs and national trainings so that the core competencies or roles of a BHC can be addressed in training.

A limited number of studies have begun to examine the impact of BHCs on health outcomes (Graff et al., 2007; Ray-Sannerud, et al., 2012; Bryan, Marrow, & Appolonio, 2009). However, additional studies need to be conducted that focus specifically on the type of behavioral health interventions, the theoretical and/or techniques utilized, and the skills level of the BHC. Finally, future research needs to be conducted to evaluate developing training curriculum for counselors in integrated primary care.

### **Conclusion**

This qualitative study of ten behavioral health clinicians provides insight into the roles, attitudes, and training needs for working in an integrated primary care setting. This

study found that the core attitude of the BHCs working in IPC was a belief in a holistic mind/body approach. These BHCs reported multiple roles and responsibilities within the IPC setting that can have an influential change in the health care system. These participants recommended training to help prepare the next generation of BHCs to work in IPC.

Peek (2009) in his article, *Integrated Care for Persons, Not only Diseases*, indicated a need to look beyond conditions and focus on the needs of the person. He stated that a health care system can become narrowly focused on quality improvement focusing only on diseases rather than considering the person. Peek addresses the need for referral that originates from the primary care office to other specialists and community services being more than simply an administrative process.

The counseling profession developed from a core philosophy of being person-centered. As a profession, counselors have much to offer as primary care offices that are working to embrace the concepts of changing systems to be person-centered through consulting/teaching, not only relevant is mental health, substance abuse, and behavioral health interventions, but also with regards to core philosophies derived from humanistic approaches. Carl Rogers believed in the concepts of personal living and personal choice (Rogers, 1961). He also believed in providing services to a broad range of the population in a way that reduced stigma and avoided labels. He stated throughout his career, "I have been trying to be of help to a broad sampling of our population: to children, adolescent sand adults; to those with educational, vocational, personal and marital problems; to 'normal,' 'neurotic,' and 'psychotic' individuals (the quotes indicate that for me these are all

misleading labels); to individuals who come for help, and those who are sent for help; to those whose problems are minor, and those whose lives have become utterly desperate and without hope” ( Rogers, 1961, p. vi). Does this not capture the broad spectrum of individuals that present in need within a primary care office? Participants from this present study provided compelling reasons to provide services and access to care in integrated primary care. If this is the case, then the counseling profession is poised on edge of a new beginning. Counselor education can be part of the national movement to provide training and education for the next generation of clinicians, skilled to provide a new kind of service in the community, meeting the people where they are -- in primary care offices, providing integrated care.

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**APPENDICES**

## Appendix A

North Carolina State University  
Informed Consent for Research

### Title of Study

*An Interpretative Phenomenological Study of Behavioral Health Clinicians' Experiences in Integrated Primary Care Settings*

Principal Investigator: Bethany P. Glueck  
Faculty Sponsor: Dr. Sylvia Nassar-McMillan

### **What are some general things you should know about research studies?**

You are being asked to take part in a research study. Your participation is voluntarily. It is your right to choose to participate and at any time you can stop participation. In this consent form you will find information about the research. If the information is not clear and you do not understand what is being asked of you as a participant it is your right to ask this researcher for more information before agreeing to participate or at any time during your participation.

### **The purpose of this study**

The purpose of this current dissertation study is, to explore and describe the lived experiences of behavioral health clinicians who are working in integrated primary care to learn about their roles, attitudes, and training exposure. Participants for this study have been purposefully selected for their current experience working on-site in a primary care office providing integrated primary care. Participants are licensed in North Carolina to provide mental health counseling as a Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), or Psychologist (LP). Results of this study may help inform future training needs for mental health counselors who may provide integrated primary care. And, your participation will help this PI in completion of her doctoral degree requirements at North Carolina State University.

### **What will happen if you take part in the study?**

Participants will be asked to participate in a semi-structured interview, located in North Carolina in a place and time convenient for you. You will be asked to sign this informed consent and complete a brief demographic questionnaire. During the interview you will be asked broad questions about your role, attitudes, and training experience toward integrated primary care. The interview will be audio-recorded on two digital records. After this PI transcribes the interview, participants will be sent an electronic copy of the document to check the accuracy. A copy of the transcription will be sent to you so that you may confirm and validate your responses.

**Risk**

The researcher anticipates no foreseeable risk regarding questions asked to obtain information regarding mental health counselors' role, attitudes toward, and training in integrated primary care. The researcher anticipates no significant stress, anxiety, threat, or content of the individual interview that would be collectively viewed as emotionally harmful to the participants engaging in this study.

**Benefits**

Your participation will help expand counseling research on mental health counselors who are working in the role of a behavioral health clinician in integrated primary care. Indirectly, participants may benefit from contributing to advancing research for other behavioral health clinicians and, as part of the interview process, increase their own knowledge through personal insight that may positively impact his or her self-awareness, attitudes, and professional practice.

**Confidentiality**

Because this research is qualitative research, you will be sharing thoughts, beliefs in person with this PI. The interview will be audio recorded and you will be asked to provide a pseudonym so that your identity remains confidential. A Word document with your transcribed data will be sent to a coding team will identify themes and provide information to the researcher for final data analysis. Care will be taken that any quotations included in the qualitative write-up will not be identifiable to a specific person.

**Compensation**

As you may be giving up your lunch or dinner time to participate in this study a meal will be provided at a value no more than \$10 to compensate for your time.

**For questions about this study**

If you have questions about this this research study please contact Beth Glueck at 919.696.1995 or [bp glueck@ncsu.edu](mailto:bp glueck@ncsu.edu) ,or the faculty sponsor, Dr. Sylvia Nassar-McMillan at [sylvia\\_nassarmc@ncsu.edu](mailto:sylvia_nassarmc@ncsu.edu). If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Deb Paxon, regulatory Compliance Administrator, Box 7514, NCSU Campus, 919.515.4514.

**Consent to participate**

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may choose not to participate or to stop participating at any time without penalty or loss of benefits to which I am otherwise entitled.

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Investigator signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix B

### Recruitment E-mail

Email subject heading: Behavioral Health Clinicians in Primary Care Needed for Research Study

Dear Integrated Care Behavioral Health Clinician:

I am seeking licensed behavioral health clinicians (LPC, LCSW, LMFT, LP) in North Carolina who are currently working in an integrated primary care setting to participate in one individual interview for the purpose of educational research. This dissertation research study aims to capture the experiences of behavioral health clinicians' in their roles, attitudes, and training experience working in integrated primary care settings.

If you participate in this study, you will be interviewed in person for approximately one hour. The interview will be conducted at a time and location in North Carolina that is convenient for you and will include a meal (valued up to \$10). The interview will be taped and your confidentiality will be protected. This study meets the requirements of a Ph.D. in Counselor Education at North Carolina State University and has been approved by the Institutional Review Board (IRB #2979).

To participate in this research study please contact Beth Glueck at [bpglueck@ncsu.edu](mailto:bpglueck@ncsu.edu) or 919.696.1995. If you are not able to participate, please help in my search for finding participants by forwarding this e-mail to any behavioral health clinician in North Carolina who meets the above description. Thank you.

Sincerely,

Beth Glueck, MA, LPCS, NCC

## Appendix C

### Participant Screening E-mail

Subject Heading: Participation in Research

Dear Behavioral Health Clinician:

Thank you for your interest in participating in a North Carolina State University dissertation study on behavioral health clinicians' experiences working in integrated primary care settings.

To confirm that you meet the participant eligibility, please respond to the following questions.

- 1) Are you a licensed mental health counselor in North Carolina? And, what is your licensure (LPC, LMFT, LCSW, LP)?
- 2) Are you currently providing services on-site in a primary care office setting (primary care, pediatrics, health department) as part of a medical team in which you provide same day or joint appointments with the primary care providers?

I am located in Raleigh, NC and willing to travel within North Carolina to meet you for this interview. Please provide an optimal date/ time and your location. I may be contacted at [bp glueck@ncsu.edu](mailto:bp glueck@ncsu.edu) or at 919.696.1995.

Sincerely,

Beth Glueck

## Appendix D

### Demographic and Background Information

Instructions: Please complete the following demographic questions by selecting the appropriate response (s) to each question.

1. Sex/Gender

- Female
- Male

2. Race/ Ethnicity

- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- Hispanic or Latino
- White
- More Than One Race
- Unknown or Not Reported

5. What is your mental health license?

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Licensed Psychologist (LP)

5. Highest degree achieved?

- Master
- Doctoral

6. How long have you been in the profession of mental health?

7. How long have you been working in an integrated primary care setting?

## Appendix E

### Semi-structured interview

#### Section I Research Questions

- 1) How do behavioral health clinicians view their roles in integrated primary care?
- 2) What are behavioral health clinicians' attitudes toward integrated primary care?
- 3) What training is needed for behavioral health clinicians' to work in integrated primary care setting?

#### Semi-Structured Interview:

1. How would you describe your role as a behavioral health clinician working in an integrated primary care setting?  
Prompts: Can you share more about that?  
Prompt: Are there any other roles that you have not mentioned?
2. What are your attitudes and beliefs about providing behavioral health services in integrated primary care?  
Prompts: Can you share more about this?  
Prompts: What experiences do you think lead to this belief?
3. What theoretical training did you receive prior to your work in integrated primary care?  
Prompt: Has this been helpful to you in your work in integrated primary care?
4. Where have you received training in how to provide mental health services in an integrated primary care setting?  
Prompts: What about in your graduate program?
5. To what degree do you feel confident in your abilities to provide services in integrated primary care?  
Prompts: for mental health?  
Prompts: for chronic disease behavioral interventions?
6. What kind of training and knowledge do you think is needed for behavioral health clinicians providing integrated primary care?