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Competence of Behavioral Health Clinicians in Integrated Care Settings

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Walden University
2018

Abstract

Competence of Behavioral Health Clinicians in Integrated Care Settings

by

Agyenim Akuamoah-Boateng

MS, East Carolina University, 1998

MD, Kharkov State Medical Institute, 1987

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

August 2018

Abstract

Collaborative efforts between medical and behavioral health professionals is required to simultaneously treat individuals with medical and mental health disorders. However, there is lack of focus on the competencies and trainings needed by behavioral health clinicians (BHCs) transitioning to integrated primary care (IPC) settings. The purpose of this qualitative interpretive phenomenological study was to describe the lived experiences of BHCs who have transitioned from specialty outpatient behavioral healthcare settings to IPC settings. Semi-structured interview questions were used to collect data. Using interpretive phenomenological data analysis approach, themes and the shared meanings and experiences of 8 licensed BHCs were explored. Seven participants had graduate degrees and 1 participant had post-graduate degree. All participants had at least a year of experience working in IPC settings, worked full-time in North Carolina, and had over a year of experience in traditional behavioral healthcare settings. Results indicated that participants shared experiences in 5 themes: (a) clinical experience, (b) effective communication, (c) collaboration with primary care providers(PCPs), (d) continued education and trainings, and (e) care coordination. The outcome of this research will inform institutions, administrators, and credentialing boards to consider implementation of defined competencies for BHCs in community health centers that operate on IPC principles to ensure collaborative efforts between BHCs and PCPs in order to help provide effective holistic and affordable health care in a systems-based approach.

Competence of Behavioral Health Clinicians in Integrated Care Settings

by

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MS, East Carolina University, 1998

MD, Kharkov State Medical Institute, 1987

Final Research Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

August 2018

Dedication

This dissertation is dedicated to the three most precious people to me, my wife, Mary, my son, Richard, and my daughter Courtney, without whose unwavering support, I would not have been able to reach this milestone, attaining my second doctorate degree. I am especially thankful to my wonderful wife, who has been my supporter and encourager throughout my educational endeavor. This dissertation is also dedicated to the memory of my late parents, my mother, Grace Adomah and father, who preferred to be called "Capital K," who had no formal education but thought me the value of education and instilled in me that "working with my maximum potential, my mind will take me there."

Acknowledgement

I would like to first, thank God the Omnipotent, Omniscient, and Omnipresent for his mercy and guidance, that made this history making milestone, a second doctorate degree, a possibility.

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Last but not the least, I would like to thank my family, my wife Mary and children, Richard and Courtney for supporting me spiritually throughout my second doctorial study and dissertation journey.

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Chapter 1: Introduction to the Study

Researchers have long observed that primary care settings and physicians have important roles to play in integrated medical, mental health, and substance abuse treatment (Hooper, 2014). According to Hooper (2014), primary care providers (PCP) have traditionally been the sole providers of brief counseling and prescription of psychotropic medications for most individuals with mental health disorders, especially among the underserved, and individuals with lower socioeconomic status. The role of behavioral health clinicians (BHCs) in integrated treatment is also needed to fill the services and treatment gap (Glueck, 2015). Though researchers have increased their advocacy for the incorporation of mental health services into primary care, little effort is being made to "promote the transportability of counseling theories and culturally sensitive counseling practices to primary care settings" (Hooper, 2014, p. 95).

One of the current social issues facing the nation is the inadequate treatment offered to individuals who are dealing with medical problems with comorbidity of mental health and substance use disorders (Chesher et al., 2012; Glueck, 2015). Chesher et al. (2012) suggested that the occurrence of chronic medical problems in patients with dual diagnosis of mental health and substance use disorders is higher than the general population, requiring medical and behavioral health professionals to collaborate in their efforts to effectively conduct assessment, establish diagnoses, and simultaneously treat the triply-diagnosed individuals with medical, mental health, and substance use disorders. Similarly, Tew, Klaus and Oslin (2010) stated that most individuals with history of

mental illness and substance abuse also have medical disorders, which often complicate the course of treatment resulting in poorer treatment outcomes.

Researchers estimated that over 70% of individuals who received treatment for depression and other mental health disorders involving BHCs in integrated primary care (IPC) settings improved tremendously (Bridges et al., 2015; Peek, Cohen & deGruy, 2014). Similarly, Bryan et al. (2012) posited that individuals with severe mental illness are likely to improve significantly when their disorders are identified early with treatment offered in IPC settings. Psychosocial intervention improved the quality of life of individuals suffering from mental health and co-morbidity of thyroid cancer, receiving postoperative radiation therapy (Wu et al., 2016).

Whetten et al. (2006) stated that in a study of psychiatric comorbidities among HIV-infected individuals in selected North Carolina treatment facilities, most of the study participants reported mental illness and substance abuse. Tegethoff, Stalujanis, Belardi and Meinlschimidt (2016) argued that individuals with mental disorders are at risk of developing certain medical disorders in early life and vice versa. According to Tegethoff et al. (2016), provision of integrated mental health and physical health care require collaborative efforts of BHCs and PCPs. Proponents of integrated treatment have therefore, argued that to effectively treat triply-diagnosed patients, all disorders must be treated simultaneously, either at the same setting or through collaboration of PCPs and BHCs (Chesher et al, 2012; Tew et al., 2010; Whetten et al., 2006). However, there is lack of research done to determine the roles, attitudes, training needs, and the

effectiveness of behavioral health counselors who transition to IPC settings (Glueck, 2015).

Background of the Study

The medical and mental health establishments have recently focused on integrated treatment due to the passage of the Patient Protection and Affordable Care Act of 2000 (ACA) (Cooper & Gardner, 2016). Integrated treatment requires collaborative efforts and partnerships between PCPs and BHCs (Beacham, Kinman, Harris & Masters, 2012; Cox, Adams, & Loughran, 2014; Glueck, 2015). The ACA requires organizations to institute patient care medical homes (PCMHs) with PCPs serving as team leaders and BHCs participating as team members (Beacham et al., 2012; Cox et al., 2014; Glueck, 2015).

According to Glueck (2015), the use of the qualitative method of inquiry, with an interpretive phenomenological approach to explore the lived experiences of BHCs in IPC settings would help identify and analyze themes and meanings of lived experiences of BHCs from several IPC settings. Beacham et al. (2012) and Cox et al. (2014) focused on the exploration of the training of interns using a course in graduate programs to prepare students for employment in integrated treatment. Although the training of psychology graduates would help in effective provision of behavioral care in integrated setting (Beacham et al., 2012; Cox et al., 2014), the BHCs currently working in IPC settings would benefit from the outcome of research studies on IPC settings to explore the competencies required to provide effective behavioral health care services by mental health and substance abuse professionals (Glueck, 2015). It is therefore apparent that there is a need to identify the competencies and characteristics of mental health

professionals and their effectiveness in the provision of integrated treatment in primary

care settings (Beacham et al., 2012; Cox et al., 2014; Glueck, 2015). Transitioning to an

integrated health care setting would require BHCs to experience a change in mindset and

be aware of differences in service provision in traditional outpatient behavioral health

centers versus service provision in integrated healthcare settings, requiring them to adapt

their clinical skills and intervention style to meet demands in IPC settings (Glueck,

2015).

Problem Statement

Recent research studies indicate that individuals' medical conditions may

deteriorate if they are not simultaneously treated with their mental health and substance

use disorders (Kallenberg, 2015). Similarly, O'Cleirigh, Magidson, Skeer, Mayer and

Safren (2015) argued that mental health and substance use disorders could tremendously

affect the course and treatment outcome of chronic medical illness in individuals with

triply-diagnosed medical, mental health, and substance use disorders. There is, therefore,

the need to provide integrated treatment in primary care settings, where most patients

seeking help for medical disorders, often present mental health and substance use

disorders (Kallenberg, 2015; Miller-Matero et al., 2016). However, researchers studying

provision of integrated care argued that best practices of effective integrated care, require

collaborative efforts of BHCs and PCPs to focus on integrated medical, mental health,

and substance use disorders treatment (Chesher et al., 2012; Glueck, 2015).

There is growing concern that currently, there are mental health professionals

with various backgrounds working as BHCs using their trainings and skills acquired in

traditional outpatient behavioral healthcare settings to work as part of the medical team in IPC settings (Glueck, 2015). According to Glueck (2015), in the absence of licensure or an accreditation body relative to integrated behavioral health practice, BHCs are left to design and apply their own version of care. Similarly, Blount and Miller (2009) argued that there is lack of training and education of BHCs to effectively practice in IPC. Cox et al. (2014) and Glueck (2015) observed that current training of psychology graduates would potentially help improve provision of behavioral healthcare in integrated settings, while research on the roles of BHCs currently working in IPC settings would help explore the competencies required to provide effective behavioral health care services by mental health and substance abuse professionals in primary care settings.

Aforementioned studies regarding BHCs in IPC illuminate important findings about BHCs in IPC settings. However, in my literature search, there was lack of focus on the competencies and trainings needed by BHCs transitioning to IPC settings. Therefore, further research was warranted that could explore the competencies needed by BHCs in an effort to provide effective behavioral healthcare in IPC settings (Glueck, 2015; Hooper 2014; Marlowe & Hodgson, 2014).

Purpose of the Study

The purpose of this qualitative phenomenological study was to describe the lived experiences of BHCs, who have transitioned from specialty outpatient behavioral healthcare settings to primary care settings. In this study I explored the competencies needed by BHCs to provide effective behavioral healthcare in IPC settings. In this

research study I described the type of skill levels of BHCs appropriate for service

provision in IPC settings.

Research Questions

RQ1: How do BHCs who have transitioned from specialty outpatient behavioral

healthcare settings describe their lived experiences in IPC settings?

RQ2: How do BHCs describe best practices in IPC settings?

Conceptual Framework

For this phenomenological study to understand the lived experiences of BHCs in

IPC settings, the conceptual framework I selected was the systems-based approach,

which is known to be one of the core principles of the PCMH (Beacham et al., 2012).

According to Beacham et al. (2012), BHCs' role as key treatment team members is

important, inseparable, and required in order to provide holistic care in a system-based

approach. According to Jackson et al. (2013), the system-based PCMH is a team-based

care, accessible and comprehensive, requiring care coordination that helps patients

receive a continuum of integrated medical, mental health, and substance use disorders

treatment. According to Chiappelli (2011), the systems-based PCMH encapsulates the

coordinated efforts of the researchers, BHCs, and the patients. Chiappelli (2011) stated

that a systems-based approach is patient-centered and fosters a relationship between a

team of providers and patients with the goal of meeting patients' fundamental and diverse

needs, while respecting their values and preferences. Carver and Jessie (2011) argued that

the systems-based approach of PCMH promotes the provision of person-centered care

rooted in collaborative efforts. Transitioning to an integrated health care setting would

require BHCs to experience a change in mindset and be aware of competencies required in integrated healthcare, enjoining them to adapt clinical skills and intervention styles, relative to a team-based approach and the need to work in collaboration with medical providers to be effective (Beacham et al, 2012; Glueck, 2012).

Nature of the Study

Due to the need for in-depth understanding of the experiences of BHCs in natural settings (IPC settings), I used a qualitative method of inquiry, and interpretive phenomenological analysis approach to analyze themes from the shared meanings and experiences of BHCs who have transitioned to IPC settings (Glueck, 2015). Participants had previously worked in traditional behavioral health centers and currently worked in offices providing IPC in North Carolina. The basic purpose of using a phenomenological study was to select a few BHCs to describe their experiences in their own words (Polkinghorne, 1989, 2005). The selected BHCs allowed me to use critical case samples, which according to Marshal (1996), are subjects who have specific experience relative to a research design.

Definitions

Best practices of effective integrated care: - Collaborative efforts of BHCs and PCPs focusing on integrated medical, mental health, and substance use disorders treatment (Chesher et al., 2012).

Collaborative care model: - An evidence based-based approach for integrating physical and behavioral health services that can be implemented in the IPC setting; care

by a multidisciplinary group of behavioral and medical professionals in a coordinated fashion.

Critical case sampling: - The selection of participants who have specific experience relative to the research design (Marshal, 1996).

Integrated primary health care: - Establishment of curricula, policies, and best practices to provide mental health treatment in primary care settings, with the utilization of qualified professionals and the use of evidenced based treatment modalities (Hooper, 2014).

Integrated treatment: - Simultaneously treating individuals with triply-diagnosed medical, mental health, and substance use disorders. (Chesher et al., 2012; Tew et al., 2010).

Phenomenological research: **-** A method of inquiry that allows researchers to study a small number of participants and describe their lived experiences and develop patterns and relationships of meaning (Polkinghorne, 2005).

Primary care settings: - Community and private facilities where most patients seek help for medical disorders.

Reflexivity: - Researchers' responsibility to make the research process itself the focus of inquiry, lay open pre-conceived ideas, and become aware of situational dynamics in which the interviewer and respondent are jointly involved in knowledge production (Morrow, 2005),

System-based patient care medical home (PCMH): - A team-based care, that is accessible, and comprehensive, requiring care coordination that helps patients to receive

a continuum of integrated medical, mental health, and substance use disorders treatment (Beacham et al., 2012).

Utilization of biopsychosocial approach to care: - Providing integrated treatment beyond treatment of disease and engaging in generic and holistic practices of care irrespective of what conditions the individuals have (Glueck, 2015).

Assumptions

In this research study I assumed that participants would be cooperative and willing to honestly share their experiences to help inform other BHCs and stakeholders. I assumed that transitioning to an IPC setting would result in changes in service provision and treatment modalities, requiring BHCs to make some adjustments. I also assume that selected participants will be able to honestly and accurately describe their experiences.

Scope and Delimitations

This study was focused on BHCs who had transitioned from traditional outpatient behavioral health settings to IPC settings. Making such a transition may result in the BHCs experiencing a different culture, and they may need to change their attitude to ensure best practice in the new environment. In this study, therefore, I sought to understand the competencies required to help BHCs make a smooth transition to provide effective treatment in IPC settings.

North Carolina is at the forefront in the implementation of integrated healthcare (North Carolina Center of Excellence for Integrated Care, n.d.). Fortunately, the leadership at North Carolina Center of Excellence for Integrated care assisted in identification of integrated settings and participant selection. This study was therefore,

limited to a sample of participants from a relatively small geographical area in the Southeastern seaboard of United States.

Limitations

The use of purposeful sampling (Tuckett, 2004) to select participants allowed the selection of BHCs who worked in IPC settings, and were critical case samples, which according to Marshal (1996), are subjects who have specific experience relative to a research design. However, according to Tuckett (2004), this method of sampling may result in issues that undermine the trustworthiness of the study, including gatekeeper bias, sample framing bias, and other logistical issues. Researchers are therefore advised to consider the broader picture of the subjects including individuals' characteristics, and temporal, spatial, and situational influences relative to the context of the study (Marshal, 1996; Morrow, 2005).

Because the issue of purposeful sampling was unavoidable in this study based on the method of inquiry, I approached this research study reflexively. Rennie (2004) defined reflexivity as "self-awareness and agency within that self-awareness" (p. 183). Reflexivity, according to Morrow (2005), is the researchers' responsibility to keep a self-reflective journal from the beginning to the completion of the investigation. Awareness of any assumptions or biases that emerge should be recorded in the journal and these emerging self-understandings should then be examined and consciously incorporated into the analysis. Due to the fact that this study was not randomized, the results of the study would be generalizable only to the participating group. Other BHCs who did not participate in the study may relate to IPC differently.

Significance of the Study

The purpose of this qualitative phenomenological study was to explore the competencies required by BHCs to work in IPC settings. This research study was done to address the competencies required to help BHCs transitioning to IPC settings provide effective treatment. Although researchers have conducted studies focusing on roles and attitudes of BHCs in IPC settings (Glueck, 2015), there is a lack of studies focusing on the formal standardized measures for establishing core competencies of BHCs, hence the need to conduct further research on the type of skill levels of BHCs appropriate for service provision in IPC settings.

Integrating behavioral health care into primary care can potentially benefit rural older adults who seek help mainly in primary care settings for mental and physical stability (Ogbeide, Stermensky, & Rolin, 2016). According to Ogbeide et al. (2016), effective integrated care in primary care settings will address the biopsychosocial aspects of the lives of these individuals and provide generic and holistic care. According to Petersen, Hutchings, Shrader, and Brake (2011), integrated health care has the potential to reduce the healthcare inequalities, morbidity, and mortality among diverse populations through accessibility to treatment, improvement in diagnosis and referral, increase in collaboration among health care professionals, improvement in cross-cultural interface, effective treatment for the medically disenfranchised, and improved compliance to treatment. Consultation and collaborative efforts between medical providers and BHCs can result in education of physicians about the urgent behavioral health needs of the diverse population (Kitts, 2010) and effective communication with psychiatrists and

BHCs about mood changes in individuals with chronic medical problems (Petersen et al., 2011).

On the international level and over three decades after the symbolic and historic World Health Organization-United Nations International Children's Emergency Funds conference in Alma-Ata, world leaders are beginning to recognize the need for integrated primary health care (Khenti et al., 2012). The outcome of this study may encourage organizations and stakeholders to engage in conversations and establish curricula, policies, and best practices that may improve mental health treatment in primary care settings (Hooper, 2014). The outcome of this dissertation may also inform clinical directors to be cognizant of the need for professional development and for shared electronic medical records to improve treatment outcomes (Alvarez, Marroquin, Sandoval & Carlson, 2014).

Considering the current wave of healthcare reforms and the need to provide affordable healthcare, the outcome of this research study will inform the legislature to enact legislations that will require the establishment of credentialing boards and service definitions for BHCs in primary care settings (Alvarez et al., 2014). Tew et al. (2010) argued that with current financial constraints, whereby the federal government and states are cutting budgets and reducing service authorization units, providing integrated treatment will result in cost-effectiveness in healthcare and make healthcare affordable. The outcome of this dissertation will also inform clinical directors to ensure that BHCs employed in IPC settings are well trained interventions and electronic health records to

improve collaboration among professionals and treatment outcomes (Alvarez et al., 2014).

Summary and Transition

In this research study I explored the competencies required by BHCs to provide effective behavioral health services in an IPC setting. One of the issues affecting the healthcare delivery system is uncertainty in the provision of effective treatment for individuals with medical, mental health, and substance use disorders in IPC setting (Chesher et al., 2012; Glueck, 2015). This situation is worsened by the lack of best practices defining the role of BHCs who have transitioned to primary care settings. Various mental health professionals with various backgrounds have transitioned to IPC settings using skills acquired in traditional BHC settings (Glueck, 2015). This phenomenological study used a conceptual framework based on systems approach (Beacham et al., 2012) to study life experiences of BHCs who have transitioned to IPC settings and the competencies required to provide effective treatment in IPC settings.

In Chapter 2 of this dissertation I review scholarly journals and literature on IPC and the effectiveness of triply-diagnosed medical, mental health, and substance abuse treatment with a special focus on clinician competency and collaborative care. Chapter 3 provides a description of research design and rationale, role of the researcher, methodology, participant selection, instrumentation, and data analysis. I also describe appropriate strategies to address issues of trustworthiness in Chapter 3.

Chapter 2: Literature Review

Introduction

Recent research on integration indicates that the health of individuals with triple diagnosis of medical, mental health, and substance use disorders will improve significantly if all disorders are treated simultaneously (Kallenberg, 2015; O'Cleirigh et al., 2015). Kallenberg, (2015) and Miller-Matero et al. (2016) argued that effective integrated treatment could be provided in primary care settings where triply-diagnosed individuals often seek mental health and substance abuse treatment. Research studies on best practices for effective integrated care require collaborative efforts between BHCs and PCPs (Chesher et al., 2012; Glueck, 2015). However, there is growing concern about BHCs who have transitioned to IPC settings from traditional behavioral health care settings in regard to working as part of the medical team without formal trainings to provide effective treatment in integrated settings ((Glueck, 2015). BHCs are therefore left to design and use their own version of care when they transition to IPC settings due to lack of training and education on effective behavioral health care in IPC (Blount & Miller, 2009; Glueck, 2015). Aforementioned studies regarding BHCs in IPC illuminate important findings about BHCs in IPC settings. Therefore, further research is required to explore the competencies needed by BHCs to provide effective behavioral healthcare in IPC settings (Glueck, 2015; Hooper 2014; Marlowe & Hodgson, 2014).

Literature Search Strategy

Research database and scholarly resources I used to search for literatures to review included PsychINFO, SocINDEX, PsychARTICLES**,** Google Scholar, Proquest

and books. I used the following key phrases and words to narrow the search and identify

literature on BHCs and best practices in IPC: - *"integrated primary care," "behavioral*

health clinicians," integrated treatment," "substance abuse," "mental health," medical

integration," and "collaboration."

In this section, I review articles on the conceptual framework and major

theoretical and conceptual propositions, as well as assumptions relevant to the systemic

approach to PCMH. In this section, there is a comprehensive review of current literature

on methodology, researchers' approaches to BHCs and integrated care, as well as

highlights on strengths and weaknesses identified in reviewed literature. I end this

chapter with a summary of the major themes in the literature reviewed. The summary

includes synthesis of the literature reviews and transitional information to connect the gap

in the literature to the methods described in Chapter 3.

Conceptual Framework

In this phenomenological study undertaken to better understand the lived

experiences of BHCs in IPC settings, the conceptual framework selected was the

systems-based approach, which is known to be one of the core principles of (PCMH)

(Beacham et al., 2012). According to Beacham et al. (2012), the role of BHCs as key

treatment team members is important, inseparable, and required in order to provide

holistic care in a system-based approach. According to Jackson et al. (2013), the system-

based PCMH is a team-based care, that is accessible, and comprehensive, requiring care

coordination that helps patients receive a continuum of integrated medical, mental health,

and substance use disorders treatment. According to Chiappelli (2011), the systems-based

PCMH encapsulates the coordinated efforts of the researchers, BHCs, and the patients. Chiappelli (20110 argued that a systems-based approach is patient-centered and fosters relationship between a team of providers and patients with the goal of patients' fundamental and diverse needs, while respecting their values and preferences. According to Carver and Jessie (2011), the systems-based approach of PCMH promotes the provision of person-centered care rooted in collaborative efforts. Transitioning to an IPC setting would require BHCs to experience a change in mindset and be aware of competencies required in integrated healthcare, enjoining them to adapt clinical skills and intervention styles, relative to team-based approach and the need to work in collaboration with medical providers to be effective (Beacham et al., 2012; Glueck, 2012).

The need for a treatment team in integrated care requires that BHCs receive training in clinical health psychology that allows them to develop the competence needed to provide holistic healthcare in IPC settings (Beacham et al., 2012; Cox et al., 2014; Glueck, 2015). Similarly, Aarons (2004) posited that it is apparent that BHCs will be providing services in a different healthcare setting, requiring the development of new attitudes and skills to help guide them to operate in collaborative environment.

Marlowe and Hodgson (2014) posited that health care organizations should be cognizant of the fact that effective IPC requires providers to acknowledge the importance of relational competencies, which require collaboration between PCPs and BHCs in primary care settings. According to Marlowe and Hodgson (2014), effective implementation of IPC will depend on highly developed competencies of providers. Cox et al. (2014) argued that the utilization of collaborative and biopsychosocial approach to

health care to improve integrated treatment will require the training of BHCs to provide

holistic care in IPC. Without training in clinical health psychology, BHCs would use their

own ineffective treatment modalities (Cox et al., 2014). To implement effective

integrated care, it is incumbent upon BHCs and PCPs to acknowledge each other and

mutually build and maintain rapport, while competencies of both PCPs and BHCs are

clearly defined (Marlowe a Hodgson, 2014).

Valentijn, Schepman, Opheij, and Bruijnzeels (2013) concluded in their research

that IPC encompasses a clinical organizations' ability to assess, triage and provide

continuous and coordinated care of individuals with medical, mental health, and

substance use disorders in a professionally collaborative manner. According to Valentijn

et al. the collaborative effort of clinicians demands relational competencies between

PCPs and BHCs in an environment that supports person-centered treatment. Effective

integrated services include encouragement of personal experience in a continuous

manner, provision of person-centered comprehensive services, and effective coordination

of services in horizontal and vertical manners (Valentijn et al., 2013).

Literature Review

The collaborative effort of medical providers and BHCs is paramount to effective

provision of IPC. The following literature review provides insight into the importance of

collaborative care and relational competence of BHCs and medical providers in IPC.

Understanding Integrated Primary Care

The functional conceptualization of IPC is rooted in the provision of person-

centered and population-based care in a holistic approach (Tew et al., 2010; Valentijn et

al., 2013). The person-centered approach is a reflection of biopsychosocial aspects of individuals' health and not just a matter of health care professionals dealing with diagnoses or diseases (Tew et al., 2010; Valentijn et al., 2013). According to Valentijn et al, (2013), the person-centered approach focuses on the idea of bridging the gap between medical and socio-environmental issues in recognition of the fact that diseases encompass medical, psychological, and socio-environmental aspects. In recognition of the fact that behavioral health and medical issues are intertwined, the provision of medical, mental health, and substance use disorders treatments simultaneously, offers triply-diagnosed individuals the opportunity to receive holistic care in a collaborative environment (Valentijn et al., 2013; Vogel, Malcore, Illes, & Kirkpatrick, 2014). Effective IPC should be viewed within the collaborative environment of a macro (systemic), meso (organizational) and micro (clinical integration) levels of integration (Valentijn et al., 2013). In reference to the macro level of integration, researchers argue that both vertical and horizontal integration are needed to support provision of collaborative services and relational competencies of professionals (Beacham et al., 2012; Valentijn et al., 2013; Volgel et al., 2014). According to Valentijn et al., vertical integration refers to the focus on treating diseases by specialized professionals at specialized settings, while horizontal integration focuses on a holistic approach to help improve the overall health of individuals and populations through collaboration of medical providers and BHCs in IPC settings. According to Valentijn et al., effective integration requires provision of biopsychosocial services at different levels in an

integrated setting, supported by intra-professional collaboration and services

coordination.

Pomerantz, Kearney, Wray, Post and McCarthy (2014) posited that communities

and organizations that focus on mental health and overall health of their constituents are

able to successfully address them through IPC. The Veterans Administration's (VA's)

systematic incorporation of behavioral health care into its primary care has resulted in the

improvement of identification and treatment of mental illness and substance abuse in

veterans with triple diagnoses of medical, mental health, and substance use disorders

(Pomerantz et al., 2014). Effective provision of IPC requires collaborative efforts of

PCPs and BHCs (Glueck, 2015). However, Blount and Miller (2009) said that simply

employing BHCs in primary care settings without training and required competencies

will not result in effective integrated care. Cox et al. (2014) posited, therefore, that

academic institutions should train future mental health professionals on effective

provision of behavioral healthcare in primary care settings. The authors suggested that

course requirements of doctoral programs should include health psychology practice

(Cox et al., 2014).

The Patient-Centered Medical Home

PCMH is designed to integrate behavioral health services into primary care

(Beacham et al., 2012). PCMH is designed to offer a patient-centered, comprehensive,

and accessible continuum of care using a systems-based approach (Kaslow et al., 2007).

According to Beacham et al. (2012), considering the duties of the psychologists and other

BHCs in primary care settings, it is expected that the BHCs would serve as consultants or

direct care providers, making their responsibilities inseparable from services provided to other clients in integrated settings. Despite expert conceptualizations that integrated care should include mental health services in primary care, the roles and skills of the BHCs are not well defined (Beacham et al., 2012). Beacham et al. suggested that trainings be required to help BHCs assume professional and leadership status in primary care settings in accordance with the principles of PCMH.

Provision of effective integrated care requires diverse providers and collaboration between PCPs, including physicians and nurses, and BHCs, including, psychologists, mental health and substance abuse counselors. IPC settings and services provided are based on the systems-based approach, which is known to be one of the core principles of PCMH (Beacham et al., 2012). According to Beacham et al. (2012), when PCPs and BHCs collaborate and work as key treatment team members, they are able to provide holistic care in a system-based approach. Mauer (2008) argued that BHCs transitioning to integrated primary settings should be cognizant of the fact that they will be tasked with the provision of services other than mental health and substance abuse treatment. BHC's transitioning to primary care settings would have to also provide interventions that address behavioral medicine issues (Mauer, 2008). Such competence allows appropriate leadership and supervision to assess, monitor, and coordinate services between BHCs, who play an essential role in the evolution of integrated care and PCMH, and PCPs, who may not be experts in behavioral care (Glueck, 2015).

Researchers therefore emphasize that the effectiveness of PCMH in integrated care requires that BHCs receive appropriate training and supervision in clinical health

psychology that allows them to develop the competence needed to collaborate with PCPs in order to provide holistic healthcare in integrated care settings (Glueck, 2015; Hoodin, Beacham, Alschuler & Bierenbaum, 2008; Levant 2004). Similarly, Aarons (2004) suggested that since BHCs and PCP will be providing integrated services in an integrated healthcare setting, requiring the development of new attitudes and skills, they will need appropriate training and supervision to help guide them provide effective treatment in collaborative environment.

Blount and Miller (2009) stated that due to lack of training in clinical psychology, some BHCs working in integrated settings lack training required to provide collaborative services in integrated settings. Similarly, Tew et al. (2010) and Peek (2009) suggested that it is not best practice to have BHCs engage in integrated care in primary care settings without appropriate training and supervision. Marlowe and Hodgson (2014) argued that to implement effective integrated care, leadership in community health centers and integrated settings should encourage BHCs and PCPs to acknowledge each other and work collaboratively, while defining the competencies of both PCPs and BHCs to promote the core principles of PCMH.

BHCs in primary care settings are expected to serve as consultants or direct care providers, making their responsibilities inseparable from services provided to other clients in integrated settings (Beacham et al., 2012). The gap in this literature is the lack of specific competencies and what constitute clinical health psychology and how it can benefit psychologists and other BHCs in primary care settings and in a fast-paced setting of PCMH where patients are diverse. Beacham et al. (2012) proposed that training

programs and funding agencies should accept research designs high in external validity;

training in Real Efficacy, Effectiveness, Adoption, Implementation and Maintenance

(RE-AIM).

The role of BHCs in IPC is not limited to mental health concerns but must include

the understanding of clinical health psychology and how to work collaboratively with

PCPs to help provide holistic treatment to triply diagnosed individuals (Beacham et al.,

2011). According to Beacham, Hodin, Sieber, Ponkshe, and Goodie (2008), the role of

primary care BHCs should include treatment modalities that address behavioral and

medical issues including how to manage clinical illness, prevention services to help

motivate clients to change their behaviors to reduce physical health risks.

The VA has instituted a policy requiring its medical centers and outpatient clinics

with a patient population of more than 10,000 veterans to operate integrated mental

health services (Veteran health Administration, 2008). With the evolution of PCMH and

its importance in primary care and Community Health Care Centers, BHCs will be

considered essential members of the treatment team (Beacham et al., 2011). However,

without recognition of adequate training needs of BHCs, especially those transitioning

from traditional outpatient MHCs, BHCs will not have the competencies needed to

effectively provide holistic treatment in IPC settings (Glueck, 2015; Hodin et al., 2008;

Levant, 2004)

Mental health and substance use disorders greatly affect the course and cost of

treating other chronic illnesses. With budget cuts and reduced service authorization units,

treating these disorders simultaneously will cut healthcare cost, make revenue available

to benefit individuals and communities, and most certainly result in improved treatment

outcome for individuals with triply-diagnosed medical, mental health and substance use

disorders, who would in turn become productive citizens and not burden on the

community (Tew et al., 2010). Secondly, our men and women in uniform, who return

from the battlefield with medical (such as traumatic brain injury), mental health and

substance use disorders, deserve appropriate and comprehensive medical care (Tew et al.,

2010). There is compelling evidence that the Behavioral Health Laboratory (BHL),

according to Tew et al. (2010) is consistent with the guiding principle of the PCMH.

PCMH, implemented by VA, utilizes "chronic illness disease management principle to

render more continuous, coordinated and efficient primary care services to patients with

diverse needs" (p. 130). Successful implementation of PCMH will ensure that qualified

behavioral health professionals are hired to provide mental health and substance abuse

assessment and treatment in a primary care setting (Tew et al., 2010). According to Tew

et al. (2010), this will allow our returning triply-diagnosed veterans get needed help at a

central location. This in turn will improve their health, reduce the burden on families and

communities and help alleviate relationship issues, including domestic violence.

Duplication of PCMH in public and private medical centers will also ensure improvement

of services to triply-diagnosed individuals (Tew et al., 2010).

Behavioral Health Laboratory

Tew et al. (2010) reviewed the Behavioral Health Laboratory (BHL), a program

based on the principles of the Patient-Center Medical Home (PCMH) within the Veteran

Affairs (VA) health care system. This treatment approach applies chronic illness disease

management principles in provision of continuous and coordinated and efficient integrated treatment for individuals with mental health and comorbidity of medical problems in primary care setting. In this study, the authors reviewed the BHL care management model within the Veteran Administration's hospitals and clinics and how the standardized integrated treatment modality provided improved services for the nation's veterans dealing with triple diagnosis of medical, mental health and substance use disorders. Although the authors reviewed the importance of using standardized and comprehensive screening, assessment, treatment and referral to appropriate level of care, they failed to review the role BHCs play in the implementation of the BHL.

Tew et al. (2010) were concerned about the traditional model for the delivery of mental health, whereby there was lack of coordination and collaboration between PCPs and BHCs, which is required to provide comprehensive care to veterans suffering from triply-diagnosed medical, mental health and substance use disorders. The purpose of the research study was to review the effectiveness of the newly implemented BHL and the role of the IPC system in the future of the Veterans Administration's (VA) PCMH (Tew et al., 2010).

Tew et al. (2010) stated that although there is improvement in screening and identification of mental illness by PCPs, fewer veterans with mental illness and chronic medical problems receive adequate follow-up care. According to Tew et al. (2010), the BHL model will ensure that PCPs who play the role of frontline mental health providers, would be able to provide effective, safe and efficient treatment if they a supported by care coordinators to provide effective case management.

Tew et al. (2010) reviewed more than 20 VA facilities together with private insurance companies to determine how they will fit in the PCMH. This was a program evaluation. The authors concluded that the BHL provides mental health needs of veterans with co-occurring medical problems using effective time-limited and evidence-based treatment modality. The BHL also fostered collaboration between the PCP and other professionals with the help of electronic medical records.

Tew et al. (2010) concluded in their research that the success of this protocol will require a shift in culture for both PCPs and BHCs. According to Tew et al. (2010), resistant to change in mind set and attitude of physicians and BHCs will result in lack of collaboration and PCPs' failure to utilize available services. The authors argued that PCPs may not have time to deal with severely mentally ill client and may also overlook mild to moderately affected patients who may benefit from care coordination and case management. The authors suggested that other services for pain management, alcohol dependence, posttraumatic stress and sleep disorders be added.

Behavioral Health Training and Inter-professional Collaboration.

Cox, Adams and Loughran (2014) conducted research to explore the training efforts of two universities and the outcome of trained mental health professionals and effective provision of behavioral healthcare in primary care settings. The authors discussed the course requirements of doctoral programs in health psychology practice (Cox et al., 2014). The study described the outcome of a research study of four psychology students in IPC setting (Cox et al., 2014). The study then explored six themes, including "mental health culture, primary care context, challenging entry,

adapting to the primary care context, managing complex cases, and results of the collaborative process" (Cox et al., 2014, p 115).

The study participants were trained in a graduate program that was accredited by American Psychological Association (APA) (Cox et al., 2014). According to Cox et al. (2014) participant were of different cultural background and representatives of three ethnicities. The sampling procedure was purposeful and theoretical, and the researchers used one on one and focused group interviews (Cox et al., 2014). The focused group was used to exhaust, saturate and clarify comments made by participants. The researchers used qualitative data analysis and interpreted data to uncover and developed empirical knowledge (Gorbin & Strauss, 2008; Cox et al., 2014).

The study participants also participated in treatment team meetings to understand medical aspects of patients in primary care (Cox et al., 2014). According to Cox et al. (2014), the collaborative effort benefitted both study participants and patients. The study participants increased their primary care counseling related competencies and patients had increased access to mental health services and resultant improvement of health. Blount and Miller (2009) posited that it is incumbent upon administrators and management as well as proponents of integrated care to realize that training and education of BHCs is required to effectively practice in IPC and effect positive treatment outcomes. According to Blount and Miller (2009), there is a need to address the shortage of experienced and competent BHCs in primary care settings. Blount and Miller (2009) argued that transitioning of BHCs and the rush to employ BHCs straight from specialty mental health settings into primary care may have negative effect on treatment outcomes

and may result in program failure due to poor skills fit, inappropriate treatment modalities, assumptions about services needed, and routines of traditional and specialty behavioral health care practice these clinicians bring from their specialty behavioral health settings. Peek (2009) argued that BHCs and PCPs should realize that there are personal specific factors that often interfere with the care of triply-diagnosed individuals, requiring BHCs working in IPC settings to work collaboratively with PCPs to move beyond treatment of disease and engage in generic and holistic practices of care irrespective of clients' presenting problems. According to Peek (2009) this holistic approach of integrated health care would need specialized trained BHCs by an accredited body.

Attitude of Medical Providers in Integrated Primary Care

Torrence et al. (2014) argued that integrated medical and behavioral health treatment increases service utilization and help improve treatment outcomes. In their research study, the authors examined the attitudes of PCPs and the perceptions of BHCs in IPC settings with the utilization of self-report measures. In this research, the authors provided 6-item surveys to 45 medical providers (MP) who worked in healthcare system that included integrated behavioral health services. The survey items assessed the attitude of the MPs and perceptions about BHCs. The outcome of the study indicated that MPs who interacted more with BHCs felt comfortable discussing mental health and substance abuse issues with their patients. The authors argued that adding behavioral health services to primary care most often increase service utilization and improve care for triply diagnosed individuals.

Despite the favorable results, there were some limitations. The authors argued that due to the nature of the survey that was brief to encourage higher response, they could not obtain in-depth information. The research design prevented the authors from obtaining and understanding the qualitative aspect of the survey, including the reason why some providers had neutral and unfavorable beliefs about behavioral health care. Due to the limited number of providers, the authors reported that there was social desirability response bias. The survey also failed to address the roles and competencies of BHCs and what motivated BHCs in IPC settings. Such research study could be done through a qualitative phenomenological approach to explore the lived experiences of BHCs in IPC settings. Qualitative method of inquiry, interpretive phenomenological analysis approach is appropriate to analyze themes and the shared meanings and experiences of BHCs working in IPC settings (Glueck, 2015).

Roles of Behavioral Health Clinicians in Integrated Primary Care

Although many research studies focus on the effectiveness of mental health providers working as BHCs, there is lack of research on the roles, attitudes and training needs of BHCs in IPC (Blount, 2009: Glueck, 2015). There is growing concern that currently, there are mental health professionals with various backgrounds working as BHCs using their trainings and skills attained in specialty settings to work as part of the medical team in IPC settings (Blount & Miller, 2009: Glueck, 2015; Tew et al, 2010). According to Tew et al. (2010), in the absence of licensure or accreditation body relative to integrated behavioral health practice, counselors are left to design and apply their own

version of care. There are questions about their roles, attitudes, preparation and motivation for IPC.

To determine the roles of BHCs researchers have used qualitative study to explore the experiences of BHCs who provide behavioral health services in IPC in an effort to understand their roles, attitudes and training needs (Glueck, 2015). According to Glueck (2015), there is the need to identify the characteristics of BHCs and their effectiveness in the provision of integrated treatment. Researchers argued that due to the fact that BHCs are engaged in the provision of services in an IPC, they would play different roles relative to making a career change (Christian & Curtis, 2012). Aarons (2004) argued that it is incumbent upon mental health practitioners to realize that attitudes can guide decisions about beginning a new career, training and treatment in a different healthcare setting. Due to change in mindset and differences in service provision in outpatient behavioral health center versus service provision in integrated healthcare setting, BHCs would need to adapt their clinical skills and intervention style to meet demands in primary care settings (Glueck, 2015). Similarly, Tew et al. (2010) and Peek (2009) argued that it is not best practice to have BHCs engage in integrated care in primary care settings without appropriate training and supervision.

In a recent study to determine the roles and competencies of BHCs in primary care settings Glueck (2015) used qualitative method of inquiry, interpretive phenomenological analysis approach to explore the shared meaning of BHCs working in IPC settings. The results of this study are generalizable only the participating group (Glueck, 2015). Other BHCs who did not participate in the study may relate to IPC

differently (Glueck, 2015). This was not a randomized study (Glueck, 2015). According to Glueck (2015), since the current situation in integrated care does not have formal standardized measure to establish competencies of BHCs, future research should focus on "specifically the type of behavioral health interventions, theory and techniques utilized, and the skill level of BHCs" (p. 186).

Behavioral Health and Interprofessional Collaboration in Integrated Setting

Collaboration of care among BHCs and PCPs have contributed to effective provision of integrated care. Marlowe and Hodgson (2014) argued that to implement effective integrated care, it is incumbent upon BHCs and PCPs to acknowledge each other and mutually build and maintain rapport, while competencies of both PCPs and BHCs are clearly defined. According to Boon, Verhoef, O'Hara and Findlay (2004), it is incumbent upon administration and supervisors in integrated settings should be aware of the individuality among providers, including PCPs and BHCs that exists in integrated settings. Boon et al. (2004) argued that management and supervisors should be cognizant of the fact that there are four components of integrative health care practice, including "philosophy or value, structure, process and outcome" (p. 2). Effective provision of collaborative care requires that management understanding of these practices to help them resolve issues surrounding collaboration among professionals in an effort to encourage relational competence (Beacham et al., 2012; Boon et al., 2004).

In reference to philosophy or value, management should realize increasing diversity of team members acquired diversity of health care philosophies due to the involvement (Boon et al., 2004) of a wider range of team members from different

disciplines and from the increasing involvement of each team member (Boon et al.,

2004). It is incumbent upon management to realize that PCPs have developed

philosophical tendencies towards biomedical model of disease model, which often

conflict with the biopsychosocial and spiritual model of holistic approach in integrated

treatment with greater emphasis on the treatment of the whole person in his/her social,

environmental and cultural context and a greater recognition of an increased number and

variety of determinants of health (Boon et al., 2004). PCPs' reliance on the biomedical

model of disease would be challenged, requiring them to minimize and to some extent

dispute with their philosophical values and compromise with BHCs while working in

integrated setting (Beacham et al., 2012; Boon et al., 2004).

Management should be aware that integrated treatment relates to increase in the

complexity of the structure of the team-oriented practice model. This requires

management to clarify roles and recognize that formal hierarchical structure decrease,

with emergence of structures that facilitate team building and development of trust and

respect among BHCs and PCPs (Boon et al., 2004). In integrated care setting,

communication between and among providers must increase as professionals who are

actively involved in the process of care of one patient increase (Boon et al., 2004).

Providers should recognize that respect for diversity of opinions and attempts at making

consensus-based decisions also increase among practitioners, limiting their individual

autonomy, as they are called to work more closely together in delivering patient care

(Boon et al., 2004; Torrence, 2014). Synergy among the component services, programs

and care givers increases in integrated settings (Boon et al., 2004).

Motivated Behavioral Health Clinicians and Primary Care Providers and Effective

Integrated Primary Care

Recent research studies have concluded that biopsychosocial approach to care is a considered best practice in IPC, requiring the treatment of the whole person and the need to have BHCs available at Emergency Departments and primary care settings where triply-diagnosed individuals often seek care (Glueck, 2015; Hooper, 2014). Blount and Miller (2009) and Glueck (2015) argued that collaboration between PCP and mental health clinicians can significantly improve the services provided to address "spectrum of problems that patients bring to their primary medical care providers" (p. 175). Since the culture of primary care settings is different from regular outpatient mental health settings, mental health clinician would have to adapt to the provision of mental health services in primary care settings (Glueck, 2015; Hooper 2014). According to Glueck (2015), primary care professionals provide services at a pace that allows for solution focused brief interventions and the frequency of services is based on a different model than it is in the outpatient mental health settings.

Researchers have long observed that primary care settings and physicians have important roles to play in integrated medical, mental health and substance abuse treatment (Hooper, 2014). According to Hooper (2014), PCPs have traditionally been the sole providers of brief counseling and prescription of psychotropic medications for most individuals with mental health disorders, especially among underserved, and individuals with lower socio-economic status, as well as the racial minority populations. The role of BHCs in integrated treatment is also needed to fill the services and treatment gap.

Though researchers have increased their advocacy for the incorporation of mental health services into primary care, little effort is being done to "promote the transportability of counseling theories and culturally sensitive counseling practices to primary care settings (Hooper, 2014, p. 95). Experts are concerned that little research is done on provider motivation to adopt researched and evidence-based integrated treatment modalities and put them into practice in a primary care setting to improve integrated treatment and help motivate clients to enhance their self-efficacy (Glueck, 2015; Hooper 2014). There is therefore, the need for future research to focus on the usefulness of motivated BHCs and PCPs and effective provision of integrated medical, mental health and substance use disorders treatment in primary care settings.

Limited research studies have been done to examine the effectiveness of motivated behavioral healthcare clinicians (BHCs) and enhancement of patient's self-efficacy, reduction in clients' resistance and effective integrated medical, mental health and substance use disorders treatment in a primary care setting (VanBuskirk & Wetherell, 2014). Researchers have often focused on client motivation to effect positive changes and lack of research on motivated BHCs to adopt researched and evidence-based competencies and put them into practice in a primary care setting to improve integrated treatment and help motivate clients to enhance their self-efficacy (Glueck, 2015; Hooper 2014).

Effective Treatment Modalities in Integrated Primary Care

Individuals dealing with medical, mental health and substance use disorders, continue to receive inadequate treatment despite years of discussions on integrated

treatment (Chesher et al, 2012; Glueck, 2015). Researchers have argued that Transtheoretical model of treatment helps providers identify individuals' stage of readiness, which makes it easy for providers to meet triply-diagnosed patients where they are and to help provide effective integrated treatment accordingly (Whetten et al.'s, 2006).

According to Forbes (2011), motivation is directed by the desire to effect positive change in the circumstances of the motivated individual. In pursuing change, Forbes (2011) argued that it is important for individuals to be cognizant of aspirational focus, including intrapsychic, which is change of one's sense of self; instrumental, which is change in one's relationship with the outside world; and interpersonal, which is change in one's social relationships. According to Miller and Tonigan (1996), motivation for change is a multifaceted construct and is regarded as prerequisite for responsiveness to change. Sniehotta (2009) argued that individuals' behavior changes are preceded by their motivation, which is their intentions or goals to perform assigned or intended task. According to Sniehotta (2009), individual's motivation becomes the most important proximal predictor of respective behavior change.

Clinicians are always eager to find frame of reference that can help them understand the cause of behavior change. Motivational readiness to change is posited by researchers to be one of the determining factors of treatment outcome for patients with alcohol and other drug use disorders (Ilgen, McKellar, Moos & Finney, 2006). According to Ilgen et al. (2006), treatment outcomes are predicted by client's motivation prior to initiation of treatment. Researchers have therefore used psychosocial interventions to

strengthen motivation in individuals with mental illness, alcohol and other drug use

disorders, especially clients who report low motivation at the beginning of treatment.

Researchers using Project MATCH to test the effectiveness of Motivational

Enhancement Therapy (MET), Cognitive Behavioral Therapy (CBT) and 12-Step

Facilitation (TSF) with individuals with alcohol use disorders, concluded that patients

randomized to MET did better than patients randomized to CBT or TSF (Babor & Del

Boca, 2003; DiClemente, Carbonari, Zweben, Morrel & Lee, 2001). The outcome was

attributed to the match between MET and patients with low motivation that produced

better therapeutic alliance and enhancement of self-efficacy in patients, which in turn

motivated them to quit using alcohol and maintain abstinence (Babor & Del Boca, 2003;

Diclemente et al., 2001). According to Miller and Tonigan (1996), client motivation to

change problem drinking has been attributed to the therapeutic alliance, therapist style

and environmental characteristics. Prochaska and DiClemente (1992) developed the

transtheoretical model depicting the stages of change from precontemplation, a stage of

unawareness of problem or need for change to the stage of ambivalence or contemplation,

through preparation, action and maintenance stages. As the client's progress through the

stages, they are motivated by their awareness of the adverse consequences (cons), which

outweighs the perceived advantages (pros) to quit and maintain abstinence. Clients'

successes in treatment in turn motivate them to maintain abstinence and help others

(Prochaska, DiClemente & Norcross, 1992).

Client therapist alliance is necessary to motivate client to change in substance

abuse counseling. Based on the transtheoretical theory, it is apparent that the more

directive, action-oriented counselor would find clients who are at contemplative stage to be highly resistant to their counseling styles (DiClemente, 2005; Prochaska & DiClemente, 1992). It is therefore incumbent upon counselors to acknowledge the fact that lack of motivational enhancement will lead to increased client resistance. According to Ilgen et al. (2006), "motivational readiness to change is important to improve treatment outcomes for alcohol use disorders" (p. 160).

Although there are studies examining the effect of BHCs on health outcomes of triply diagnosed individuals (Glueck, 2015), they failed to study effective evidence-based treatment modalities. Hence the need to reference a research on the type of behavioral health interventions, theory and techniques that can be utilized to improve the skill level and competence of BHCs appropriate for service provision in IPC settings. Motivational enhancement approach becomes one to the evidence-based treatment modality that could be added to the required competence of BHCs working or aspiring to work in an IPC setting.

Impact of Integrated Care on Social Change

Integrating behavioral health care into primary care can potentially benefit rural older adults who seek help for mental and physical stability, mainly in primary care settings (Ogbeide et al., 2016). Ogbeide et al. (2016) argued that effective integrated care in primary care settings will address the biopsychosocial aspects of their lives and provide generic and holistic care. Petersen et al. (2011) argued integrated health care has the potential to reduce the healthcare inequalities, morbidity, and mortality among diverse populations through accessibility to treatment, improvement in diagnosing and

referral, increase in collaboration among health care professionals, improvement in cross cultural interface, effective treatment for medically disenfranchised and improve compliance to treatment. Consultation and collaborative efforts between medical providers and BHCs can result in education of physicians about the urgent behavioral health needs of the diverse population (Kitts, 2010) and effective communication with psychiatrists and BHCs about mood changes in individuals with chronic medical problems (Petersen et al., 2011).

On the international level and over three decades after the symbolic and historic World Health Organization-United Nations International Children's Emergency Funds conference in Alma-Ata, world leaders are beginning to recognize the need for integrated primary health care (Khenti et al., 2012). Organizations and stakeholders are being encouraged to engage in conversations, establish curricula, policies and best practices that may improve mental health treatment in primary care settings (Hooper, 2014).

Patients' medical conditions may worsen if they are not simultaneously treated with their mental health and substance use disorders (Chesher et al., 2012). Similarly, Tew et al. (2010) stated that mental health and substance use disorders could tremendously affect the course and treatment outcome of chronic medical illness in individuals with triply-diagnosed medical, mental health and substance use disorders. According to Glueck (2015), effective provision of integrated care would require uniformity and standardized competence to change the mindset of BHCs with various backgrounds, trainings and skills, who have transitioned to IPC settings. According to Glueck (2015), in the absence of licensure or accreditation body relative to integrated

behavioral health practice, counselors are left to design and apply their own version of treatment modalities that may not be effective in integrated care. Although the aforementioned research regarding the employment and training of competent BHCs to ensure effective integrated healthcare illuminates important concerns, limited research studies have been conducted to explored the competencies of behavioral healthcare clinicians (BHCs) and enhancement of patient's self-efficacy, reduction in clients' resistance and effective integrated medical, mental health and substance use disorders treatment in primary care settings (Glueck, 2015; Hooper 2014; Marlowe & Hodgson, 2014). Given such, further research is warranted that could examine the importance of motivated BHCs to adopt researched and evidence-based competencies and put them into practice in a primary care setting for effective provision of integrated medical, mental health and substance use disorders treatment in an effort to address the problem of ineffective integrated healthcare and increased client resistance to treatment (Glueck, 2015; Hooper 2014; Marlowe & Hodgson, 2014).

Integrating behavioral health care into primary care can potentially benefit women, racial and ethnic minorities, as well as other disenfranchised in poor communities, hence contributing to the effective healthcare for all in America (Petersen et al, 2011). According to Petersen et al. (2011), integrated health care has the potential to reduce the healthcare inequalities, morbidity, and mortality among diverse populations through accessibility to treatment, improvement in diagnosing and referral, increase in collaboration among health care professionals, improvement in cross cultural interface, effective treatment for medically disenfranchised and improve compliance to treatment.

Consultation and collaborative efforts between medical providers and BHCs can result in education of physicians about the urgent healthcare needs of the culturally diverse community (Kitts, 2010) and effective communication with psychiatrists and BHCs about mood changes in HIV positive clients (Petersen et al., 2011).

After the historic World Health Organization-United Nations International Children's Emergency Funds conference in Alma-Ata several decades ago, organizations and world leaders are beginning to recognize the need for integrated primary health care (Khenti et al., 2012). Research on integrated care will encourage organizations and stakeholders to engage in conversations, establish curricula, policies and best practices that will improve mental health treatment in primary care settings (Hooper, 2014). The outcome of research studies on integrated care will also inform the WHO to persuade leaders in developing countries to define the role of BHCs in primary health care (Khenti et al., 2012).

Considering the current wave of healthcare reforms and the need to provide affordable healthcare, research study on integrated care will inform the legislature to enact legislations that will require the establishment of credentialing boards and service definitions for BHCs in primary care settings (Alvarez et al., 2014). Tew et al. (2010) argued that with current financial constraints, whereby the federal government and States are cutting budgets and reducing service authorization units, providing integrated treatment will result in cost-effectiveness in healthcare and make healthcare affordable. The outcome of research studies on integrated care will also inform clinical directors to

be cognizant of the need for professional development and the need for shared electronic

medical records to improve treatment outcomes (Alvarez et al., 2014).

Whetten et al. (2006) argued that integrated medical, mental illness and substance

abuse treatment resulted in improvement in mental health, decrease in substance use and

hospital admissions for individuals with HIV infection, mental health and substance use

disorders. Stoner and Gold (2012) concluded in their research that there was initial

success in the "money follow the whole person in Texas" (para. 3), a program in Texas in

which health insurance is offered to support integration of mental health and substance

abuse treatment into home and community-based services (HCBS) for patients

transitioning from nursing facilities to HCBS. Tew et al. (2010) echoed this finding with

their report on the collaborative efforts of Veterans Administration's healthcare system

and the private insurance agencies in the implementation of integrated treatment program

to provide effective care to triply diagnose veterans with medical problems and

comorbidity of mental health and substance use disorders in a setting described as

"Behavioral Health Laboratory (BHL) care management model" (p. 130).

Tew et al. (2010) argued that mental health and substance use disorders greatly

affect the course and cost of treating other chronic illnesses. With budget cuts and

reduced service authorization units, treating these disorders simultaneously will cut

healthcare cost, make revenue available to benefit individuals and communities, and most

certainly result in improved treatment outcome for individuals with triply-diagnosed

medical, mental health and substance use disorders, who would in turn become

productive citizens and not burden on the community (Tew et al., 2010). Secondly, the

men and women in uniform, who return from the battlefield with medical (such as

traumatic brain injury), mental health and substance use disorders, deserve appropriate

and comprehensive medical care (Tew et al., 2010). There is compelling evidence that the

Behavioral Health Laboratory (BHL) which is consistent with the guiding principle of the

Patient-Center Medical Home (PCMH) and implemented by Veterans Administration

(VA), utilizes "chronic illness disease management principle to render more continuous,

coordinated and efficient primary care services to veterans with diverse needs (Tew et al.,

2010). Successful implementation of PCMH will ensure that qualified BHCs are hired to

provide mental health and substance abuse assessment and treatment in a primary care

setting (Tew et al., 2010). This will allow our returning triply-diagnosed veterans get

needed help at a central location and improve their overall wellbeing and become

productive citizens in their various communities (Tew et al., 2010). The challenge posed

for the implementation of successful integrated treatment setting is the use of uniform,

effective and reliable standardized assessment tools, interview and appropriate treatment

techniques by qualified BHCs to effectively diagnose mental health and substance use

disorders in a primary care setting (Tew et al., 2010).

Effectiveness of Evidence Based Treatment Modalities in Primary Care Settings.

The theoretical framework for effective treatment of behavioral health issues in

triply- diagnosed individuals is based on the following treatment modalities:

Transtheoretical model of behavior change (DiClemente & Prochaska, 1982); Evidenced-

based treatment for dually diagnosed individuals (Drake et al., 2011); Cognitive

Behavioral therapy (Beck, 2011); and Therapeutic Community (TC) model (De Leon, 2010)

The Transtheoretical model of behavior change is based on the work of Prochaska and DiClemente (1982) who argued that changes occur overtime in five distinct stages of change (precontemplation, contemplation, preparation., action and maintenance stages). The Transtheoretical model identifies an individual's stage of readiness, making it easy to meet the patients where they are and to help provide treatment accordingly. To successfully apply this modality to triply diagnosed individuals, BHCs are required to assess readiness for behavior change for all three diagnoses, and plan treatment objectives that are congruent with the stage of behavior for each diagnosis (Whetten et al., 2006, p. 19). The Transtheoretical therapy originated from the following variables: Preconditioning of therapy, process of change, content of change and therapeutic relationship (Prochaska & DiClemente, 1982).

Velasquez, Maurer, Crouch and DiClemente (2001) in their analysis of the Transtheoretical theory, stated that "engines of Change" (p. 8) are the experiential process, which is associated with consciousness raising and self-reevaluation, and behavioral processes, which is associated with stimulus control and self-liberation. The limitation to this model is that the more directive and action-oriented therapist would find clients who are at contemplative stage to be highly resistant to their therapies (Prochaska & DiClemente, 1982).

Regarding other treatment modalities that have been used successfully to treat dually diagnosed individuals, the following components were identified by Drake et al.

(2011); Assertive client outreach that include, motivational enhance approach, cognitive behavioral therapy(CBT), case management to assess, monitor and coordinate services among professionals and agencies and Therapeutic Community model.

Therapeutic Community (TC) model is used primarily in residential settings. De Leon (2000) described therapeutic community as a "powerful treatment approach for substance abuse and related problems in life" (p. 3). De Leon (2000) referred to TC as a self-help approach which is very sophisticated and used to treat the whole person through the use of peer community process and often provided additional services such as family therapy, psychoeducation, vocational rehabilitation, medical and mental health services. The limitation to therapeutic community model is rule blurring between staff, patients and group responsibilities become nobody's responsibility and individual needs may not be met.

The next treatment modality is the use of medication in combination with cognitive behavioral therapy (CBT) in both outpatient and residential settings. Anton et al. (1999) argued that Naltrexone can reduce the high associated with alcohol use and drastically reduce the level of intoxication, while CBT has been shown to address issues of craving, management of slip drinking and reduction of relapse episodes. The use of pharmacotherapy is essential in crisis stabilization and helps clients become motivated enough to adhere to treatment recommendations and maintain abstinence.

Beck (2011) describes CBT as interconnection between thought, feelings and behaviors and the resultant consequences. Through psychoeducation, clients are able to discover the conflict between their self-talk and perception of events that cause ill-

feelings and resultant behaviors, including substance abuse. Beck (2011) argues that through CBT, clients are able to develop coping skills to help them maintain sobriety and prevent relapse on alcohol and other drugs. There have been several studies on the effectiveness of CBT in the treatment of dually diagnosed individuals. Not enough research data is available on the effectiveness of CBT in the treatment of triply diagnosed individuals with medical, mental health and substance use disorder.

Preparing the Workforce for Behavioral Health and Primary Care Integration

In the wake of IPC becoming a reality, it has become incumbent upon healthcare organizations to work together to prepare health care professionals including BHCs primary care clinicians (PCCs) and train them to develop skills and competencies needed to work collaboratively and effectively in primary care settings (Hall et al, 2015). Researchers are concerned about the current situation, whereby PCCs and BHCs, who are trained in discipline specific silos and with different clinical orientations are currently employed in the same IPC settings to provide shared patient-centered care (Blount & Miller, 2009; Hall, 2015). Mauer (2008) argued that BHCs transitioning to integrated primary settings are expected to provide services other than mental health and substance abuse treatment and would have to also provide interventions that address behavioral medicine issues. Aarons (2004) argued that in addition to the responsibilities of BHCs and PCCs to provide integrated services in integrated healthcare settings, there is a need for them to develop new attitudes and skills, and appropriate training and supervision to help guide them provide effective treatment in collaborative environment. Boon et al. (2004) argued it is incumbent upon the healthcare establishment to be aware of the

individuality among providers, including PCPs and BHCs that exists in integrated

settings.

Hall et al. (2015) conducted cross-case comparison study of 19 IPC settings to

identify these organizations' preparedness towards integrated behavioral and primary

care. According to Hall et al. (2015), a well-established primary care requires that BHCs

and PCPs, including medical doctors and support staff work together with patience to

address patients' behavioral and medical needs. The sample for this study was

purposefully chosen and studied for over 3 years. In this study, the authors visited the

selected sites 2-5 days and with the help of trained researchers observed and interviewed

both BHCs and PCCs as they provided their daily clinical assignments. The researchers

used semistructured interviews with 8-12 BHCs and PCCs at each location. The

semistructured interviews allowed BHCs and PCCs to share their lived experiences and

information about their training needs and organizational socialization and orientation

offered to prepare them to work in integrated settings (Hall et al., 2015). Hall et al. (2015)

observed that the integrated settings had difficulty recruiting BHCs and PCCs with prior

experience in integrated care. There was a significant gap between providers'

competencies and required experience needed to practice in integrated care. Concerning

training needs, the authors determined that, especially new integrated settings had

difficulty providing appropriate trainings for their clinicians and where trainings were

provided, they were not sufficient to help clinicians meet required competencies to work

collaboratively in integrated settings. Hall et al. (2015) argued standardization of the

skills and competencies BHCs and PCCs require for effective provision of integrated care

was lacking. Hall et al. (2015) argued integrated care settings need orientation and continued education of best practices in integrated care to help newly employed and experienced clinicians learn and continue to provide effective collaborative care.

Hall et al. (2015) acknowledged that there were some limitations to their research study, including selection and observer bias, which was mitigated by multi-disciplinary team involvement in data collection and analysis. Hall et al. (2015) concluded that PCCs and BHCs lack required trainings and experience to provide effective integrated care. Academic and graduate programs are required to meet the demand for training the workforce that is competent to provide effective and collaborative integrated care (Hall et al., 2015). Organizations are therefore encouraged to prepare and support PCCs and BHCs to increase their skills and competencies required to provide effective integrated care (Hall et al., 2015).

Summary and Conclusions

The literature review indicated that there are gaps including the lack of approved competencies, as well as effective treatment modality to treat triply diagnosed individuals with medical, mental and substance use disorders in IPC settings. It has become apparent that implementation of integrated treatment for triply diagnosed individuals is in an infant stage. Further research on this issue is needed to find uniform assessment tools, effective screening, triage and referral system, and patient-centered medical homes to help improve collaboration between BHCs and PCPs.

The literature review revealed that the use of qualitative method of inquiry, interpretive phenomenological approach would be appropriate to explore the lived

experience of BHCs in IPC settings. This method of inquiry would help identify and analyze themes and meanings of live experience of BHCs from several IPC settings. Some of the literature reviewed focused on the exploration of the training of interns using a course in graduate programs to prepare students for employment in integrated treatment. Although the training of psychology graduates would help in effective provision of behavioral care in integrated setting, the BHCs currently working in IPC settings would benefit from the outcome of research studies on primary care settings to explore the competencies required to provide effective behavioral health care services by mental health and substance abuse professionals. It is therefore apparent that there is a need to identify the competencies and characteristics of mental health professionals and their effectiveness in the provision of integrated treatment.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to describe the lived experiences of BHCs, who had transitioned from specialty outpatient behavioral healthcare settings to primary care settings. Current research studies have focused on the importance of incorporating mental health services into primary care. However, there has been little effort to explore the lived experience of BHCs who have transitioned from traditional outpatient behavioral health centers to IPC settings.

This chapter is devoted to description of research design and rationale, role of researcher, and methodology, including participant selection, instrumentation, and data analysis. The research design and rationale section includes research questions and the definition of the central concepts and phenomena of the research study, as well as the rationale for the chosen research method. In the role of researcher section, I define and explains my role as an interviewer, including biases and ethical issues. The methodology section presents (a) a thorough identification and justification of the participant selection strategy; (b) identification of the data collection instrument and its source, including the establishment of the sufficiency of data collection instruments to answer the research questions; (c) the procedures for recruitment; (d) the data analysis plan; and (e) a description of issues of trustworthiness, including credibility, transferability, dependability, confirmability and ethical procedures.

Research Design and Rationale

The research purpose, conceptual frameworks of selected articles reviewed, and the fact that this research study was conducted to explore the lived experience of BHCs in primary care settings led to the following research questions.

RQ1: How do BHCs who have transitioned from specialty outpatient behavioral healthcare settings describe their lived experiences in IPC settings?

RQ 2: How do BHCs describe best practices in IPC settings?

The fundamental purpose of my dissertation was to explore the type and level of skills required of BHCs to provide effective behavioral health care in IPC settings. Laverty (2003) argued that phenomenology helps gain profound understanding of the meaning of our everyday experiences. Incorporating phenomenology in a framework for research study helps to capture the principle of the experience of participants (Moustakas, 1994; Smith, Flowers & Larkin, 2009; Van Manen, 1990). Although the understanding comes from the conscious mind, the experience must be described, explicated, and interpreted (Smith et al., 2009). It is also apparent that phenomenology does not contain an obvious theoretical orientation, and because my main aim and objective was to find the meaning of the lived experience from the research participants, interpretive phenomenological method of inquiry (Smith et al., 2009) was the appropriate method of inquiry for my dissertation.

The purpose of inquiry depends on the research questions and the perspectives of the researcher (Dicicco-Bloom & Crabtree, 2006). According to Dicicco-Bloom and Crabtree (2006), researchers who seek to explore lived experience of participants use

different forms of qualitative interviewing that allows participants to share rich

descriptions of the phenomena, leaving the interpretation and analysis to the researcher.

The promise of IPC can be achieved through acknowledging the significance of relational

competencies and collaborative efforts between PCPs and BHCs in IPC settings

(Marlowe & Hodgson, 2014). According to Marlowe and Hodgson (2014), it would be

incumbent upon BHCs and PCPs to acknowledge each other and share resources in order

to achieve effective implementation of integrated care. Marlowe and Hodgson argued that

required standards and competencies of BHCs in integrated care setting can help improve

service provision and accelerate the process, practice, and effectiveness of integrated

care. Therefore, in designing this research study, I focused attention on questions that

would help gather data that would lead to a textual and structural description of

experience of participants in order to help understand their common experiences (Gibbs

& Taylor, 2005).

Role of the Researcher

Although observation is important in a qualitative study, researchers encounter

difficulties interpreting the meaning of events observed without interviewing the people

involved. According to McDougall (2000), interviewing adds to the observation of the

"perceptions and sense making of the people being studied" (p. 417). McDougall argued

that the most rewarding component of any qualitative research project is interviewing.

According to Dicicco-Bloom and Crabtree (2006), researchers who seek to explore lived

experience of participants use different forms of qualitative interviewing that allow

participants to share rich descriptions of the phenomena, leaving the interpretation and analysis to the researcher.

Due to prior literature reviews and awareness of conceptual frameworks and my profession as a BHC, it is apparent that I began this research study with several preconceived ideas and themes that I anticipated may be generated from my data collection. Additionally, in reference to the theoretical and conceptual framework, the research questions and purpose of my study, which was to explore the lived experience of BHCs in IPC settings, I expected certain skill levels and competencies to emerge in my data analysis. Clancy (2014) posited that precoding helps build on, as well as corroborate previous research and investigation.

The awareness of preconceived ideas, therefore, impelled me to conduct this research study using a phenomenological approach. Therefore, I began my dissertation by writing down my reflections for reference during the analysis process (Carolan, 2003). Clancy (2013) posited that reflexivity helps qualitative researchers evaluate and develop explicit awareness of themselves, including their "positionality" (p. 13) or particular perspective, revealing their values, beliefs, and ambitions that might influence the outcome of a research study. Similarly, Carolan (2003) argued that reflection helps researchers become aware of their biases and assumptions in order to bracket them, or set them aside, so that they may engage the data collection and analysis experience without preconceived notions about what will be found in the investigation. This awareness is seen as a protection from imposing the assumptions or biases of the researcher on the study (Carolan, 2003; Clancy, 2013).

Qualitative researchers are aware of the fact that in qualitative research, especially during the interview process and when using interpretive phenomenological analysis, attention should be paid to the understanding of individuals' experiences through interpretation (Clancy, 2013). Clancy (2013) argued that in an effort to make sense of selected participants' experiences, a double hermeneutic may be created. Similarly, Laverty (2003) argued that when researchers decide to study lived experience from a hermeneutic or phenomenological perspective, researchers begin the process with self-reflection. It is typical for the phenomenologist to begin research by writing down these reflections for reference during the analysis process (Carolan, 2003), in order to bracket them, or set them aside. It is therefore, important to engage in a process of reflexivity, which allows the researcher to provide a credible and plausible explanation of participants' accounts and avoid assumptions (Clancy, 2013; Janesick, 1999, 2011).

According to Clancy (2013), reflexivity is a process by which researchers are able to evaluate and develop explicit awareness of themselves, including their values, beliefs and ambitions that might influence the outcome of a research study. Reflexivity is therefore researchers' way of questioning their attitudes, thoughts, reactions, and habitual actions in an effort to understand their roles in reference to the participants (Clancy, 2013). Therefore, I conducted the research study using in-depth self-analysis in order to become fully aware of any preconceptions that I might harbor, that might affect data collection and analysis (Clancy, 2013). Writing down my reflections helped me realize my biases and assumptions and bracket them, or set them aside, in order to engage the

experience without preconceived notions about the outcome of the investigation. This

awareness prevented the imposition of my assumptions or biases on the study.

I abided by the policy of Walden University, which stipulates that researchers

have to state that any biases will be addressed, including researcher biases and/or power

relationships (Walden University, 2015). I therefore, paid attention to ethical issues and

avoided conducting this research study at my workplace to obviate conflict of interest or

power differentials. To accomplish this, I ensured that selected participants were not

individuals I supervised.

Methodology

In this section I describe the participant selection process, including identification

of population and participant selection logic. This section also contains discussions on

sample size and instrumentation. Specific instruments are discussed in this session,

including information on developers of selected instruments.

Participants

Participants who met the study criteria included licensed or certified professional

mental health and substance abuse clinicians. Selected participants had at least a year of

experience working in offices providing IPC in North Carolina and had transitioned from

traditional outpatient behavioral healthcare settings. The use of a phenomenological study

method allowed me to select eight BHCs who worked in IPC settings in North Carolina

to describe their experiences of the phenomenon in their own words (Polkinghorne,

2005). Selecting BHCs who worked in IPC settings allowed me to use critical case

samples, which according to Marshal (1996), are subjects who have specific experiences relative to a research design.

In this research study, I focused my attention on questions that helped me gather data that led to textual and structural descriptions of the experience of participants to help understand their common experiences (Gibbs & Taylor, 2005). Experiences and context of experience were considered because my research was created with phenomenological approach (Gibbs, & Taylor, 2005). It was therefore, appropriate to select BHCs who had transitioned from traditional outpatient settings to IPC settings.

Participant Selection Logic

In this research study, a massive amount of data was collected from eight BHCs who had transitioned from specialty outpatient behavioral health centers to IPC settings in North Carolina. I therefore used ppurposeful sampling to select information-rich participants for an in-depth research study (Tuckett, 2004). The use of purposeful sampling and the study of information-rich participants allowed me to gain in-depth understanding of the study subject. These BHCs had at least a year experience working at a specialty behavioral care setting prior to transitioning to an integrated setting, as well as at least a year of experience working in an IPC setting.

Sample Size

Most research synthesists refrain from rigidly prescribing a minimum or maximum number of primary research studies to be included in a synthesis (Suri, 2011). However, Dworkin (2012) posited that researchers interview from 5-50 participants in a natural setting, using open-ended questions until saturation is reached. Marshal (1996)

argued that an appropriate sample size for a qualitative study is the one that adequately answers the research question. Norlyk and Harder (2010) argued phenomenological research is a method of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by the participants. This approach allows researchers to study lived experience of a small number of participants to help develop patterns and relationships of meaning (Norlyk & Harder, 2010).

Conversely, due to advancement in qualitative data analysis with the use of software, larger sample sizes could be managed (QSR International, 2015). I used NVivo 11 Pro in a limited way to organize my themes and store my codes in nodes. By using line-by-line process for coding and identification of themes and phrases, and documents created and imported into NVivo via MS Word (QSR International, 2015), a larger sample of 5-25 participants could be used in my study. My preference, though, was at least eight BHCs currently working in IPC settings. According to Marshal (1996), researchers need participant numbers in the single figures when conducting highly detailed research studies. Therefore, purposeful sampling (Marshall, 1996; Suri, 2011) was used to find eight BHCs from IPC settings across North Carolina.

Instrumentation

This dissertation research study was designed to explore lived experiences of participants/BHCs who have transitioned to primary care settings and according to Dicicco-Bloom and Crabtree (2006), research studies that seek to explore lived experience of participants use different forms of qualitative interviewing that allows participants to share rich description of the phenomena, leaving the interpretation and

analysis to the researcher. Semi-structured interview protocol (Appendix C) was used to know interviewees and their lived experiences. The interviews were interactive, in-depth, reflexive and added to a body of knowledge that was conceptual, sometimes theoretical and based on the meaning and experiences of participants (Dicicco-Bloom & Crabtree, 2006; Maxwell, 2013).

Due to the nature of this study, participants were initially interviewed face to face and follow-up interviews through telephone. Email invitations were sent to BHCs who work in IPC settings in North Carolina. Upon acceptance of my invitation, each participant was interviewed at a location of their convenience.

BHCs who agreed to participate were asked to be part of an individual interview for approximately 45–60 minutes for the initial interview and 15-30 minutes for the follow up interview. Every participant had the option to extend the duration or schedule a follow up interview. The initial interview was conducted face to face and the follow up interview, via the telephone. Interviews were audiotaped with digital audio recorder and professionally transcribed verbatim and transcription verified through member-Checking. In-depth data was collected through semi-structured interviews to determine the background of participants and explore the live experiences of participants. After the initial face to face interview, participants were asked to keep journals to record their after thoughts including participants' digested perceptions and impressions. Participants were asked to write in their journals at least twice before the follow-up interview, which was scheduled in one week. Participants were asked to start writing in their journals, which was provided by me after the first interview. Participants were asked to share their after

thoughts during the follow up interview. Participants were also encouraged to discuss any additional information they recorded in their journals.

Due to the need for in-depth understanding of the lived experiences of BHCs in IPC settings, the semi-structured interview consisted of open-ended interview questions (Dicicco-Bloom & Crabtree, 2006). These questions were intended to stimulate interviewees to express their experiences and opinions. According to Dicicco-Bloom and Crabtree (2006), semi-structured interviews are scheduled in advance at a designated time and location and mostly afterhours. The questions were predetermined, open-ended and other probing questions emerged during the interview.

The idea that research studies have research purpose, theoretical and conceptual framework, indicate that researchers have preconceived expectations and notions (Clancy, 2013). It is therefore true that I pre-coded with notions and assumption in mind. I therefore, conducted in-depth self-analysis in order to become fully aware of any influences I might harbor, that might affect data collection and analysis. It was therefore incumbent upon me to set questions and conduct the interview without preconceived notions about what will be found in this study (Rennie, 2004). This awareness is seen as a protection from imposing assumptions or biases on the study (Clancy, 2013). Participants' responses, including text documents were formatted in Microsoft Word, then imported to NVivo 11 Pro (QSR International, 2015).

In this research, initial line-by-line process for coding was used to identify themes and phrases, and inductive coding frame (Gibbs, & Taylor, 2005) allowed the concepts to emerge through common phrases and patterns (Patton, 2014) from interviewees'

responses. Transcripts and themes obtained through line-by-line coding were imported to

NVivo 11 Pro for Windows via MS Word (QSR International, 2015). NVivo 11 Pro was

used in a limited way to organize my themes and store my codes in nodes. Data was

linked to documents or nodes and items viewed and managed (Richard, 1999). NVivo

will help provide security by storing database and files together in a single file (QSR

International, 2015).

Procedures for Recruitment, Participation, and Data Collection

In collaboration with the North Carolina Center of Excellence for Integrated Care,

BHCs were contacted from identified IPC settings in North Carolina. I also emailed

invitations to network of BHCs through the publicity of North Carolina Center of

Excellence for Integrated Care, as well as the entire membership of the Collaborative

Family Healthcare Association (national network of people working in integrated

settings). I also emailed letters of invitation to other BHCs, using email lists obtained

online from various behavioral healthcare associations in North Carolina. The responses

received initially were not overwhelming. The few responses received initially, who

expressed interest in participating in the research study had varied in their eligibility.

Some of these BHCs who responded did not meet the requirements to be approved by the

IRB, either they worked in IPC settings in other states, had not been employed in

integrated settings for a year, or did not transition from traditional behavioral healthcare

settings.

I sent consent forms to participants who met the requirements and contacted them

upon receipt of the signed consent forms and scheduled appointments for interview, a

couple of consent forms were signed prior to initial interview. Eight participants were

recruited from three settings in Western, Eastern and Southeastern parts of North

Carolina, including one BHC from Western, five BHCs from Southeastern and two BHCs

from Eastern North Carolina respectively. Table 1 illustrates the summary of study

participants, including ethnicity, educational level and age group. Table 2 illustrates

credentials and work experience of study participants

In-depth data was collected through interviews at the beginning of the study to

determine the background of participants and during the study to explore the live

experiences of participants. Further follow-up interviews were conducted to inquire about

lasting impacts of study on participants and revisit questions and responses that need

clarification. In essence, two interviews were conducted with initial face to face and

follow-up interview via the telephone. Interviews were audiotaped and professionally

transcribed and transcription verified through member-checking. A confidentiality

agreement was signed with the transcriptionist. The duration of the initial interviews were

approximately 45-60 minutes and 15 minutes for the follow-up interview. Each

participant had the option to exit or extend the duration. A digital audio recorder was

used to record interviews. In the follow-up phase, participants were asked to discuss

journals of recorded after- thoughts including participants' digested perceptions and

impressions.

Data Analysis Plan

Experts have identified many steps in general data analytic strategy, which

include sketching ideas, taking notes, summarizing field notes, working with words,

identifying codes, reducing codes to themes, relating categories to analytic framework in literature, creating a point of view, and displaying the data (Gibbs & Taylor, 2005). Gibbs and Taylor (2005) posited that thematic coding is appropriate for interpretative phenomenological analysis, template analysis, and framework analysis. The data set for my research was created with phenomenological approach hence experiences and the context of experience was the desired consideration.

Data Analysis

Since my research was created with phenomenological approach, I focused on experiences and context of experience (Gibbs & Taylor, 2005). Gibbs and Taylor (2005) posited that thematic coding is appropriate for interpretative phenomenological analysis. MacLean, Meyer and Estable (2004) argued that researchers should regard the importance of verbatim transcripts for qualitative analysis.

Transcribed responses obtained from participants were read multiple times to allow themes and categories to emerge (Gibbs & Taylor, 2005). Content analysis was used to search available document for words and count re-occurring themes (Gibbs & Taylor, 2005). Gibbs and Taylor (2005) identified a method that includes applying a number to text, which is used to identify themes, and frequency. I cross-referenced all responses and available documents. After a content analysis with an inductive coding frame (Gibbs & Taylor, 2005), allowing the common themes to emerge, I began a deductive process by eliminating items that did not repeat, or that were not found from each of the interviews (Gibbs & Taylor, 2005). Common themes and sub themes were identified through cross-case analysis, identifying common themes from each of the

interviews (Gibbs & Taylor, 2005). I used line-by-line process for coding to identify

themes and phrases that emerged through the detailed evaluation of each line or

responses. An inductive coding frame (Gibbs & Taylor, 2005) was used, while

approaching the process without preconceived thoughts or themes, and allowing the

concepts to emerge through common phrases and patterns (Gibbs & Taylor, 2005).

NVivo 11 Pro was used in a limited way to organize my themes and store my

codes in nodes. Data was linked to documents or nodes and items viewed and managed

(Richard, 1999). NVivo will help provide security by storing database and files together

in a single file (QSR International, 2015). According to QSR International (2015), coding

is the process of gathering material by topic, theme or case and nodes are containers for

codes that let researchers gather related material in one place to enable researchers look

for emerging patterns and ideas.

Ethical Procedures

After receiving permission from IRB, I contacted the North Carolina Center of

Excellence for Integrated Care to assist me to identify IPC centers in North Carolina and

help promoted my research study. The North Carolina Center of Excellence for

Integrated Care's responsibilities included, helping me to publicize the research study;

assisting to identify recognized integrated care settings in North Carolina by making

available recognized integrated care settings and making my research information

available. The organization had no influence in how the participants were selected and

did not assume a supervision role. Participants were selected through email and phone

(followed by email).

The Center of Excellence for Integrated Care works with a network of integrated health care systems in North Carolina and beyond. They maintain an online networking group for BHCs working in integrated health settings to share news, training and research opportunities. The Center distributed my research study participation invitation and contact information to their online network via an online message (using the Basecamp platform). The Center did not distribute or share any contact information for the BHCs within the network with me. The Center did share my research study information with the network and directed interested clinicians to my email for follow up. The Center of Excellence for Integrated Care assists health care clinics and systems in integrating their physical and mental healthcare. Their mission is to spur the creation of evidence based integrated care models across health systems to improve the mental and physical healthcare of primary care patients and clients of mental health homes.

In my introductory letter to participants, they were assured that the interview was voluntary. Their decision of whether they choose to be in the study was respected. Participants were informed that they will not be treated differently if they decided not to be in the study, and if they decided to be interviewed, they could still change their mind later and may stop at any time. Participants were also informed that in the event, they experienced stress or anxiety during their participation in the study they may terminate their participation at any time and may refuse to answer any questions they consider invasive or stressful. No payments were offered to participants, but participants were given gift cards to buy lunch in their local restaurants after the initial interviews in appreciation of their willingness to participate. Participants were able to sign consent

forms, emailed to them before interviews to assure that the information they provide would be kept confidential. Participants were informed that their personal information would not be used for any purposes outside of this research study and their names and place of work would not be published in the study report. Each participant consented to release of confidential information, including audio tapes for transcript, and to committee members and IRB.

During the participant selection phase of this study, I paid attention to the three basic principles that are particularly relevant to the ethics of research involving human subjects, including the principles of respect of persons, beneficence and justice, referenced in the Belmont Report (US Department of Health and Human Services, 1979). Respect for persons required me to treat participants as autonomous agents and protect them with diminished autonomy (US Department of Health and Human Services, 1979). Beneficence required me to treat participants in ethical manner by respecting their decisions, protecting them from harm and secure their wellbeing through minimization of possible harm (US Department of Health and Human Services, 1979; Walden University, 2015). Justice in research study required me to fairly distribute the benefits and burden of research (US Department of Health and Human Services, 1979). According to the Belmont Report (US Department of Health and Human Services, 1979), injustice occurs when researchers deny individuals benefits they are entitled without good reason or impose unduly burden on participants.

Summary

In this chapter, my responsibility as a researcher is described, including identification of participants and sampling strategies. There are also discussions on sample size and instrumentation. Due to the nature of this study, face to face interviewing of participants was selected and the use telephone and email for follow-up and participant checking respectively. In this chapter, the procedure for selecting participants is described, including the alliance with the North Carolina Center of Excellence for Integrated Care to assist in the identification of integrated settings and publicizing study to their online network via an online message. The data analysis plan is also discussed in this chapter, including the use of audiotaping and verbatim transcription, as well as the use of line-by-line process for coding to identify themes and phrases that emerge through the detailed evaluation of each line or responses. I also discussed how NVivo 11 Pro was used in a limited way to organize my themes and store my codes in nodes. This chapter was concluded with appropriate strategies to establish ethical protection.

Chapter 4: Results

Introduction

The promise of IPC can be achieved through acknowledging the significance of relational competencies and collaborative efforts between PCP and BHCs in IPC settings (Marlowe & Hodgson, 2014). According to Marlowe and Hodgson (2014), it would be incumbent upon BHCs and PCPs to acknowledge each other and share resources in order to achieve effective implementation of integrated care. Marlowe and Hodgson argued that required standards and competencies of BHCs in integrated care setting can help improve service provision and accelerate the process, practice and effectiveness of integrated care. Glueck (2015) argued that it is incumbent upon hospitals, health clinics, and other treatment facilities willing to provide integrated treatment in primary care settings, to use a biopsychosocial approach to care in order to improve integrated treatment by employing BHCs who are trained to provide holistic care in collaboration with providers in primary care settings.

The purpose of this qualitative phenomenological study was to describe the lived experiences of BHCs, who have transitioned from specialty outpatient behavioral healthcare settings to primary care settings. This study explored the competencies needed by BHCs to provide effective behavioral healthcare in IPC settings.

Research Questions

The objectives of this research study were met by probing the following questions:

RQ1: How do BHCs who have transitioned from specialty outpatient behavioral

healthcare settings describe their lived experiences in IPC settings?

RQ2: How do BHCs describe best practices in IPC settings?

Procedure

As stated in Chapter 3, participants were selected through the publicity of North

Carolina Center of Excellence for Integrated Care, letters of invitation sent to the entire

membership of the Collaborative Family Healthcare Association (national network of

people working in integrated settings). I also e-mailed letters of invitation to other BHCs,

utilizing e-mail lists obtained online from various behavioral healthcare associations in

North Carolina.

Eight participants were recruited from three settings in Western, Eastern and

Southeastern parts of North Carolina, including one BHC from Western, five BHCs from

Southeastern, and two BHCs from Eastern North Carolina. Initial and follow-up

interviews were done using semi structured open-ended questions (Appendix C) to

collect in-depth data to explore the lived experiences of participants.

Demographics

The participants selected for these interviews were eight BHCs who had

transitioned from the traditional outpatient behavioral healthcare settings to IPC settings.

All participants were licensed professional BHCs. Selected participants had at least a year

of experience working in offices or settings providing integrated primary care, full-time,

in North Carolina and had transitioned from traditional outpatient behavioral healthcare

settings, after having over a year's experience in the traditional setting. Seven of the eight

participants had a master's degree in social work and one participate had a doctorate

degree in psychology. Three participants were in a supervisory position. Participants'

ethnicities included one mixed race, two Caucasians and five African Americans. Their

ages ranged from 32 to 68. Two participants were between 30 and 40 years of age, two

participants, between 41 and 50, three between 51 and 60, and one between 61 and 70.

Participants consisted of seven women and one man.

      Table 1 represents each participant's demographic information, including gender,

ethnicity, educational background/degree, and age group. Table 2 represents participants'

credentials, and years in traditional and IPC settings.

Table 1

Summary of Study Participants

Participants	Ethnicity	Degree	Age group
A	Mixed Race	Master's	30-40
B	African American	Master's	30-40
C	African American	Master's	41-50
D	African American	Master's	51-60
E	African American	Master's	61-70
F	Caucasian	Master's	51-60
G	Caucasian	PhD	61-70
H	African American	Masters	41-50

Table 2

Summary of Credentials and Work Experience

Participants	Credentials	Settings: Traditional	Integrated primary care
A	LCSW	4 Years	11.5 Years
B	LCSW	8 Years	3 Years
C	LCSW	2 Years	4 Years
D	LCSW	5 Years	10 Years
E	LCSW	25 Years	12 Years
F	LCSW	8 Years	8 Years
G	LCSW	35 Years	10 Years
H	LCSW	4 Years	1.5 Years

Data Collection

As explained in Chapter 3, I used the qualitative method of inquiry and open-ended semi-structured interview questions (Appendix C) to get an in-depth understanding of the lived experiences of eight BHCs in IPC settings. The use of semi-structured interview questions allowed me to probe participants for more in-depth responses. Interviews were conducted in participants' offices, restaurants, and the public library in each case respecting participants' right to privacy. Interviews were recorded with a digital audio recorder.

Trustworthiness

To increase trustworthiness and credibility, participants were asked to do member-checking. Therefore, the transcripts of the interviews were sent via private e-mail to participants, within a week of the interview for review and verification of the contents. Participants were given 24 to 72 hours to read the transcripts, make the necessary corrections, and return corrected transcripts. All participants responded positively to the member checking, two participants needed reminders, and only one participant made a minor correction. Morrow (2005), argued that social scientists regard multiple standards of quality in qualitative research, including validity, credibility, rigor, and trustworthiness. According to Morse, Barrett, Mayan, Olson, and Spiers (2002), in both quantitative and qualitative methods of inquiry, rigor is a desired goal that is met through specific verification of strategies with responsibility placed on the researcher.

Analysis

As explained in Chapter 3, I used a line-by-line process for coding to identify themes and phrases that emerged through the detailed evaluation of responses. I used an inductive coding frame (Gibbs & Taylor, 2005), while approaching the process without preconceived thoughts or themes, allowing the concepts to emerge through common phrases and patterns (Gibbs & Taylor, 2005). In my analysis, I used NVivo 11 Pro for Windows in a limited way to organize my themes and store my codes in nodes. Transcripts were imported into NVivo via MS Word (QSR International, 2015). Imported documents were differentiated, color coded, and labeled into themes. Data was linked to nodes and items viewed and managed (QSR International, 2015; Richard, 1999).

The line-by-line process for coding used in my data analysis helped me identify themes and phrases. Common themes were identified through cross-case analysis, identifying themes and subthemes. The headings identifying themes and subthemes are seen on Table 3.

Table 3

Summary of Themes and Subthemes

#	Themes	Subthemes
1	Clinical experience	• Licensed practitioners • Able to do brief screenings and intervention • Provide holistic care • Fast pace service provision
2	Effective communication	• Know medical aspects • Able to effectively communicate with PCPs
3	Collaboration with PCPs	• Warm handoff • Team work • Humility
4	Continued education and trainings	• Training in clinical health psychology • BHCs able to train PCPs
5	Care coordination	• Know community resources • Assess, monitor and coordinate services with other providers and agencies

Clinical Experience

When participants were asked to describe the skill levels of BHCs appropriate for effective service provision in IPC settings, all participants reiterated that BHCs working in IPCs should be (a) licensed, (b) able to do brief screenings and interventions, (c) able to provide holistic care, and (d) able to engage in fast pace service provision.

Licensed Practitioners

Every participant stressed on the fact that BHCs who intend to work in IPCs should be licensed and if possible be in a capacity of a licensed independent practitioner (LIP). Participant B, a Licensed Clinical Social Worker (LCSW) stated:

I would say that in order to be a successful integrative behavioral health person, that you have to have at least 10-years' experience before you go into that type of role. Must have varied experience in the behavioral health field. Yes, I would say, prior to my current role as a social worker, I'm an LCSW. As an LCSW, I worked in varied locations before I got to the point where I actually took a job as an integrative behavioral health specialist in the community, and it was a big jump. And I had worked in substance abuse treatment program. I had worked in medical social work. I had worked in HIV care, and all of those case management before I got to the point where I was in a primary care clinic as a collocated person. So, all of my other jobs kind of prepared me to start to understand what I needed to know. If I had taken a job like this right out of social work school, I would have failed.

Participant C stated that the IPC settings she works, demands that BHCs work at their highest level of competency in the integrated setting.

Really someone who is post-licensed. A minimum of two years. So, experience beyond just being associate licensed clinician, but definitely being an independent licensed professional. And then having at least a minimum of two years' experience, so that they will have the skills to support this independent role as a behavioral health care clinician.

There was an unexpected response as to the type of licensed BHC that may be employed in an IPC setting. Participant G, who has a doctorate degree in psychology and

happens to be in administrative position stated that reimbursement issues may force IPC settings to employ LCSWs and Licensed Psychologists.

> I'm really looking more at a clinician's personality, and their passion, and their interest in this work, first of all. But beyond that, psychologists would sometimes argue, "Well, you need a licensed psychologist—in other words a doctoral-level psychologist - to do this work. I don't agree with that even though that's what I am. I think we have had very effective work done at the clinic level with patients with LCSWs, or masters-level trained clinicians. We're kind of limited about the skill set when we have to take into account the business aspect of it, which is for FQHCs because this is a federally qualified health center (FQHC). But anyone who wants to bill Medicare that you have to—it either has to be an LCSW or a licensed psychologist. A doctoral-level psychologist or an LCSW. Medicare won't reimburse a licensed professional counselor. They won't reimburse a licensed marriage and family therapist, I mean, they're very specific. North Carolina Medicaid however, will reimburse LMFTs, and LPAs, and LPCs, and so on. So, it's also just that weird, tedious information you need to know about the business aspect of this to get it running.

Participant E stated succinctly;

> I believe anybody who works in integrated primary care must be fully licensed. I don't mean provisionally licensed, I mean fully licensed as an independent practitioner. Just like your doctor is licensed as an independent practitioner, they have to be.

Participant D stated:

> I think this is not an entry-level position. This position needs to have a higher skill
>
> set level, whether it's being a licensed social worker or a psychologist. The mental
>
> health behavioral clinician, especially in the primary care setting, needs to have
>
> some experiences in dealing with chronic mental illness, and definitely a healthy
>
> knowledge of pharmacology as well.

Able to Do Brief Screenings and Brief Interventions

All participants reiterated the need to know how to do brief screenings and

provide brief interventions and not psychotherapy in IPC setting. Participant G, who is

also in the administrative and supervisory position, stated:

> I expect them (BHCs) to be good at brief intervention. They're not going to be
>
> doing psychotherapy, we're not providing psychotherapy, this is not long term,
>
> we're not seeing people on a weekly basis. We might see them once a month at
>
> the most, sometimes once every three months, maybe only twice a year. So, I
>
> would expect them to know something about just being able to connect with a
>
> patient fairly quickly. They don't have a whole hour, they're not sitting in an
>
> office somewhere. They're in an exam room, holding up an exam room, because
>
> we're not going to move out of the exam room in most cases to another location,
>
> ideally. Now, sometimes we do, of course. For the most part we need to be in and
>
> out of the room with the patient within 20 to 30 minutes at the most. And so, we
>
> need folks to understand it's going to be a very different way of practicing, that
>
> they're going to be interrupted, that they're going to have to have a tolerance for a

very flexible schedule. Because they might have a couple of patients that are on their schedule, and then they might be pulled in by a provider saying, "I need you right now, this person is needing to do X, Y, Z." So, somebody with a good flexibility, an ability to do in-the-moment discernment about what might be best for that patient, and a willingness to move fairly quickly.

Participant B spoke about intervention and brief solution focused services in IPCs and not the focus on pathology and psychotherapy as normally done in traditional outpatient behavioral healthcare settings, stating:

So, the short-term goals and the solution-focus type of care really is about helping people to get a set of tools that they might need to manage their own kind of life stressors, as opposed to mental health which is more geared towards managing pathology. So, in primary care, where we might recognize that the pathology is there, really, we want to just give you a set of tools to kind of be able to manage your life. And I think that that's a little bit different. We're thinking about the health of a person and also the medical parts to that. Whereas a mental health patient in a traditional outpatient clinic is only focused on the mental health. So, in primary care, when we do an assessment, we're interested in knowing that you have a long history of suicide attempts. But what we're more interested in knowing is if you're sick today, and what would be the plan long-term to make sure that you're not having more suicide attempts. Traditional mental health clinicians would spend a lot of time talking about each attempt, what happened,

what's going on. Whereas in primary care, are you safe today, and what do we

need to keep you safe?

Participant H described the provision of brief screening and intervention by BHCs

in IPC settings as working towards immediate needs of patients and addressing their

problems using a brief solution focused therapy or referring them for long term treatment

in outpatient behavioral health setting, stating;

Okay, my role is to do a brief early intervention assessment in the primary care

setting for mental health issues, and to move the person through the system,

depending on their level of acuity, if they need to stay in behavioral primary care

to be serviced with six short-term sessions, or if they need to go to a much higher

level of care.

Participant B stated:

You're always going to see chronic pain issues. You're always going to see

insomnia. You're always going to see stress-management issues. So those areas

you really have to be able to be confident, identify, and know how you can kind

of give interventions for those right off the bat.

Participant B described provision of intervention as the BHC in the IPC setting

focusing on helping patients set short-term goals and get some tools to manage their lives

at the moment and not managing pathology as done in the traditional mental health

setting, stating:

So, in primary care, where we might recognize that the pathology is there, really,

we want to just give you a set of tools to kind of be able to manage your life at the

moment. And I think that that's a little bit different. We're thinking about the health of a person and also the medical parts to that. Whereas a mental health clinician in a traditional outpatient clinic is only focused on the mental health. So, in primary care, when we do an assessment, we're interested in knowing that you have a long history of suicide attempts. But we're more interested in knowing is if you're sick today, and what would be the plan long-term to make sure that you're not having more suicide attempts. Mental health would spend a lot of time talking about each attempt, what happened, what's going on. Whereas in primary care, are you safe today, and what do we need to keep you safe?

Holistic Care

Participants stressed the need to treat the whole person and not just the presenting problem. Participants described holistic care as providing patient-centered treatment. Participant C stated:

For me, it's really allowing the patient to choose what they want to focus on and what their outcomes will be. Often for me, it is asking the patient what they desire for their best health or optimal health. And then treatment must be comprehensive, really comprehensive treatment is taking care of that total patient from head to toe, not only their physical needs but also their mental health care needs and really even perhaps looking at some type of alternative treatments and offering the patient just a variety of services in the primary care setting.

Participant D stated:

I would describe the comprehensive piece as definitely the team effort and with

the person as a whole. That means we take into consideration the medical piece,

the physical piece, the spiritual piece. We take all of that in, in helping the

physician kind of design the care around the person. So, we take a person who has

a special need, whatever that need may be. So, that means we get pharmacology

involved. We kind of make sure that one medication is not going to cancel out the

other medication. We definitely get nursing involved. It's definitely the

biopsychosocial approach to caring for the person as whole, not only visible

elements but the socio-environmental, spiritual and the mental elements.

Fast Pace Service Provision

Participants unanimously stated that BHCs in IPC settings have no choice but to

realize and accept the fact that service provision in the IPC setting is done in a fast pace

environment. Some participants stated that assessments and interventions are done in the

exam room, and limited time is allowed to ensure that the exam room is vacated to allow

other medical providers to use it. Due to the warm handoff system, BHCs may also be

needed to conclude sessions in a timely fashion and see other clients referred by medical

doctors. Participant F stated;

In traditional outpatient setting, you're going to spend 45 minutes to an hour with

that patient. And for the first time, maybe in an hour and a half. And here, for the

first time, if I'm doing an in-depth assessment, I may take half an hour. But then

again, if I know that this is not going to be something that needs to take half an

hour, I may spend 5 to 10 minutes with that patient. And the push is always to

speed it up so that you can get the rooms open and providers can get other patients in there. It's not my office. I'm not sitting at a desk. I'm in the exam room with the patients so it's a very unusual setting.

Participant H stated that:

Everything is going at a faster pace. So, you have to be able to assess, connect, and refer people at a rate that's much faster and higher than your traditional outpatient comrades because you have less time to do it in, because people are coming and seeing so many diverse disciplines to get their need, their mental and physical health needs met. So, you have to do it at a much faster pace. I've had to get used to that. I really did.

Participant E stated:

The behavioral health care provider that is successful in making the transition will be one that is willing to learn different techniques of training. They have to be able to adapt to a quick environment. So, if they need to do everything slowly, if they need to do everything by hand, primary care is not the setting for them. Primary care is a quick, fast-paced setting. So, you need a behavioral health clinician that can work quickly, who can make an assessment quickly, and who can make a decision quickly. If you have to have . . . I would say, if you have to take a show of hands for your decision, primary care integration is not where you should be. You have to be able to make a decision about treatment, about where this person should be for today. The primary care provider is relying on you to move the patient because they have other patients to be seen.

Participant G stated:

Ideally, and I'm certainly guilty of spending more time, but ideally like I said, if you are seeing them for the first time and trying to get a little extra information, 20 to 30 minutes is ideal. Sometimes it goes to 45. But follow-up appointments really ought to be no more than 15 minutes, or 20. Because if I've set a goal with you, if we've decided that you're going to walk to your mailbox and back three times a week by the next time I see you, then that's what I'm addressing when you come back. I'm not going to go in, "Well, how do you feel about your mother?" or, "How do you feel about what happened to you when you were 14?" We're not doing that. We may acknowledge that has an influence, but, "You and I agreed that you're going to walk three times to your mailbox, how did that go?" And that's what I record. And then we decide, "Can you do that again or do we want to change that?" And I'd be out of the room in 15 or 20 minutes.

Participants stated that interventions need to be briefer in primary care settings, giving the amount of time that the BHC may have with a patient, which is short. Participants reiterated the need to work in a fast pace, spending little time with patients, including learning to adjust the time spent with patients and what to do during that time. Participant A stated that

And so oftentimes, in a traditional behavioral health setting, you may have more time. You may have a whole hour and a half to do an initial assessment on someone that's coming in, whereas the first time I meet someone in a primary care setting, they may not have come in to see me at all. And the only reason they're

seeing me is because their primary care provider and them thought, "maybe it

would help just to chat a little bit today about housing and how that's related to . .

."So, they might be readying to get out of here in five minutes. So, in five

minutes, I have to be able to bring them back. Convince them that this could be a

benefit. This is a valuable service potentially. And so again, building rapport is

always important, but doing it in a really quick way, in a quick manner. So, I've

had to adjust how I do that with folks, how I talk to them, what I say. I'm certainly

being more experiential with the time.

<div align="center">**Effective Communication**</div>

Participants unanimously stated that effective communication between BHCs and

PCPs is essential to facilitate team building and development of trust and respect among

BHCs and PCPs. Participants stated that in integrated care setting, effective

communication between and among a team of providers improves caring for mutual

patient. Participants reported that effective communication promotes respect for diversity

of opinions and consensus-based decisions that will result in effective integrated care.

Effective communication in IPCs was described by participants as (a) BHCs ability to

effectively communicate with PCPs and (b) BHCs knowledge in medical aspects.

Ability to Effectively Communicate with Primary Care Providers

PCPs' reliance on the biomedical model of disease is challenged in integrated

primary care, requiring them to minimize and to some extent dispute with their

philosophical values and compromise with BHCs (Beacham et al., 2012; Boon et al.,

2004). This sentiment was reflected in the response of participants when they described

the importance of BHCs having good communicating skills about how clinical cases are presented to PCPs. Participant E stated:

As behavioral health clinician, you're supposed to be doing a treatment plan as well. You're supposed to be looking at the whole person as well. So, when you communicate that information to the primary care provider, they become more confident in your ability to treat their patients. As their confidence grows in your clinical ability, their trust will grow, and then you'll have a better-- and hopefully your relationship, not only with them but with your team. That's true. And then the behavioral health clinician has to be confident enough that, when they're challenged, that they don't get upset or get defensive, but they can explain their position clearly and then hear the other provider, because communication is the key. And then allowing people the space to learn and develop with you, because this is just as new for the primary care as it is for the behavioral health clinician.

Participant F stated succinctly:

I think that being able to effectively communicate with medical providers is a challenge, even for me, and the experience that I have, so, it takes a while, I think, to get the confidence of the providers that you're working with. Because I've moved within rural health group to different clinics and it's like starting over again with the providers and letting them know that I do know something and I'm not just here to make their lives miserable or whatever. I'm here to help them be better providers and help them with their patients. Some of them always are like testing me to see what, okay, can she-- what can she do to help me with this

patient. And they don't want me to take too much time with the patient. They don't want me to take too much of their time to explain what I think the patient needs. So, I think you have to get to know each provider individually, first of all, and figure out what they want from you. And then you have to kind of be a chameleon [laughter] and do different things for different providers because they all kind of want to know, "Well, are you really going to help me, or are you just here to waste my time?"

Know Medical Aspects

Most of the participants stated that knowing medical aspects including terminologies and relationship between medical problems and psychosocial issues can help BHC communicate effectively with PCPs. Participants stated that the amount of information BHCs need to know to effectively communicate with PCPs and the primary care team and make recommendations as behavioral health care specialist would come from your knowledge in medical aspect and training in clinical health psychology as well as knowledge in psychopharmacology. Participant B stated that:

> Yes, it is about teamwork, definitely and a lot about communication. If you're not able to effectively communicate and really speak doctors' languages … because they do speak a different language from a social worker - then you're not going to be an asset to a team. And so, for that, that might be really being able to name all of the symptoms very succinctly and how they are interacting with the medical condition very quickly to be able to give them a follow-up about a patient in 60 seconds or less because they are thinking about five other things. To be able to

huddle in rounds in the morning and give input without it being a long, drawn-out

conversation. Or to be able to say to your RN or your provider that you need to

see that patient because some of the things that are happening to them medically

can be managed as a behavioral health issue.

Participant C stated:

Communicating the needs of the patient is important. A lot of the times the patient

will tell you something about their medical situation. It may be out of your scope,

out of my scope as a behavioral health clinician to really take care of or really

handle, so I definitely have to have open communication with my providers, with

the nurses. Sometimes I do communicate with the pharmacists, they're a part of

this team to help give me suggestions or give the provider suggestions on

medications that the client may be able to use that maybe-- the symptoms that

they present, what may be a good suggestion. If they've had other medications and

failed trials, in the pharmacy, I would communicate with them to see what their

recommendations are, and really, we work as a team.

Collaboration with Primary Care Providers

Irrespective of the setting the participants worked, they all expressed the need for

BHCs and PCPs to work collaboratively to achieve effective provision of services to

patients in integrated primary care settings. All participants reiterated that the

collaborative effort between BHCs and PCPs benefitted both providers and patients.

Participants unanimously stated that it is important that providers working with a patient

are aware of what is going on with the patient, and this can be achieved through

collaborative efforts of BHCs and PCP, in reference to sharing of information through instant messaging and other media set forth by the setting. Participants described collaboration with PCPs as (a) Team work, (b) warm handoff and (c) humility.

Team Work

Participants reiterated that BHCs must be prepared to work with other provider as a team and be able to contribute to treatment team discussions and by providing clinical information that can help the team effectively treat mutual patients. Participant E, while responding to comprehensive and patient centered treatment, stated that:

I would describe it as every member of the team knowing what goes on with the patient. If the patient goes to the heart doctor, the primary care should know about it, but so should the behavioral health person. Because if you have a heart condition, you might have anxiety about being treated for the heart condition. So, everybody on that team has to know what's going on with the patient. If one person has one piece of information and somebody else has another piece of information, the treatment plan is not complete. So, by having a complete treatment plan, they work together. That's how you integrate good care, so the patient is treated effectively.

Participant G, who is also in administrative position, while responding to comprehensive and patient centered treatment, stressed on team work as the key to managing patients with triple diagnosis of medical, mental health and substance use disorders. Participant G described teamwork as:

What we wanted to do was to be sure that it was patient-centered and team-based.

So rather than talk about referral, we talk about activating a team member,

because that's an in-house service. So, If I'm the behaviorist on a particular

treatment team and they want me to help somebody manage their diabetes more

successfully - because behaviorally they're not doing a very good job of it - they

activate me as the behaviorist on the team. I meet with the patient, we talk about,

"What are some of the things that are interfering with you taking your medicine

on time, or checking your blood sugars, or whatever." The other piece is that

behaviorists are-- our expectation is we get used for healthcare, not just mental

health, substance use, and so on. So, if you're a patient and you're in front of the

primary care provider, we need to know what in this episode of care are your

needs. So, it may be, I've got to treat your diabetes and your A1C, you're also

depressed, and your hypertension is out of control. So how many of the team

members need to be involved in addressing any of those things in a given exam?

Warm Handoff

To be able to provide effective integrated care BHCs are required to work

collaboratively with PCPs in a process known as warm handoff. Participants stated that

BHCs are required to work in an environment where patients are transferred to them from

PCPs directly. Participant E described warm handoff as:

What happens is, normally in the integrated primary setting, you have what we

call the warm handoff. A warm handoff is when the doctor basically introduces

you to the patient that day … in their primary care visit, and you see the patient

that day. But that day, what you're doing is not a full assessment. You're doing a

screening to see what is going on in the patient's life at that time that caused the

referral and report back to the doctor and possible provide brief intervention….

Then you bring the patient back at another day to do the assessment, and the

assessment is more in-depth, but the assessment is also very targeted towards

what is the immediate concern and need.

Participant B described collaborative effort as the BHC's ability to work with the

physician and provide same day services for a client with dual or triple diagnoses.

Participant B stated:

It means, as the primary care providers are seeing patients, we are taking those

patients and seeing them as warm handoffs most of the time. So, we try to be

there at the same day. So, we're also meeting with the primary care teams in the

mornings for team huddles, talking to them about what's going on with the

patients who are presenting that day, doing treatment planning, talking to the docs

about scheduled medication increases, talking with them about treatment

recommendations for chronic pain, insomnia, and stuff like that.

Humility

There were some unexpected results from the data analysis. While describing

collaborative efforts between BHCs and PCPs, most participants stressed on the need for

transitioning or entry level BHCs to be humble while dealing with PCPs and working

with experienced BHCs in IPC settings. Participant G stated that BHCs planning on

transitioning to integrated primary care setting, should exhibit some humility and learn

how to provide interventions in a collaborative manner. Participant G stated:

> So, it's really kind of like, "Okay, I got to be open to realigning. I'm taking my
>
> skills with me and my good insight, but I've got to be willing to shift how I do it."
>
> And some people can't do it, they can't make the transition. They want to take
>
> traditional… move it into integrated and still stay isolated as a traditional
>
> therapist, and want to still do psychotherapy. So, they have to understand even
>
> from the get-go you're not going to be doing . . . in terms of what we
>
> consider integrated care. So, I'm still looking for their stage of change and for
>
> their willingness to be flexible, humble and learning new ways to do stuff. I think
>
> the people that want to have to make the transition have to . . . we go back to
>
> some of your earlier questions and those points, must be flexible, a willingness to
>
> be humble about the fact that they don't know what it's like to be in a primary care
>
> setting, a desire to learn what that means, a willingness to give up some of their
>
> old patterns of intervention behavior because they must work faster and
>
> collaboratively.

Participant F stated:

> We're not always the one that is the most important on the team. So, I think there's
>
> some humbleness that needs to come along with being the behavioral health
>
> specialist and knowing how to come into somebody else's house, I guess. This is
>
> primary care, it's not mental health so it's a different setting. We're coming in kind
>
> of into another world and we have to fit in, blend in, and see where we can fit

instead of coming in and saying, "Now this is my place. This is how I'm going to do things." "I think we need to learn how to mesh with other providers."

Continued Education and Trainings

Participants unanimously stated that training of BHCs before and after transitioning to IPC settings is necessary to ensure effective provision of behavioral health treatment in IPC setting. There were also diverse opinions on when trainings should be provided. Some participants stated that it would be ideal for BHCs to have the training before they transition to IPC setting, others stated that ongoing training should be part of in-service orientation in IPC setting. Other participants stated that institutions should prepare graduates to work in IPC settings and maybe it would be good to have students do their field placement in IPC settings. All participants unanimously stated that BHCs should (a) have trainings in clinical health psychology and (b) be able train PCPs.

Trainings in Clinical Health Psychology

Participants in this study had transitioned to IPC settings from traditional behavioral health care settings. All participants stated that they received on the job training and some continued education training outside of their respective settings. Participant A stated that a community organization has done a good job in supporting integrated care in primary care settings in their catchment area. Participant A stated that clinical staff at his IPC setting have received training in identifying ways to integrate care more effectively and in a way that speaks specifically to the needs and culture of that particular clinic.

Participant D stated that:

You definitely have to continue with your training, your CEUs, definitely having

a passion in learning, your skill set needs to rise in pharmacology, your skill . . . if

you specialized in a specific clinic, like if you're dealing with the geriatric

population, definitely getting more training on maybe identifying certain

cognitive, maybe like Alzheimer's or dementia. Making sure that you can kind of

identify those things and look for those things that might kind of identify people

instead of saying, "Oh, maybe this person is mentally ill." Something that's kind

of making them behave in a certain . . . diabetes can kind of present as psychosis

in the elderly population. So, you kind of have to know that and recognize that. In

my particular clinic, when I have a patient that presents, and she has had a baby

two month prior, I'll have to know and look for . . . yeah, if she tells me she's

depressed, "How long have you been depressed? What are your feelings?" "I'm

just not connecting with this baby." I have to know that this may be a sure sign of

postpartum depression.

While responding to the question on trainings BHCs transitioning to integrated

primary care need to effectively provide integrated medical, mental health and substance

use disorders treatment, Participant B stated:

So general competence? So again, they have to be competent in medications, both

medical and psychiatric. They have to be able to recognize a class that something

is in. So, if they're looking at a blood pressure medicine, even if they don't know

what it is and what it treats, what kind of blood pressure it treats, they should

recognize that it is a blood pressure medicine versus a diabetes medicine. They

should be competent enough to know a motivational interviewing. They should be

competent enough to know . . . sorry. CBT for depression, for chronic pain, for

insomnia. Those are just general stuff that they're going to use all the time in a

primary care setting.

Behavioral Health Clinicians Able to Train Primary Care Providers

Most of the participants stated that BHCs should be competent enough to provide

trainings to PCPs about behavioral health. Over half of the participants stated that they

have provided trainings to PCPs on behavioral health and feel such trainings are needed

to help PCPs. Concerning the training of PCPs, Participant G stated that although

providing trainings to PCPs is not easy, in reference to their reception of information

given, trainings on behavioral health is offered. Participant G stated:

Absolutely can be. But again, it's only if somebody wants to be trained. Why

would I train you if you're not interested? You have to want it and you have to be

open to it. Now we do meetings and trainings all over our system every month in

different formats about different things, whether it's depression, suicide, whether

it's racial equity, whether it's adverse childhood experiences (ACEs) or so on. And

we offer it to everybody because we want everybody to be exposed to it, from the

front desk to the medical providers. We're not in charge of what they receive,

we're only in charge of what we offer. Now if it becomes an issue, a performance

issue, and they are actively negative, actively resistant, then it's a supervisory

issue.

Participants F, while responding to a question on skill levels of BHCs appropriate for service provision in IPC setting, stated:

> I believe that it should be a masters level social worker and a licensed clinician. I think that we have the background of knowing the patient where they are which is very important in integrating care. Sometimes that's something I can coach medical people on. They will say we can't do everything for this patient today and in my advocacy role for the patient, I might say, this patient has a lot that they're dealing with, and they have all the right in the world to be irritable right now. And we just have to start from where they are instead of blaming the patient for all their symptoms. And I find that people with more of a medical background, do come to the table more with … "they have to do what I want them to do mentality", more of a parental role instead of trying to meet the patient where they are. So that's why I think social workers have a good background to train PCPs about behavioral health care.

Care Coordination

Although some participants reported working in IPC settings where they have nurse care coordinators, all participants reported that they often assume the responsibility of referral coordinators. Participants reported that if brief intervention does not work in IPC setting, it is incumbent upon the BHC to refer the patient to a higher or appropriate level of care. The care coordination was described as (a) knowing community resources, (b) able to assess, monitor and coordinate services with other providers.

Knowing Community Resources

Participants stated that it is incumbent upon BHCs to know about resources in the community. All participants stated that it also helps to know agencies and organizations that provide assistance to patients in need of financial and social support, including self-help groups. Participant C stated that:

It definitely does help to know where to refer patient to and really where to give them adequate resources. They don't just ask me, as the behavioral health clinician, about their mental health, but they may ask me about labs, or where to do-- MRIs, or different things. They may reference to me, "where can I get resources for my lights?" or they're going to be turned off.

Assess, Monitor and Coordinate Services with Other Providers and Agencies

Participants stated that it is equally important be proficient in not only assess, providing interventions and monitoring patients, but also coordinate services with other providers, internally and externally. All participants reiterated that knowing where to refer patients will improve continuum of care. Participant D stated that:

The care coordination in primary care, again, it goes back to the level of experience. Because when you're listening to a person kind of explain what their symptoms are, I have to be acute in listening. Is this really something that can be managed with sleep? Do I need to help you get effective sleep? Is that going to help with the anxiety? And definitely kind of placing that person where I feel that they would get the best treatment. And understanding that in this short-term treatment, that the goal is to kind of help you manage this. If it cannot be

managed, in my clinical judgment, within four to six sessions, then it is best for

the patient to be referred out to where they can have a longer time to kind of

manage the-- get these symptoms under control.

Participant C stated that:

Well, we use the term a warm handoff approach, which is basically passing the

patient from one provider on the team to one discipline on the team. We refer to it

as discipline whether it's social, or pharmacy, nursing, or the actual provider,

passing them from one discipline to the next. So really, contacting that provider or

that person on the team saying, "Hey, can you see this patient?" We even have a

PACT social worker who does a lot of the case management resources, as a part

of the team.

Participant H stated:

In terms of consults, assessing the situation, connecting and linking people to

other parts of the system where they can get specialized training in trauma,

specialized treatment in trauma and substance abuse, or whatever. You're

constantly linking people to the PACT social worker who does resources and

connects them to legal resources and housing resources, and you may have to see

the homeless social worker, the social worker that works with the homeless

program. So, you're always connecting people to services. You're like, "I'm like

the gatekeeper here."

Summary

In this chapter, I described the purpose of the research study and research questions. This was followed by description of the procedure, including the selection of eight BHCs from three organizations, providing integrated primary care services and located in the Western, Eastern and Southeastern parts of North Carolina. I described the demographics, credentials and experiences of participants. Data collection and analysis were discussed, including the use of semi-structured interview to collect data from participants and the use of line-by-line coding and the limited use of NVivo software in my data analysis to help me identify themes and phrases, and inductive coding frame that allowed concepts to emerge through common phrases and patterns from interviewees' responses. Identified themes and subthemes were described using a table and description to illustrate participants lived experiences and meanings to support the phenomenological nature of my interview.

In Chapter 5, I will discuss the findings of this study, the limitations, recommendations and how the research study affect social change. I will describe what the findings confirm, disconfirm, or extend knowledge in the discipline by comparing them with what has been found in peer-reviewed literature described in Chapter 2. I will also interpret the findings in the context to conceptual framework. I will conclude chapter 5 by providing a strong recommendation that captures the key essence of the study.

Chapter 5: Discussions, Conclusions and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to describe the lived experiences of BHCs, who had transitioned from specialty outpatient behavioral healthcare settings to IPC settings. In this study I explored the competencies needed by BHCs to provide effective behavioral healthcare in integrated primary care settings. Chesher et al. (2012) argued that effective integrated primary care requires establishment of a treatment team, that consists of PCPs and BHCs who have received training in clinical health psychology providing them with the competence needed to provide holistic healthcare in IPC settings. Similarly, Beacham et al. (2012) stated that BHCs' roles as key treatment team members are important to, inseparable from, and vital to the provision of holistic care in a system-based approach. Blount and Miller (2009) argued that BHCs transitioning from the traditional outpatient mental health centers and clinics to integrated primary care settings, usually have different clinical backgrounds and may not have the training needed to excel and provide effective services in IPC settings. Similarly, Tew et al. (2010) and Peek (2009) argued that implementers of integrated care should be concerned about the use of BHCs to provide treatment in integrated settings, without appropriate clinical training and specific licensure and credentialing relevance to the practice of behavioral healthcare in integrated behavioral healthcare.

The objectives of this research study were met by probing the following questions:

RQ1: How do BHCs who have transitioned from specialty outpatient behavioral healthcare settings describe their lived experiences in IPC settings?

RQ2: How do BHCs describe best practices in IPC settings?

Qualitative researchers are required to focus their attention on questions that will help gather data that will lead to a textual and structural description of experience of participants to help understand their common experiences (Gibbs, & Taylor, 2005). Because my research study was created with the use of a phenomenological approach, experiences and context of experience (Gibbs, & Taylor, 2005) were considered. The selection of BHCs, who work in IPC settings and the similarities in their responses indicated that the tool selected was effective in promoting rigor (Davies & Dodd, 2002).

Overview of Findings

I had the opportunity to interview eight BHCs, who worked at three integrated primary care settings in the Western, Eastern, and Southeastern parts on North Carolina. In this study, I used an interpretive phenomenological analysis to explore and determine the shared meaning of interviewees. Interestingly, most of the responses I received from these BHCs aligned with my expectations. The initial line-by-line process for coding, identified themes and phrases, in an inductive coding frame (Gibbs, & Taylor, 2005) allowing the concepts to emerge through common phrases and patterns from interviewees' responses. Five themes emerged from the data analysis, including: (a) clinical experience, (b) effective communication, (c) collaboration with PCPs, (d) continued education and trainings, and (e) care coordination.

Interpreting Findings

Clinical Experience

Participants described clinical experience for a BHC as having a graduate degree, years of clinical experience, and ability to work as a licensed independent practitioner, do brief screenings and interventions, provide holistic care, and engage in a fast-paced service provision. According to Marlowe and Hodgson (2014), effective implementation of integrated primary care depends on clearly defined competencies of providers. Similarly, Beacham et al. (2012) and Glueck (2012) posited that BHCs who are planning to transition to IPC settings would be required to have a change in mindset and be aware of the competencies required in integrated healthcare, including the adaptation of new clinical skills and intervention styles. Cox et al. (2014) concluded in their research study that successful implementation of integrated care would require a biopsychosocial approach to health care and the training of BHCs to provide holistic care in IPC settings. According to Beacham et al. (2012), BHCs' role as key treatment team members is important, inseparable, and required to provide holistic care in a system-based approach.

The gap in the literature reviewed lacked specific competencies and what constitute clinical health psychology and how it can benefit psychologists and other BHCs in primary care settings and in a fast-paced setting of PCMH (Beacham et al., 2012) where patients are diverse. Participants in this study unanimously stated that it is incumbent upon BHCs to realize the need to provide fast intervention and not psychotherapy in a fast pace environment in IPC settings. Participants unanimously stated that BHCs in IPC settings have no choice but to realize and accept the fact that service

provision in the IPC setting is done in a fast-paced environment. Some participants stated

that assessments and interventions are done in the exam room, and limited time is

allowed to ensure that the exam room is vacated to allow other medical providers to use

it. Due to the warm handoff system, BHCs may also be needed to conclude sessions in a

timely fashion and see other clients referred by the medical doctor. According to

Beacham et al. (2012), BHCs in IPC settings are expected to serve as consultants or

direct care providers and therefore, assume responsibilities that are inseparable from

services provided to other patients in IPC settings.

Effective Communication

Participants unanimously stated the importance of effective communication

between BHCs and PCPs to facilitate team building and development of trust and respect

among BHCs and PCPs. Participants stated that in an integrated care setting, effective

communication between and among a team of providers improves care for mutual

patients. Participants reported that effective communication promotes respect for

diversity of opinions and consensus-based decisions that will result in effective integrated

care. Effective communication in IPCs was described by participants as (a) BHCs' ability

to effectively communicate with PCPs, and (b) BHCs knowledge in medical aspects.

Research studies on the implementation of IPCs indicated that PCPs have the

tendency to rely on the biomedical model of disease. This may challenge PCPs in

integrated primary care, requiring them to dispute with their philosophical values to

accept the biopsychosocial model and compromise with BHCs to effectively provide IPC

(Beacham et al., 2012; Boon et al., 2004). This sentiment was reflected in the response of

participants when they described the importance of BHCs having good communication

skills about how clinical cases are presented to PCPs. Over half of the participants stated

that BHCs' ability to effectively communicate with PCPs will determine how confident

the PCPs become in the BHCs' ability to treat their mutual patients. Participant E stated

succinctly that BHCs' have to be confident enough that, when they're challenged, they

don't get upset or defensive, but are articulate enough to explain their position clearly and

then listen to the other providers. All participants stated that effective communication,

including effective presentation of clinical information, is the key to earning the trust of

PCPs.

Participants stated that, to effectively communicate with PCPs, it is incumbent

upon BHCs to know medical details including terminologies and the relationship between

medical problems and psychosocial issues, which can help BHCs communicate

effectively with PCPs. Participants stated that the amount of information BHCs need to

know to effectively communicate with PCPs and the primary care team and make

recommendations as a behavioral health care specialist would come from the knowledge

of medical aspects and training in clinical health psychology as well as

psychopharmacology. Terence et al. (2014) examined the attitudes of PCPs and their

perceptions of BHCs in integrated primary care settings self-report measures. The survey

items assessed the attitude of the PCPs and their perceptions about BHCs. The outcome

of the study indicated that PCPs who interacted and communicated more with BHCs felt

comfortable discussing mental health and substance abuse issues with their patients.

Collaboration with Primary Care Providers

Beacham et al. (2012) argued that effective implementation of integrated care requires the collaborative efforts of PCPs, including physicians, nurses, and BHCs, including psychologists, and mental health and substance abuse counselors. According to Beacham et al. (2012), integrated primary care settings and services provided are founded on the systems-based approach, which is known to be one of the core principles of PCMH. When PCPs and BHCs collaborate and work as key treatment team members, they are able to provide holistic care in a system-based approach (Beacham et al., 2012). Effective provision of collaborative care requires that management of IPC settings understand that these practices often help them resolve issues surrounding collaboration among professionals in an effort to encourage relational competence (Beacham et al., 2012; Boon et al., 2004). According to Carver and Jessie (2011), the systems-based approach of PCMH promotes the provision of person-centered care rooted in collaborative efforts.

Irrespective of the setting in which the participants worked, they all expressed the need for BHCs and PCPs to work collaboratively to achieve effective provision of services to patients in IPC settings. All participants reiterated that the collaborative effort between BHCs and PCPs benefitted both providers and patients. Participants unanimously stated that it is important that BHCs and PCPs know what is going on with a mutual patient, and this can be achieved through collaborative efforts of BHCs and PCP. According to participants, the collaborative efforts can occur through the sharing of information through instant messaging and other media set forth by the setting, including

electronic health records. Participants described collaboration with PCPs as (a) team-work, (b) warm handoff, and (c) humility.

All participants reiterated the importance of the readiness of BHCs to work together with PCPs as a team and be able to contribute to team treatment discussions and provide clinical information that can help the team effectively treat mutual patients. Participants unanimously stated that effective comprehensive and patient-centered treatment would require every member of the team to know what goes on with a mutual patient. If one person has one piece of information and somebody else has another piece of information, the treatment plan is not complete. Participants stated that by having a comprehensive treatment plan, with the participation of all professionals in an activated team, the patient is treated effectively.

In response to comprehensive and patient-centered treatment, Participant G, who is also in administrative position, stressed team work as the key to managing patients with triple diagnosis of medical, mental health, and substance use disorders. Participant G stated:

> For us here at our IPC settings, the BHC is considered a member of the
> primary care treatment team. We consider us to be practicing health care.
> We're trying not to silo mental health, substance use, medical, all
> separately. So, we have the . . . our treatment team is headed by the
> primary care provider. And then the primary care provider directs the
> various team members, whether they're case managers, behavioral health,
> nurses, dentists, we have pharmacy, we have women's health and so on.

And so, we activate or deactivate those team members as needed by the patient according to the primary care physician. So as integrated behavioral health providers, we are on the floor and we see patients in the exam room. Sometimes with the primary care provider, sometimes before, sometimes after, but we try to schedule same day, same time appointments. So, we're right there with the medical provider and the patient in the exam room.

Participants reiterated that effective provision of integrated care requires BHCs to work in collaboration with PCPs in a process known as warm handoff. Participants stated that BHCs are required to work in an environment where patients are transferred to them from PCPs directly. Participant B described collaborative effort and the BHC's ability to work with the physician and provide same day services for a client with dual or triple diagnoses. Participant B stated,

It means, as the primary care providers are seeing patients, we are taking those patients and seeing them as warm handoffs most of the time. So, we try to be there at the same day. So, we're also meeting with the primary care teams in the mornings for team huddles, talking to them about what's going on with the patients who are presenting that day, doing treatment planning, talking to the docs about scheduled medication increases, talking with them about treatment recommendations for chronic pain, insomnia, and stuff like that.

There were some unexpected results from the data analysis. While describing collaborative efforts between BHCs and PCPs, most participants stressed the need for

transitioning or entry level BHCs to be humble while dealing with PCPs and working with experienced BHCs in IPC settings. Participant G stated that BHCs planning on transitioning to integrated primary care setting, should exhibit some humility and learn how to provide interventions in a collaborative manner. Participant G stated:

They want to take traditional counseling … move it into integrated setting and still stay isolated as a traditional therapist and want to still do psychotherapy. So, they have to understand even from the get-go you're not going to be doing . . . in terms of what we consider integrated care. So, I'm still looking for their stage of change and for their willingness to be flexible, humble and learning new ways to do stuff. I think the people that want to have to make the transition have to … we go back to some of your earlier questions and those points . . . must be flexible, a willingness to be humble about the fact that they don't know what it's like to be in a primary care setting, a desire to learn what that means, a willingness to give up some of their old patterns of intervention behavior because they must work faster and collaboratively.

According to Tew et al. (2010), resistance to change in mind-set and attitude of physicians and BHCs will result in lack of collaboration and PCPs' failure to utilize available services. Providers should recognize that as respect for diversity of opinions and attempts at making consensus-based decisions increase among practitioners, their individual autonomy may be somewhat limited, as they are called to work more closely together in delivering patient care (Boon et al., 2004; Torrence et al., 2014).

Continued Education and Training

Although participants stated that training of BHCs before and after transitioning to IPC settings is necessary to ensure effective provision of behavioral health care in IPC settings, there were also diverse opinions on best time trainings should be provided. Some participants preferred training of BHCs in integrated primary care before they transition to IPC setting, others stated that ongoing training should be part of in-service orientation in IPC settings. Some participants stated that institutions should prepare graduates to work in IPC settings, while other participants suggested that it would help to have students do their field placements in IPC settings. All participants unanimously stated that BHCs should (a) have trainings in clinical health psychology and (b) be able to train PCPs.

In the wake of integrated primary care becoming a reality, healthcare organizations are required to work together to prepare health care professionals including BHCs and PCPs and train them to develop skills and competencies needed to work collaboratively and effectively in primary care settings (Hall et al, 2015). Institutions and healthcare organizations are tasked to pay attention to current situation, whereby PCPs and BHCs, who are trained in discipline specific silos and with different clinical orientations are currently employed in the same integrated primary care settings to provide shared patient-centered care (Blount & Miller, 2009; Hall, 2015). It is apparent that BHCs transitioning to IPC settings are expected to provide interventions that address behavioral medicine issues (Mauer, 2008). Aarons (2004) argued that in addition to the responsibilities of BHCs and PCPs to provide integrated services in IPC settings, there is

a need for them to develop new attitudes and skills, and appropriate training and supervision to help guide them to provide effective treatment in collaborative environment.

All participants in this study had transitioned to IPC settings from traditional behavioral health care settings and had received on the job training and some continued education training outside of their respective settings. Participant A stated that a community organization has done a good job in supporting integrated care in primary care settings in their catchment area by training clinical staff at his IPC setting to identifying ways to integrate care more effectively and in a way that speaks specifically to the needs and culture of that particular clinic and its patients. Other participants stated that training in psychopharmacology and biopsychosocial aspects have greatly helped them to work with the type of patients who come to their IPC settings.

Blount and Miller (2009) said that to ensure effective integrated care, BHCs, who are employed in primary care settings would need training and required competencies. According to Cox et al. (2014), academic institutions should train future mental health professionals on effective provision of behavioral healthcare in primary care settings. The authors suggested that course requirements of doctoral programs should include health psychology practice (Cox et al., 2014). Researchers therefore, emphasize that the effectiveness of PCMH in integrated care requires that BHCs receive appropriate training and supervision in clinical health psychology that allows them to develop the competence needed to collaborate with PCPs in order to provide holistic healthcare in integrated care settings (Glueck, 2015; Hoodin et al., 2008; Levant 2004). Without training in clinical

health psychology, BHCs would use their own ineffective treatment modalities (Cox et al., 2014).

Most of the participants stated that BHCs should be competent enough to provide training to PCPs about behavioral health. Over half of the participants stated that they have provided trainings to PCPs on behavioral health and feel such trainings are needed to help PCPs. Concerning the training of PCPs, Participant G stated that although providing trainings to PCPs is not easy, in reference to their reception of information given, trainings on behavioral health is offered. Participant F stated that when PCPs are receptive to suggestions offered by BHCs, there is improvement in communication and collaboration, resulting in effective integrated care. Marlowe and Hodgson (2014) said that the effective implementation of integrated care would require BHCs and PCPs to acknowledge each other and mutually build and maintain rapport, while competencies of both PCPs and BHCs are clearly defined (Marlowe and Hodgson, 2014).

Care Coordination

Some participants reported they work in IPC settings where they have nurse care coordinators, responsible for making referrals for their various teams. However, all participants reported that they often assume the responsibility of referral coordinators. Participants reported that there are times brief interventions may not work in IPC setting, requiring BHCs to refer patients to a higher or appropriate level of care. The care coordination was described as (a) knowing community resources, (b) able to assess, monitor and coordinate services with other providers. Participants stated that to ensure continuum of care, BHCs need to know about resources in the community. All

participants stated that it also helps to know agencies and organizations that provide assistance to patients in need of financial and social support, including self-help groups. Participant C stated succinctly that patients at times may have questions other than mental health issues, including resources in the community to help them get basic necessities, including where to get money to pay light bills.

Participants stated that it is equally important to be proficient in not only assessing, providing interventions and monitoring patients, but also coordinate services with other providers, internally and externally. All participants reiterated that knowing where to refer patients will improve continuum of care. Participant D stated that the care coordination in primary care goes back to the level of experience. Participant D stated that if patients condition cannot be managed by BHC's clinical judgment, within four to six sessions, then it is best for the patient to be referred out to where they can have a longer-term treatment to get their symptoms under control.

Participant C stated that it is also important to adhere to the warm handoff approach, which is basically passing the patient from one provider on the team to providers in another discipline on the team, including pharmacist, social worker or nurse. "So really, contacting that provider or that person on the team saying, Hey, can you see this patient? We even have a PACT social worker who does a lot of the case management resources, as a part of the team."

Participant H stated that it is incumbent upon BHCs to link patients with other units of the system where they can get specialized treatment, including treatment in trauma and intensive substance abuse treatment. As stated in chapter 2, in reference to the

macro level of integration, researchers argued that both vertical and horizontal integration

are needed to support provision of collaborative services and relational competencies of

professionals (Beacham et al., 2012; Valentijn et al., 2013; Volgel et al., 2014).

According to Valentijn et al. (2013), vertical integration refers to the focus on treating

diseases by specialized professionals at specialized settings, while horizontal integration

focuses on holistic approach to help improve the overall health of individuals and

populations through collaboration of medical providers and BHCs in integrated primary

care settings. According to Valentijn et al. (2013), effective integration requires provision

of biopsychosocial services at different levels within an integrated setting, supported by

intra professional collaboration and services coordination.

Limitations of the Study

The utilization of purposeful sampling (Tuckett, 2004) to select participants

allowed the selection of BHCs who worked in integrated primary care settings, and the

use of critical case samples, which according to Marshal (1996), are subjects who have

specific experience relative to a research design allowed me to select BHCs who have

transitioned from traditional behavioral health care centers to IPC settings. However,

according to Tuckett (2004), this method of sampling may have resulted in issues that

undermined the trustworthiness of the study, including gatekeeper bias, sample framing

bias and other logistical issues.

Since the issue of purposeful sampling was unavoidable in this study based on the

method of inquiry, it was important to approach this research study reflexively. Rennie

(2004) defined reflexivity as "self-awareness and agency within that self-awareness" (p.

183). Reflexivity, according to Morrow (2005), is the researchers' responsibility to keep a self-reflective journal from the beginning to the completion of the investigation. Emerging awareness of any assumptions or biases that emerged was recorded in my journal and these emerging self-understandings were then examined and consciously incorporated into the analysis.

Due to my profession as a BHC working in a traditional behavioral healthcare setting, and the fact that I precoded, I approached this research study and data collection reflexively. I kept a journal and wrote down my biases. I used open ended semi-structured interview question to minimize my bias. I did member checking after the interviews were transcribed verbatim and each participant informed of their represented pseudonym/alias (with an alphabet), and participants promised access to the final publication. Since this study was not randomized, the results of the study would be generalizable only to the participating group. Other BHCs who did not participate in the study may relate to integrated primary care differently. Morrow (2005), argued that social scientists regard multiple standards of quality in qualitative research study, including validity, credibility, rigor or trustworthiness. According to Morse et al. (2002), in both quantitative and qualitative methods of inquiry, rigor is a desired goal that is met through specific verification strategies and that responsibility is placed on the researcher and not necessarily the external judge of a completed study.

Recommendations

The outcome of this research study based on the strength and limitations indicated that there are gaps including the lack of approved standardized competencies and treatment modalities to treat triply diagnosed individuals with medical, mental health, and substance use disorders in integrated primary care settings. It became apparent that implementation of integrated treatment for triply diagnosed individuals is in an infant stage, although plans to adopt integrated primary care is imminent. There is lack of directions to prepare BHCs in traditional integrated behavioral healthcare settings to make a smooth transition to integrated primary care settings. Further research on these issues are needed to help train BHCs in clinical health psychology so they can compete with recent graduates who may have had training in institutions that offer trainings in clinical health psychology, find uniform and effective best practices in IPC settings, including effective intervention modalities, and patient-centered medical homes to help improve collaboration between BHCs and PCPs.

Since this research was done with participants in North Carolina, further research could be done using participants across the country. When the invitation letters for this study went out, several BHCs contacted me. However, a few of them could not be recruited due to the fact that they lived in other States and did not meet eligibility approved by Walden University IRB.

It became apparent that participants recruited included seven LCSWs and one participant with a doctorate degree in psychology (PsyD). None of the participants worked in an agency that employed Licensed Professional Counselors (LPCs), Licensed

Clinical Addictions Specialists (LCAS) or Licensed Marriage and Family Therapists (LMFTs). Participant G, who is also an administrator stated that any IPC setting that wants to bill Medicare, would have to either employ LCSW or a doctoral level psychologist, as Medicare will not reimburse services provided by LPCs, LCASs and LMFTs. Participant G stated that although, there has been positive experiences with some of these BHCs, considering the business side of it, IPC agencies are handicaped, when it comes to the employment of LPCs, LCASs and LMFTs in integrated primary care settings. Research study is therefore needed to inform graduate programs, credentialing agencies and the legislature to offer courses in clinical health psychology, reassess the credentialing process and enact legislation to ensure parity in reimbursement, respectively.

Implications for Social Change

Two of the participants interviewed worked in a rural IPC setting and their responses indicated that integrating behavioral health care into primary care can potentially benefit rural inhabitants who seek help for mental and physical stability, mainly in primary care settings. Ogbeide et al. (2016) argued that effective integrated care in primary care settings addresses the biopsychosocial aspects of individuals, including older adults, who live in rural areas and provide accessibility, generic, and holistic care. The outcome of this research study indicates that the warm handoff protocol in IPC settings encourages patients and their families as well as, give them the opportunity to access mental health services without the stigma attached to seeking mental health services in a traditional mental health center. Petersen et al. (2011) argued

integrated health care has the potential to reduce the healthcare inequalities, morbidity, and mortality among diverse populations through accessibility to treatment, improvement in diagnosing and referral, increase in collaboration among health care professionals, improvement in cross cultural interface, effective treatment for medically and mentally disenfranchised and improve compliance to treatment. Consultation and collaborative efforts between medical providers and BHCs can result in education of physicians about the urgent behavioral health needs of the diverse population (Kitts, 2010) and effective communication with psychiatrists and BHCs about mood changes in individuals with chronic medical problems (Petersen et al., 2011).

The outcome of this research study can inform world leaders to consider implementation of community health centers that operate on IPC principles to help provide effective and affordable health care. Khenti et al. (2012) stated that on the international level and over three decades after the symbolic and historic World Health Organization-United Nations International Children's Emergency Funds conference in Alma-Ata, world leaders are beginning to recognize the need for integrated primary health care (Khenti et al., 2012). Organizations and stakeholders are being encouraged to engage in conversations, establish curricula, policies and best practices that may improve mental health treatment in primary care settings (Hooper, 2014). The outcome of this study and other research studies on integrated care will also inform the WHO to persuade leaders in developing countries to define the role of BHCs in primary health care (Khenti et al., 2012).

Considering the current wave of healthcare reforms and the need to provide affordable healthcare, research study on integrated care will inform the legislature to enact legislations that will require the establishment of credentialing boards and service definitions for BHCs in primary care settings (Alvarez et al., 2014) and ensure parity in reimbursement. The outcome of research studies on integrated care will also inform clinical directors to be cognizant of the need for professional development and the need for shared electronic medical records to improve treatment outcomes (Alvarez et al., 2014).

Tew et al. (2010) argued that mental health and substance use disorders greatly affect the course and cost of treating other chronic illnesses. With budget cuts and reduced service authorization units, treating these disorders simultaneously will cut healthcare cost, make revenue available to benefit individuals and communities, and most certainly result in improved treatment outcome for individuals with triply-diagnosed medical, mental health and substance use disorders, who would in turn become productive citizens and not burden on their communities (Tew et al., 2010). Secondly, the men and women in uniform, who return from the battlefield with medical (such as traumatic brain injury), mental health and substance use disorders, deserve appropriate and comprehensive medical care (Tew et al., 2010). There is compelling evidence that the BHL which is consistent with the guiding principle of the PCMH and PACT implemented by Veterans Administration (VA), utilizes "chronic illness disease management principle to render more continuous, coordinated and efficient primary care services to veterans with diverse needs (Tew et al., 2010). The outcome of this study has

revealed that successful implementation of PCMH and PACT will ensure that qualified

BHCs are hired to provide effective behavioral health care in IPC settings (Tew et al.,

2010). This will allow our returning triply-diagnosed veterans get needed help at central

locations and improve their overall wellbeing and become productive citizens in their

various communities (Tew et al., 2010). The challenge posed for the implementation of

successful integrated treatment setting is the use of uniform, effective and reliable

standardized assessment tools, interview and appropriate treatment techniques by

qualified BHCs to effectively diagnose and treat mental health and substance use

disorders in IPC settings (Tew et al., 2010).

Conclusion

The literature review revealed that the use of qualitative method of inquiry,

interpretive phenomenological approach was appropriate to explore the lived experience

of BHCs in integrated primary care settings. This method of inquiry helped identify and

analyze themes and meanings of lived experience of BHCs from three integrated primary

care settings. Some of the literature reviewed focused on the exploration of the training of

interns using a course in graduate programs to prepare students for employment in

integrated treatment. Although the training of psychology graduates would help in

effective provision of behavioral health care in integrated setting, the BHCs currently

working in IPC settings and those planning to transition to IPC settings from traditional

behavioral health care settings, would benefit from the outcome of research studies on

integrated primary care settings to explore the competencies required to provide effective

behavioral health care services by mental health and substance abuse professionals. It is

therefore, apparent that there is a need to identify the competencies and characteristics of all mental health professionals and their effectiveness in the provision of integrated treatment.

There is lack of directions to prepare BHCs in traditional integrated behavioral healthcare settings to make a smooth transition to integrated primary care settings. The outcome of this study has revealed that some BHCs, including LPCs, LCASs and LMFTs may find it difficult to gain employment in integrated primary care settings, requiring the attention of institutions, credentialing boards and the legislature. Due to lack of parity in reimbursement and Medicare refusing to pay for services provided by these BHCs (LPCs, LCASs and LMFTs), administrators at IPC settings are reluctant to employ them. There is hope that the outcome of this study will inform the legislature to enact a bill that will ensure parity in reimbursement.

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Appendix A: Interview Questions

Interview Protocol

Date: _____

Location: _____

Name of Interviewer: _____

Name of Interviewee: _____

Interview Number: One

Central Question:

Q1. How would you describe the role of BHCs in integrated primary care?

Response #1:

Follow Up Questions:

Q2. What do you think are the skill levels of BHCs appropriate for service provision in

integrated primary care settings?

Response #2:

Q3. How would you describe comprehensive and patient centered treatment in integrated

primary care?

Response #3:

Q4. How would you describe the trainings needed to become effective licensed BHC in

integrated primary care setting?

Response #4:

Q5. What do you like least and best about your role as a BHC in integrated primary care

setting?

Response #5:

Q6. What changes did you make when you transitioned from specialty outpatient

behavior healthcare setting to integrated primary care setting?

Response #6:

Q7. What else would you like to share about the trainings and attitudes of BHCs who

have transitioned to integrated primary care settings?

Response #7:

Q8. I appreciate your time today. I want to invite you to a follow-up conversation in one week. The span of a week will provide a chance to reflect on your thoughts about integrated primary care. I would like to offer this journal as a place for you to make notes before our follow-up conversation. If you make just two entries in the journal, that will provide continuity for us from today to next week.

You may write anything you like in the journal as it is yours to keep. If you would like a starter question to guide your writing, it is this: "How has talking about your role as a BHC in the integrated primary care setting influenced your perceptions or thoughts about your work?"

You might also use the journal to jot down new ideas that occur to you after today's interview.

> Response #8:
> Did participant accept the journal? _____
> Did participant set a day/time for the follow-up interview: _____
> Any comment made by the participant about the journal or follow-up interview:

Interview Protocol

Date: _____

Location: _____

Name of Interviewer: _____

Name of Interviewee: _____

Interview Number: Two

1. How would you describe your perception of our last interview?

2. What additional information would you like to add to your responses in our last interview?

3. What information would you like to share from your journal?

Appendix B: Confidentiality Agreement for Use with Transcription Services

Research Title: Competence of Behavioral Health Clinicians in Integrated Care Settings

1. I, _____ transcriptionist, agree to maintain full confidentiality of all research data received from the researcher related to this research study.

2. I will hold in strictest confidence the identity of any individual that may be revealed during the transcription of interviews or in any associated documents.

3. I will not make copies of any audio-recordings, video-recordings, or other research data, unless specifically requested to do so by the researcher.

4. I will not provide the research data to any third parties without the researcher's consent.

5. I will store all study-related data in a safe, secure location as long as they are in my possession. All video and audio recordings will be stored in an encrypted format.

6. All data provided or created for purposes of this agreement, including any back-up records, will be returned to the researcher or permanently deleted. When I have received confirmation that the transcription work I performed has been satisfactorily completed, any of the research data that remains with me will be returned to the research team or destroyed, pursuant to the instructions of the researcher.

7. I understand that Walden University and the researcher has the right to take legal action against any breach of confidentiality that occurs in my handling of the research data.

Transcriber's Name (printed) _____

___/___/____

Transcriber's Signature _____   ___/___/____

Researcher's Name: **Agyenim Akuamoah-Boateng_____**   ___/____/___

Researcher's Signature_____   ___/____/___

Appendix C: Journaling by Participants

Each participant will be asked to keep a journal. Participants will be asked to write in their journals at least twice before the follow-up interview, which will be scheduled in one week. Participants may start writing in their journals (which will be provided by me) after the first interview.

Instructions by Interviewer in the 1st Interview:

1. You may write anything you like in the journal as it is yours to keep.

2. If you would like a starter question to guide your writing, it is this: "How has talking about your role as a BHC in the integrated primary care setting influenced your perceptions or thoughts about your work?"

3. You might also use the journal to jot down new ideas that occur to you after today's interview.

Participants will be asked to share their after-thoughts during the follow-up interview. Participants may discuss any additional information they recorded in their journals.