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Lauren Dennelly MSW, LCSW
Lehigh Valley Health Network, lauren.dennelly@lvhn.org

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Navigating Psychosocial Challenges in Primary Care with an Integrated Behavioral Health Model

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ABSTRACT

Research has demonstrated that physical health outcomes are often related to behavioral health outcomes. Integrated behavioral health models, particularly in primary care settings, help bridge gaps in care by linking the treatment of physical and emotional problems together. Social workers are a key part of the primary care treatment team because they are trained to assess patients within the full context of their biopsychosocial and spiritual needs. The following article explores the ways in which social workers can engage in integrated behavioral health models as an adaptive healthcare practice, the common healthcare challenges social workers face, and suggested interventions in integrated settings. Implications for practice are discussed including the necessary skills and background social workers in these settings should have, the need to further expand the social work workforce in integrated healthcare, and the role of social workers in the continued development and evaluation of integrated models.

Keywords: integrated behavioral health, primary care, social worker, healthcare, integrated care

Introduction

Social work has a history of significant contribution and innovation in healthcare (Gehlert, 2012; McCoyd & Kerson, 2016). Social workers often work on multidisciplinary teams for organizations that do not hold social work values and ethics as primary. In addition to these challenges, social workers and other healthcare professionals have had to navigate rapid changes in healthcare over the past few years alongside their patients, often fielding questions about insurance coverage, county assistance, medication costs, and access to mental health and substance abuse services. Given the nature of the social work role as well as the increasing complexity of healthcare services, particularly since the introduction of the Affordable Care Act of 2010 (ACA), social workers have emerged as leaders in adaptive practices that maintain quality and access as well as work within the constraints of the current healthcare system (Andrews, Darnell, McBride, & Gehlert, 2013).

One way the healthcare system has changed is in its shift towards treating the health of whole communities rather than just the health of one isolated individual. The term *population health* has gained traction in the world of healthcare by reinforcing the 'triple aim' of healthcare: better care, better cost, and better health (Berwick, Nolan, & Whittington, 2008). The health of the population is managed via a disease specific model that views members of a population as part of a registry of patients with specific conditions, both mental and physical. These mental and physical health conditions have a multidirectional, interwoven relationship (World Health Organization, 2008), as thoughts, feelings, and behaviors impact how we understand and process information about the world around us. Social workers are trained to view the whole person in his or her environment, which includes understanding the connection between mental and physical health, as well as the individual's place within a larger systems context (Kerson, 2002). The benefits of this knowledge and expertise to the healthcare system and the patients it serves supports the inclusion of social workers in the provision of population-based care and the implementation of health policy (Andrews, et al 2013; Miller, et al., 2017).

Integrating Physical and Behavioral Health

Mental health issues have a significant impact on long term disability and dependency as well as mortality rates (Prince, et al., 2007). Recent data suggests that the prevalence rate for mental disorders in the United States is as high as 26%, with only 15.3% of the most severe cases receiving treatment (Demyttenaere, et al., 2004). Mental health issues can coincide with unexplained somatic symptoms and undiagnosed medical conditions and can act as risk factors for chronic disease (Prince, et al., 2007) as well as other co-occurring issues such as substance

abuse. In addition, certain populations with mental health and physical health concerns are at higher risk for suicide, including older adults, who have frequent contact with primary care providers within one month of completing suicide (Luoma, Martin, & Pearson, 2002).

Recent estimates have shown that approximately 42.5% of primary care patients meet criteria for a psychiatric disorder, including mood, anxiety, somatoform, and alcohol use disorder (Ansseau, et al, 2004). Further, those patients with co-occurring mental health and substance abuse disorders have a particularly difficult time accessing care, in part due to specific personal characteristics (including greater vulnerability) and structural barriers (such as service availability) within the healthcare system (Priester, et al 2016). Psychosocial and unexplained somatic symptoms consume a disproportionate amount of the primary care provider's time (Curtis & Christian, 2012) as people who experience depression often seek treatment in the primary care office rather than through a mental health agency (Borowsky et al., 2000). Mental health conditions are often misdiagnosed or underdiagnosed, particularly in minority populations or in men who frequently underreport symptoms (Borowsky et al., 2000). Through the use of an integrated behavioral health model, practitioners can address physical and mental health conditions in a more comprehensive manner than with traditional care alone. The use of an integrated model prevents patients from having to address physical and mental health needs separately, mitigating the stigma around accessing behavioral health services that often prevents people from seeking treatment (Thornicroft, 2008), as well as providing quick access to psychiatric services in times of crisis.

The term 'integrated healthcare' has been utilized to define whole systems of care as well as coordinated care among healthcare professionals for the purpose of providing patient focused healthcare services (Singer, et al., 2011). This paper will be referencing integrated healthcare in its behavioral health context in primary care, which refers to the provision of behavioral health services (mental health and substance abuse services) within a primary care setting as a means of addressing the multiple psychosocial and health needs of patients (Curtis & Christian, 2012). Integrated behavioral health models may include a behavioral health provider only or a multidisciplinary care team that includes a behavioral health provider to assist in engaging the patient in multiple services.

Specialty care, particularly psychiatry, can be prohibitively difficult to access for a variety of reasons, included but not limited to issues with insurance coverage and a dearth of treatment providers in a particular area (Cunningham, 2009; Gamm, Stone, & Pittman, 2010). In addition, patients with mental health conditions often

present in primary care with more unexplained somatic symptoms (Grandes, Montoya, Arietaleanizbeaskoa, Arce, & Sanchez, 2011) and experience higher mortality rates from multiple co-occurring conditions such as depression, diabetes and cardiovascular disease (Coventry, et al., 2015). Given that behavioral health and other psychosocial issues are already being treated in primary care settings, often without outside resources, the inclusion of an on-site behavioral health provider on the patient's treatment team is the next step in delivering quality primary care, that is, care that is provided at first contact, ongoing, coordinated, and comprehensive (Levinson-Miller, Druss, Dombroski, & Rosenheck, 2003).

Further, the changing political landscape of the past ten years has introduced the ACA, which has changed the way primary care is delivered by utilizing the Patient Centered Medical Home (PCMH) as part of a system redesign to anchor the patient's healthcare services in primary care (Curtis & Christian, 2012; Katon & Unützer, 2013; Stanhope, Videka, Thorning, & McKay, 2015). The PCMH model specifies six core components of quality patient care including care that is patient/family centered, care that is continuous, comprehensive, accessible, coordinated, and accountable (Perrin, et al 2018). Further, models of primary care behavioral health have noted that three additional components to enhance care for patients with mental illness are necessary, including additional time spent with patients, specialized training, and open communication with behavioral health providers (Perrin, et al 2018). The PCMH involves a team-based approach to chronic care management, which focuses on providing care within the context of the common challenges that chronic illness sufferers and their families face, including the emotional impact of illness (Wagner, et al., 2001). Further, providing care in this way is consistent with treating a person's overall healthcare needs, in which mind and body are not two separate entities but rather interrelated parts of a whole. Treating mental conditions in primary care allows for issues to be treated proactively and in conjunction with physical needs, resulting in better continuity of care (World Health Organization, 2008).

Treating behavioral health conditions in primary care also results in better health outcomes, particularly for diabetes, coronary heart disease, and depression (Katon et al., 2010). Those suffering with chronic conditions often struggle with self-management, and in these cases, an integrated and team based approach which includes self-management training and behavioral interventions can provide the necessary support to improve health and reduce hospitalization (Bodenheimer, Lorig, Holman, & Grumbach, 2002; Lorig, et al., 2001; Zimmerman, et al., 2016). In addition, group based primary care visits called 'care clinics' also provide an innovative approach to chronic disease management and result in better health outcomes as compared to controls (Wager et al., 2001). A

care clinic visit might include a member from two or more disciplines meeting with a patient to address multiple needs, such as a nurse care manager and behavioral health specialist addressing both medical and psychosocial needs within the context of the same visit.

Integrating physical and behavioral health is also cost effective. Multiple hospitalizations can be costly, particularly for those with chronic conditions who are hospitalized more frequently. Those with numerous comorbidities are at greater risk for medical complications resulting in higher rates of hospitalization and mortality (Katon & Unützer, 2013). Conditions such as depression often incur high costs and can impact periods of life transition including educational and occupational attainment, marriage, and child bearing (Kessler, 2012). Models of collaborative care, though requiring an initial investment in capital, have been shown to decrease the amount of time patients experience depressive symptoms, something that could have a profound impact on overall health (Simon et al., 2001).

In this way, integrated healthcare is an adaptive practice that addresses the need for multiple, interrelated services in a co-located setting. With training in the ecological model, which emphasizes viewing the person in the context of his or her social and natural environment (Rotabi, 2007) social workers are leaders in providing services that integrate the biopsychosocial and spiritual needs of patients along with the experience of chronic disease. The remainder of this paper will focus on the specific ways in which social workers can provide on-site, integrated behavioral health services as part of a comprehensive and adaptive practice.

In the primary care medical office where I work, I am the sole behavioral health specialist on the multidisciplinary care coordination team. In addition to the primary care provider, I also work with a nurse care manager, a social services coordinator, and a pharmacist. The nurse care manager on our team helps the patient understand his/her medications more clearly and reconcile any differences in medications prescribed in the hospital and in outpatient settings. The social services coordinator on our team (typically a licesnsed social worker) completes a needs assessment with an emphasis on the patient's financial, transportation, housing, and other community needs. The pharmacist on our team helps the patient manage his or her medications, which includes making sure that the medications are appropriate for the patient's diagnosis and are safe for the patient to take. Our collaborative care team model was originally designed after the Vermont Blueprint for Health Medical Home model, which emphasizes the use of community health teams as a means of linking primary care and community disease prevention strategies (Bielaszka-DuVernay, 2011).

As the behavioral health specialist on the team (typically a licensed clinical social worker or licensed professional counselor), I complete a biopsychosocial and spiritual assessment with an emphasis on the patient's behavioral health needs. The case examples I discuss in this paper are fictionalized in order to protect patient confidentiality, though they are influenced by the work I have done with patients since I began working in an integrated primary care setting in 2013. These examples not only exemplify the healthcare challenges that many patients treated in primary care face but also demonstrate adaptive practices, including multidisciplinary team work and brief clinical interventions, that social workers who are behavioral health specialists in these settings can utilize. My discussion of these case examples is drawn from my clinical experience and supported through an exploration of the literature on integrated behavioral healthcare.

Case Example #1: The 'Non-Compliant' Patient with Limited Mental Health Care Access

A 25-year-old African American male presents to the primary care office. He is diagnosed with a mood disorder and has been off his psychiatric medication since the closing of the community mental health clinic two years prior, one of only a handful of clinics in the area that takes his insurance. He has other chronic medical conditions including diabetes which causes him to frequently come in contact with primary care, emergency medicine, and inpatient medical care providers. His mental healthcare options are limited due to his insurance coverage. He has diagnosed learning disabilities and it was discovered in his last visit with the behavioral health specialist that he struggles with comprehending his medications and instructions. He also noted that he is the main financial provider for his family. He frequently interacts with multiple service providers who often do not look at one another's treatment notes and pepper his chart with the label 'non-compliant'.

The above case example presents a variety of healthcare challenges, including limited access to mental health care as well as poor coordination among service providers and the dreaded stigma that some patients carry of being 'non-compliant'. Research suggests that non-compliance among patients with mental illness arises partially due to the desire to avoid the stigma associated with mental health treatment and being labeled 'mentally ill' as well as the undesirable side effects of some psychotropic medications (Shrivastava, Johnston, & Bureau, 2012). Patients with mental illness have a high disease burden and yet poorer access to quality healthcare than patients without mental illness, and providers often dismiss their somatic complaints as psychiatric in nature (Horovitz-Lennon, Kilbourne, & Pincus, 2006). As part of an integrated and multidisciplinary team, the social

worker can view the complete picture of the patient, his/her illness, and the various facilitators and barriers to the patient's care and assist in negotiating communication among care providers.

Upon receiving the referral from the primary care provider, one of the first interventions the behavioral health specialist can utilize is engaging the patient in a conversation about what the healthcare barriers are from his or her perspective. In this example, there are underlying cognitive and psychosocial issues that clearly prevent the patient from being able to control his health. This includes other family members who are depending on him for emotional and financial support. Upon discovery of this barrier, the patient's family member can be brought in, assessed, and referred to services to help take the burden off the patient and assist him in focusing on his own needs. The nurse care manager and pharmacist could provide diabetic education and medication management and advocate for the patient regarding his medical needs. In addition, the patient could continue to see the behavioral health specialist for short term counseling in the primary care setting to address psychiatric issues and link to ongoing medication management. Whereas another professional would not assess systematically derived barriers to care, a social worker would intervene here by addressing the client's need for self-determination, addressing feelings of distrust in the medical system, and assisting him in creating a stronger support system to better advocate for his needs when interacting with medical providers (Miller, et al., 2017; Code of Ethics, 2017, revised edition).

This case example helps demonstrate the fact that mental health services are a limited commodity, particularly for those who are uninsured, low income, and lack access to many basic healthcare services (Cook et al., 2007). The emergency room and the primary care office are two settings where lack of access to mental health care manifests. For example, when local community mental health clinics and state hospitals close, patients with chronic mental health issues who frequent those facilities are without care. The quickest solution is to seek care in the ER or the primary care office to obtain refills of medications which often include complex combinations of oral or intravenous antipsychotics and other sedative medications (Little, Clasen, Hendricks, & Walker, 2011). Primary care physicians are not always prepared to manage these medications long term and would benefit from assistance with linking the patient to ongoing psychiatric support (Cunningham, 2009).

Having a behavioral health resource integrated on-site into the primary care office helps provide this kind of psychiatric support more immediately (Orden, Leone, Haffmans, Spinhoven &Hoencamp, 2017). In addition, the behavioral health specialist plays a role in strengthening the connection between the primary care office and the community through networking with local agencies (mental health, housing, welfare, corrections, etc.) and

providing consultation within a primary care visit. In this way, the integrated healthcare service, along with the newly strengthened skills of the primary care physician, can act as a bridge to assist patients in managing crises and linking to ongoing treatment. Social workers fit this integrated role well due to their awareness of the interaction between the client, the helping professional, and the surrounding system (Shulman, 2016).

Case Example #2: The Dually Diagnosed Patient in Need of Substance Abuse Treatment

A 50-year-old Caucasian female presents to the primary care office. She has a long history of alcohol use as well as dysthymia. The primary care physician is uncomfortable prescribing psychotropic medications since the patient has admitted to daily alcohol use. She is without insurance and works sporadically doing temp jobs. She reports poor social support, as most family members including her children have distanced themselves from her. The patient verbalizes being open to attending a detox and potentially a 30-day rehabilitation program. She is unable to attend without insurance unless she obtains county funding, which has already run out for the calendar year. The nearest inpatient facility is an hour away.

This case example outlines the challenges of a medically complex patient who has a co-occurring mental health and substance use issue, no insurance to pay for treatment, and few treatment options. In this scenario, the behavioral health specialist would benefit from working closely with the social services coordinator, if available, to secure medical assistance so that the patient may attend ongoing treatment for more acute issues. Clinically, the best first step with this patient would be to meet and conduct a biopsychosocial and spiritual assessment as well as utilize drug and alcohol screening tools, such as the AUDIT (Alcohol Use Disorders Identification Test), to assess frequency of use. Literature has shown that the use of screening tools as part of a comprehensive assessment assists providers in making accurate diagnoses of substance use disorders and well as initiating appropriate referrals to treatment (Bradley, et al 2007; Pilowsky & Wu, 2012). This case illustrates that a lack of public funding, poor insurance reimbursement rates and few suitable treatment options continue to plague the field of addictions, prompting the need for innovative treatment approaches to support patients with addiction issues in primary care (Priester, et al., 2016).

Since there is a considerable waiting period until approval for medical assistance can be obtained (provided the patient even qualifies financially), short term solution focused counseling could be provided in order to help the patient acknowledge current strengths and capacities for change as well as formulate goals for substance abuse treatment. Given the short term and goal focused nature of therapeutic interventions in the primary care

setting, Solution Focused Therapy (SFT) may be one viable option for behavioral health specialists in this setting. SFT is a short term and strengths-based approach that combines motivational techniques with developing solutions for change (Matto, Corcoran, & Fassler, 2003). An emphasis is placed on the aspects of the "solution" to the problem that are already present in the patient's life, as well as how the patient might recognize that the solution is present (Kim, 2008). Other elements of this modality include asking the 'miracle question', which encourages patients to think about what life would be like if the problem was somehow gone overnight, and how the patient might know that the problem has been solved (Bannink, 2011). In this way, a patient's existing resources and previous successes are highlighted for use in helping the patient solve his or her current problem.

In relation to patients with substance abuse issues, brief SFT is commonly used and thought to be effective by substance abuse program directors and staff in a variety of community settings at different levels of care (Herbeck, Hser, & Teruya, 2008). It can be utilized individually or in a group-based format to decrease symptoms of depression and improve social functioning (Smock, et al., 2008) and primary care practitioners can utilize this approach as a way to incorporate a form of brief counseling into their busy office visit schedule (Greenberg, Ganshorn, & Danilkewich ,2001). Despite its wide spread use, a common criticism of SFT is a lack of evidence-based research and mixed results in outcome studies (Kim, 2008). The social work practitioner looking to utilize this type of therapy would benefit from first reviewing research on its effectiveness and applicability to the patient's presenting issues. Perhaps one way to boost the efficacy of SFT for patients with substance use issues could be to utilize it in conjunction with motivational interviewing (MI), as both approaches are client focused, change driven, and emphasize cooperation as important in the treatment relationship (Lewis & Osborn, 2004).

MI is an evidence-based practice that supports patients that are facing ambivalence about behavior change developed by William Miller and Stephen Rollnick (Miller & Rollnick, 2002). It was first developed to treat problem drinking as an alternative to the more traditional, confrontational methods that named client resistance as an issue with the client, rather than an issue with the client-therapist relationship (Emmons & Rollnick, 2001). By examining resistance in this way, therapists utilizing MI are encouraged to elicit arguments for change from the client, as this is believed to be more effective than the therapist dictating to the client why he or she should change. The idea that it is the client's job to resolve ambivalence rather than the counselor's is part of the 'spirit' of MI (Emmons & Rollnick, 2001; pg 70). Some key skills components in MI include the use of open ended questions, affirmation of client responses, reflection, and summarization (Madson, Loignon, & Lane, 2009).

In primary care, MI can be used for the treatment of alcohol and substance use disorders (Hettema et al., 2018; Vanbuskirk, 2014) as well as in helping promote health behavior change in patients who want to quit smoking, lose weight, or increase physical activity (Armstrong, 2012; Emmons and Rollick, 2001; Martins & McNeil, 2009; Resnicow, 2002). More recently, MI has been adapted for utilization in community health settings and can be a useful style to adopt in having exploratory conversations with patients about problem behaviors. Despite an established body of evidence on the effectiveness of MI, there are still limitations to utilizing it in healthcare settings including a lack of repeated contact and time constraints that result in reduced intervention length (Emmons & Rollnick, 2001). Though MI has been found to be superior to treatment as usual, researchers are still not entirely clear on the link between its processes and outcomes (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Social workers utilizing this technique will need to adapt it to their setting and keep in mind that it is one treatment avenue to explore when working with patients who are looking to make behavioral changes.

Implications for Practice

Social workers working in integrated primary healthcare settings should be prepared to utilize a variety of innovative clinical, case management, team based and networking skills in order to provide care to patients and work collaboratively with other healthcare providers and community agencies. Social work researchers have suggested developing several skills to this effect, including strong interpersonal communication, screening and assessment, cultural competence, a systems orientation, and informatics (Stanhope, et al., 2015). Though integrated care is naturally aligned with social work values and skills, social workers looking to enter these settings should know that integration still involves a paradigm shift and should be prepared to further develop their clinical and interprofessional practice in a variety of ways.

First, becoming a clinician within a healthcare system presents several hurdles and opportunities, and is different than working in a mental health primary agency or a private practice setting. The amount of time spent with patients varies considerably from private practice, and the expectation of the agency may be to adapt interventions to a short term, 6-8 session model that could be conducted within a one to two month timespan. Prompt referral to an ongoing community therapist may also be necessary to create space for new patients that need services. In addition, social workers will be working with treatment providers who may have differing expectations about the social work role in primary care, mixed feelings about treating mental health concerns, or who may demonstrate difficulty in sharing leadership with other professionals who are also supporting the patient (Supper et

al., 2014). With an integrated model, these concerns can be addressed in a collaborative fashion in a real time. Further, the acuity level of the patient's mental health concern is often magnified by other chronic physical conditions that are being treated simultaneously in the same setting, requiring the clinician to focus on both in treatment (Pomerantz, Corson, & Detzer, 2009). Lastly, the social work role is often split into clinical and care coordination duties in order to fulfill the requirements of accountable care organizations (ACOs) under the ACA. ACOs are health organizations that are responsible for providing quality, cost effective, and comprehensive care to Medicare beneficiaries, and to receive reimbursements consistent with these requirements, organizations must provide some form of care coordination to their high-risk populations (Andrews, et al, 2013). In this way, social workers in these settings are not only keeping in mind the clinical needs of patients, but the need to fulfill requirements that are tied to reimbursement for their agencies. Though these might be areas that social workers in other settings would address, they are a larger part of the treatment process when working in a primary care setting.

Lastly, additional training is needed for social workers to work in integrated settings (Held, et al., 2019). Currently, the Council on Social Work Education (CSWE) through their Social Work and Integrated Behavioral Health Project has forged an initiative to make integrated behavioral health and primary care part of master's level social work education and have developed both clinical and policy-based syllabi to assist educators in this task ("Social Work and Integrated Behavioral Healthcare Project", 2012). Adding coursework on integrated healthcare to social work curriculum, adding a healthcare focus to existing curriculum, and adding more field placements in health and integrated healthcare settings is an important first step in growing the integrated behavioral health workforce in social work (Held, et al., 2019). Advocacy on part of professional organizations including the National Association of Social Workers (NASW) and more social workers conducting research in integrated healthcare is also needed in order to establish social workers as leaders in this area of practice. Perhaps one of the main reasons there aren't enough social workers in these settings currenrtly is the edge in research, practice, and education that other professionals, including psychologists, have gained in establishing themselves as primary providers of integrated behavioral health services. Social workers can further establish themselves as leaders in the healthcare field by participating in agency and community efforts to conduct research and program evaluation in health and integrated healthcare settings.

Conclusion

Integrating behavioral health in primary care settings offers an opportunity for social workers to apply their natural framework of treating the whole person in his or her environment within the healthcare arena. They are engaged in an adaptive practice that reflects a compromise between the need for quality care and the constraints of contemporary healthcare settings. Through their role in this setting, they are able to address needs spanning from access, a lack of appropriate treatment options, and poor care coordination. They also have the opportunity to develop an understanding of policy level issues such as poor reimbursement rates and funding disparities. Together with their patients, they face the healthcare system's current challenges by remaining innovative in their approach, maintaining flexibility, and engaging in interdisciplinary practice. If social workers are to maintain a place on integrated treatment teams, it is imperative that more social work researchers studying behavioral health integration address the specific contribution social workers and social work interventions have made on patients, providers, and health outcomes.

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References

Andrews, C. M., Darnell, J. S., McBride, T. D., & Gehlert, S. (2013). Social work and implementation of the Affordable Care Act. *Health & Social Work, 38*(2), 67-71.

Ansseau, M., Dierick, M., Buntinkx, F., Cnockaert, P., De Smedt, J., Van Den Haute, M., & Vander Mijnsbrugge, D. (2004). High prevalence of mental disorders in primary care. *Journal of affective disorders, 78(*1), 49-55.

Armstrong, M. J., Mottershead, T. A., Ronksley, P. E., Sigal, R. J., Campbell, T. S., & Hemmelgarn, B. R. (2011). Motivational interviewing to improve weight loss in overweight and/or obese patients: A systematic review and meta-analysis of randomized controlled trials. *Obesity Reviews,* no. doi:10.1111/j.1467-789X.2011.00892.x

Bannink, F. (2011). *1001 solution focused questions. 2nd revised edition. *. New York: W. W. Norton and Company.

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs, 27*(3), 759-769. doi:10.1377/hlthaff.27.3.759

Bielaszka-DuVernay, C. (2011). Vermont's blueprint for medical homes, community health teams, and better health at lower cost. *Health Affairs, 30*(3), 383-386.

Bodenheimer, T., Lorig, K., Holman, H., & Grumbach, K. (2002). Patient self-management of chronic disease in primary care. *Jama, 288*(19), 2469-2475. doi:10.1001/jama.288.19.2469

Borowsky, S., Rubenstein, L., Meredith, L., Camp, P., Jackson-Triche, M., & Wells, K. (2000). Who is at risk of nondetection of mental health problems in primary care? *Journal of General Internal Medicine, 15*(6), 381-388. doi:10.1046/j.1525-1497.2000.12088.x

Bradley, K., DeBenedetti, A., Volk, R., Williams, E., Frank, D., & Kivlahan, D. (2007). AUDIT-C as a brief screen for alcohol misuse in primary care. *Alcoholism: Clinical and Experimental Research, 31*(7), 1208-1217.

Cook, N. L., Hicks, L. S., O'Malley, A. J., Keegan, T., Guadagnoli, E., & Landon, B. E. (2007). Access to specialty care and medical services in community health centers. *Health Affairs, 26*(5), 1459-1468. doi:10.1377/hlthaff.26.5.1459

Council on Social Work Education Social Work and Integrated Behavioral Healthcare Project. Retrieved from www.cswe.org/Centers-Initiatives/Initiatives/Social-Work-and-Integrated-Behavioral-Healthcare-P

Coventry, P., Lovell, K., Dickens, C., Bower, P., Chew-Graham, C., McElvenny, D., ... & Baguley, C. (2015). Integrated primary care for patients with mental and physical multimorbidity: cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. *bmj, 350*, h638.

Cunningham, P. (2009). Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care. *Health Affairs, 28(3),* 490-501.

Curtis, R. & Christian, E. (2012). *Integrated care: Applying theory to practice*. New York: Routledge.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, [. V., Kovess, [. V., Lepine, J. P., . . . Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the world health organization world mental health surveys. *Jama, 291*(21), 2581-2590. doi:10.1001/jama.291.21.2581

Emmons, K. M., & Rollnick, S. (2001). Motivational interviewing in health care settings. opportunities and limitations. *American Journal of Preventive Medicine, 20*(1), 68-74. doi:10.1016/S0749-3797(00)00254-3

Gamm, L., Stone, S., & Pittman, S. (2010). Mental Health and Mental Disorders-A Rural Challenge: A Literature Review. *Rural Healthy People, 1(1),* 97-114.

Grandes, G., Montoya, I., Arietaleanizbeaskoa, M., Arce, V., & Sanchez, A. (2011). The burden of mental disorders in primary care. *European Psychiatry, 26*(7), 428-435.

Gehlert, S. Conceptual underpinnings of social work in health care. In Gehlert, S. and Browne, R. (2012). *Handbook of Health Social Work.* Wiley.

Greenberg, G. Ganshorn, K & Danilkewich, A. (2001). Solution-focused therapy. counseling model for busy family physicians. *Canadian Family Physician, 47*(11), 2289. Retrieved from http://www.cfp.ca/content/47/11/2289.abstract

Held, M. L., Black, D. R., Chaffin, K. M., Mallory, K. C., Milam Diehl, A., & Cummings, S. (2019). Training the Future Workforce: Social Workers in Integrated Health Care Settings. *Journal of Social Work Education,* 1-14.

Herbeck, D.|Hser, Y. & Teruya, C. (2008). Empirically supported substance abuse treatment approaches: A survey of treatment providers' perspectives and practices. *Addictive Behaviors, 33*(5), 699-712. doi:10.1016/j.addbeh.2007.12.003

Hettema, J., Cockrell, A., Reeves, A., Ingersoll, K., Lum, P., Saitz, R., Murray-Krezan, C., Carrejo, V. (2018). Development and differentiability of three brief interventions for risky alcohol use that include varying doses of motivational interviewing. *Addiction Science and Clinical Practice, 13*(6) doi:10.1186/s13722-017-0102-0

Horvitz-Lennon, M., Kilbourne, A. M., & Pincus, H. A. (2006). From silos to bridges: Meeting the general health care needs of adults with severe mental illnesses. *Health Affairs, 25*(3), 659-669. doi:10.1377/hlthaff.25.3.659

Katon, W., Lin, E., Von Korff, M., Ciechanowski, P., Ludman, E., Young, B., . . . McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *N Engl J Med, 363*(27), 2611-2620. doi:10.1056/NEJMoa1003955

Katon, W. J., & Unützer, J. (2013). Health reform and the affordable care act: The importance of mental health treatment to achieving the triple aim. *Journal of Psychosomatic Research, 74*(6), 533-537. doi:10.1016/j.jpsychores.2013.04.005

Kerson, T. (2002). *Boundary spanning: An ecological reinterpretation of social work practice in health and mental health systems.* New York: Columbia University Press.

Kessler, R. C., PhD. (2012). The costs of depression. *Psychiatric Clinics of North America, 35*(1), 1-14. doi:10.1016/j.psc.2011.11.005

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice, 18*(2), 107-116. doi:10.1177/1049731507307807

Levinson-Miller, C., Druss, B. G., Dombrowski, E. A., & Rosenheck, R. A. (2003). Barriers to primary medical care among patients at a community mental health center. *Psychiatric Services, 54*(8), 1158-1160. doi:10.1176/appi.ps.54.8.1158

Lewis, & C., &. O., T. (2004). Solution Focused Counseling and Motivational Interviewing: A Consideration of Confluence. *Journal of Counseling & Development,82(1),* 38-48. https://doi.org/10.1002/j.1556-6678.2004.tb00284.x

Little, D. R., Clasen, M. E., Hendricks, J. L., & Walker, I. A. (2011). Impact of closure of mental health center: emergency department utilization and length of stay among patients with severe mental illness. *Journal of health care for the poor and underserved, 22*(2), 469-472.

Lorig, K., Sobel, D., Ritter, P., Laurent, D., & Hobbs, M. (2001). Effect of a self-management program on patients with chronic disease. *Effective Clinical Practice, 4*(6), 256-262.

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice, 20*(2), 137-160. doi:10.1177/1049731509347850

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159*(6), 909-916. doi:10.1176/appi.ajp.159.6.909

Madson, M., |Loignon, A., Lane, C. (2009). Training in motivational interviewing: A systematic review. *Journal of Substance Abuse Treatment, 36*(1), 101-109. doi:10.1016/j.jsat.2008.05.005

Martins, R. K., & McNeil, D. W. (2009). Review of motivational interviewing in promoting health behaviors.*Clinical Psychology Review, 29*(4), 283-293. doi:10.1016/j.cpr.2009.02.001

Matto, H., Corcoran, J., & Fassler, A. (2003). Integrating solution-focused and art therapies for substance abuse treatment: Guidelines for practice. *The Arts in Psychotherapy, 30*(5), 265-272. doi:10.1016/j.aip.2003.08.003

McCoyd, J. & Kerson, T. (2016). *Social work in health settings: Practice in context (4th Edition)*. London: Routledge.

Miller, W. and Rollnick, S. (Ed.). (2002). *Motivational interviewing* (2nd ed.) The Guilford Press.

Miller, D., Bazzi, A., Allen, H., Martinson, M., Salas-Wright, C., Jantz, K., ... & Rosenbloom, D. (2017). A social work approach to policy: Implications for population health. *American journal of public health, 107*(S3), S243-S249.

National Association of Social Workers. (2017). Revised edition. Retrieved April 22nd, 2019, from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Perrin, J., Reimann, B., Capobianco, J., Wahrenberger, J. T., Sheitman, B. B., & Steiner, B. D. (2018). A model of enhanced primary care for patients with severe mental illness. *North Carolina medical journal, 79*(4), 240-244.

Pilowsky, D. J., & Wu, L. T. (2012). Screening for alcohol and drug use disorders among adults in primary care: a review. *Substance abuse and rehabilitation, 3*, 25.

Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: an integrative literature review. *Journal of substance abuse treatment, 61*, 47-59.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). Global mental health 1 - no health without mental health. Retrieved from http://researchonline.lshtm.ac.uk/8505/

Resnicow, K., DiIorio, C., Soet, J. E., Borrelli, B., Hecht, J., & Ernst, D. (2002). Motivational interviewing in health promotion. *Health Psychology, 21*(5), 444-451. doi:10.1037/0278-6133.21.5.444

Rotabi, K. (2007). Ecological theory origin from natural to social science or vice versa? A brief conceptual history for social work. *Advances in social work, 8(*1), 113-120.

Smock, S., Trepper, T., Wetchler, J., McCollum, E., Ray, R., & Pierce, K. (2008). Solution-focused group therapy for level 1 substance abusers. *Journal of Marital and Family Therapy, 34*(1), 107-120. doi:10.1111/j.1752-0606.2008.00056.x

Shulman, L. (2016). *The skills of helping individuals, families, groups, and communities (8th ed.)* Belmont, CA: Thomson Brooks/Cole.

Shrivastava, A., Johnston, M., & Bureau, Y. (2012). Stigma of mental illness-2: Non-compliance and Intervention. *Mens sana monographs, 10(1),* 85.

Simon, G., Katon, W., VonKorff, M., Unützer, J., Lin, E., Walker, E., Bush, T., Rutter, C., & Ludman, E. (2001). Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. *American Journal of Psychiatry, 158*(10), 1638-1644. doi:10.1176/appi.ajp.158.10.1638

Singer, S., Burgers, J., Friedberg, M., Rosenthal, M., Leape, L., & Schneider, E. (2011). Defining and measuring integrated patient care: Promoting the next frontier in health care delivery. *Medical Care Research and Review, 68*(1), 112-127. doi:10.1177/1077558710371485

Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated health: An opportunity for social work. *Social Work in Health Care, 54*(5), 383-407. doi:10.1080/00981389.2015.1025122

Supper, I., Catala, O., Lustman, M., Chemla, C., Bourgueil, Y., & Letrilliart, L. (2015). Interprofessional collaboration in primary health care: a review of facilitators and barriers perceived by involved actors. *Journal of Public Health, 37*(4), 716-727.

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiology and Psychiatric Sciences, 17(1)*, 14-19. https://doi.org/10.1017/S1121189X00002621

VanBuskirk, K., & Wetherell, J. (2014). Motivational interviewing with primary care populations: A systematic review and meta-analysis. *Journal of Behavioral Medicine, 37*(4), 768-780. doi:10.1007/s10865-013-9527-4

van Orden, M., Leone, S., Haffmans, J., Spinhoven, P., & Hoencamp, E. (2017). Prediction of mental health services use one year after regular referral to specialized care versus referral to stepped collaborative care. *Community mental health journal, 53*(3), 316-323.

Wagner, E., Grothaus, L., Sandhu, N., Galvin, M., McGregor, M., Artz, K., & Coleman, E. (2001). Chronic care clinics for diabetes in primary care: A system-wide randomized trial. *Diabetes Care, 24*(4), 695-700. doi:10.2337/diacare.24.4.695

World Health Organization. (2008). Integrating mental health into primary care: A global perspective. Retrieved from http://www.who.int/mental_health/policy/services/integratingmhintoprimarycare/en/

Zimmermann, T., Puschmann, E., van den Bussche, H., Wiese, B., Ernst, A., Porzelt, S., ... & Scherer, M. (2016). Collaborative nurse-led self-management support for primary care patients with anxiety, depressive or somatic symptoms: Cluster-randomised controlled trial (findings of the SMADS study). *International journal of nursing studies, 63*, 101-111.