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Integrating Behavioral Healthcare and Primary Care, Appropriate Balance on What Model is Driving Care, and, the Whole Spectrum of Individuals are Coming Through the Door…

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Abstract
With the integration of behavioral health services into primary care and other medical specialties, the community of providers and the public must address a number of questions, including: What models of care are there for these services? What kinds of providers supply these services? Are these providers trained behavioral health providers or extenders in some form? And, as these systems of care are constructed, who makes use of them? The purpose of this study is to address these questions as well as to consider some of the challenges of attending to the spectrum of needs that will arise as integrated healthcare services expand. Consideration of these questions may serve to clarify the impact that these models of healthcare will have in ways that may be readily apparent and, at the same time, in ways that may be subtler and less comprehensible. Addressing these questions is also intended to facilitate discussions within healthcare systems and among providers concerning which models of care best respond to specific populations. In turn, proactively answering these questions will, for the foreseeable future, shape not only behavioral healthcare, in perhaps small or large ways, but also healthcare in general.

Keywords Integrated behavioral health · Vertical integration · Horizontal integration · Physician extender · Spectrum of disorders

Introduction: What is the Model of Care, Are There Concerns About Extenders, and, Consequently, Who Continues to Come Through the Clinic's Doors?

With the integration of behavioral health services into primary care and other medical specialties, the community of providers and healthcare organizations must address a number of naturally arising questions. First of all, what are the models of care for these services? There are several that will be discussed below that represent a continuum of efficacy and models. Second, what kinds of providers are supplying these services, and are these providers trained behavioral health providers or extenders of some type? As described in 1976 by Glenn and Goldman as well as others at these earlier times (Morris & Smith, 1977; Schneider & Foley, 1977), descriptions of physician extenders have been in the literature for over 40 years and included the following providers (p. 64).

> Over the past ten years, two principal types of physician extenders have been developed. The first type would include physician assistants, exemplified by the Duke University Physician Associate Program and by various Medex programs. The second type would include nurse practitioners, represented by an assortment of training programs and job titles.

Third, who continues to come through the door of these clinics in need of services? Here, for those who work in these setting the answer may be obvious, while other may imagine a more circumscribed population. In reality, the whole spectrum of behavioral health service needs find their way into integrated settings.

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These are but a few of the very important questions to ask as the whole notion of integrated behavioral healthcare unfolds and develops. The purpose of this manuscript is to address these questions as well as to consider the challenges of attending to the spectrum of needs that will arise as integrated healthcare services expand. Addressing these questions is intended to facilitate discussions within healthcare systems and among providers concerning which models of care best respond to specific populations. In turn, proactively answering these questions will, for the foreseeable future, shape not only behavioral healthcare, in perhaps small or large ways, but healthcare in general.

Bringing behavioral healthcare to larger populations continues to impact healthcare in ways that may be readily apparent, but there are other changes in service provision that may be subtler and less obvious to providers, let alone the general public. For instance, some healthcare laws have a certain precedent or arguably more import in behavioral healthcare, such as the Health Insurance and Portably Accountability Act (HIPAA) and what is generally referred to as 42 CFR, which addresses privacy and substance use disorders (Department of Public Health and Human Services, 2018; Federal Register, 2017; Hodgson, Mendenhall, & Lamson, 2013; Hudgins, Rose, Fifield, & Arnault, 2013, 2014; Smolyansky, Stark, Pendley, Robins, & Price, 2013). In some instances advocates for integrated models have minimized the importance of these federal laws or deemed them unnecessary impediments to care (Havercamp, 2017; Little, 2018), a development that has been most concerning (Bütz, 2018). As another example, there is the matter of discriminating between screening tools (Kroenke & Spitzer, 2002; Spitzer, Kroenke, Williams, & Löwe, 2006) and psychological assessment instruments (American Educational Research Association, American Psychological Association & National Council on Measurement Education, 2014; Society for Personality Assessment, 2006). Although, psychologists working in these settings likely appreciate that the differences between screening tools and psychological assessment instruments are vast, other providers and psychologists working in other treatment modalities may not (Bütz, 2019). The differences in how behavioral healthcare by comparison to the broader field of healthcare addresses these matters may not be evident to medical providers, let alone the individuals being administered these screening tools. Similarly, some models developed for integrated care highlight important brief and focused methods. These models are a necessity in these new environments, but there are important differences between these service delivery models and how behavioral healthcare has been practiced. Literature associated with these new models needs further development in order to clarify the lineage of thought represented by prior behavioral healthcare researchers and theories attendant on expectations for collegial scholarship and vigilance that maintains the integrity of behavioral healthcare's continuum of care.

Considering the continuum of behavioral healthcare services, we have at one end integrated care targeted at a population model of healthcare and addressing health behaviors such as smoking cessation, substance abuse, and the maintenance of chronic illness. At the other end, specialty services require providers to have extensive additional training, supervision, and experience in order to properly serve individuals. These are modalities such as psychotherapy, family therapy, clinical assessment, and neuropsychological assessment, and it is argued that one end of the continuum can neither simply supplant nor set aside the other end of the continuum. Each level up and down this continuum requires necessary skill sets and modality-based limitations for the successful integration of behavioral healthcare. Diversity of services, modalities of care, disciplines, and theoretical orientations to the work in behavioral healthcare must ensure the field's ability to serve larger and larger populations.

Given this complexity, knowledgeable vigilance is needed to maintain an educated understanding of the continuum of behavioral healthcare and the continuum's integrity. Healthcare systems, providers, and the public need to know and understand these delivery models in order to be informed about care delivered and received. These considerations are applicable to the models of care along this continuum, the kind and quality of providers that are the face of this integration, and the spectrum of individuals who come seeking these services. In light of the many aspects involved with integration, the future of behavioral health encompasses a substantial number of considerations indeed. Yet, if we are to move forward with the inevitable growth of the field it would be best to do so with our eyes open.

Models of Care: Horizontal and Vertical Considerations

At this point a number of models of care vie for a place along the continuum of behavioral health integration programs, which range from essentially medical models of chronic illness to integration of psychosocial models into the larger health care system (Davis et al., 2013; Integrated Health Care Alliance/American Psychological Association, 2017; Kolko & Perrin, 2014; Hickey, 2013; Kwan & Nease, 2013; National Register of Health Service Psychologists, 2017; SAMHSA-HRSA Center for Integrated Healthcare Solutions, 2017). Reverse integration approaches serve people with severe and persistent mental illness at one end of the spectrum (Maragakis, Siddharthan, Rach, Beisel, & Snipes, 2016; Shackelford, Sirna, Mangurian, Dilley, & Shumway, 2013). In the middle are the Collaborative Care and the IMPACT Models that also emphasize identifying patients

who have a chronic mental illness (Unützer et al., 2002; Woltmann et al., 2012). At the other end is the Primary Care Behavioral Health (PCBH) Model that emphasizes social and behavioral components of health in all people served by a clinic (Robinson & Reiter, 2007; Vogel, Malcore, Illes, & Kirkpatrick, 2014). Briefly, some models are more open to trans-disciplinary or trans-theoretical approaches, as Vogel et al. describe (2014, p. 131):

> Within integrated care, different health care delivery models have been tested, among them care/disease management (CM) and primary care behavioral health (PCBH; Robinson & Reiter, 2007). The population-based CM model uses vertical integration to target discrete and often chronic conditions (typically high-frequency and high-cost conditions, such as depression or diabetes) with specific treatment protocols. The PCBH model is generally nontargeted (open to a variety of presenting problems); nonspecific (treatment based on provider decision); and addresses population health through horizontal integration.

These two models of care have implications, and implementation models and literature have been developing for each model. One model of care tends to represent an approach to healthcare generally characterized as disease-based, with both health and behavioral health difficulties perceived as disease states (Bzdok & Meyer-Lindenberg, 2017; Schildkrout, Benjamin, & Lauterbach, 2016). Models of care described on the other end of the continuum have represented an approach to healthcare that is arguably more holistic (Wade & Halligan, 2004) and focuses on medical as well as "…sociocultural and humanistic aspects…" (Green, Carrillo, & Betancourt, 2002). Calls to embrace one approach or the other echo through the larger literature on these matters (Kinderman, 2014; Silbersweig, 2017). However, the best outcomes up and down the continuum occur when behavioral and medical providers work together in a fashion that mirrors the integration they seek, taking the median approach and applying a whole-person focus (Crowley & Kirschner, 2015; Muse, Lamson, Didericksen, & Hodgson, 2017).

The kind and quality of provider chosen to represent the face of integrated behavioral healthcare to the public is also an important matter, since the biases described above tend to support one conceptualization or the other. If, for example, a provider is an extension of a psychiatrist within a system designed to address healthcare from a disease-model orientation, then it is possible to argue that a bachelor-level nurse or social worker would be sufficient. As noted earlier by Vogel et al. (2014), the model of vertical integration would support this notion. Through the use of registries as required by Collaborative Care Models or IMPACT, a psychiatrist is able to reach down through the primary care physician, the physician extender, other providers, and the clinic itself to reach individuals and provide a certain type of intervention.

These models are very different from those described as horizontal or through descriptors such as PCBH. In these models of care, the provider who is the face of an integrated care setting tends to be an independently licensed behavioral health provider, who collaborates with other health care providers at a clinic. They are able to diagnose and treat the whole array of behavioral healthcare maladies from a number of different approaches, but all of this is done in collaboration with their healthcare partners, who reside at the next desk or within the same clinic walls. Each model represents a different choice of representative the public interacts with and specifies what integration looks like with regard to a treatment alliance and care strategies.

These kinds of service delivery challenges are not unique to integrated behavioral healthcare, and, in fact, family medicine has been facing a similar set of challenges (Saultz et al., 2015, pp. 613–614):

> A growing number of family physicians are now employed by hospital-based delivery systems, sometimes called vertically integrated systems, where they are expected to model their practices to meet larger system priorities and to justify system investments in practice infrastructure. A second group of family physicians have embraced team-based care and population health in the PCMH[1] model while remaining in independent practices or community health centers, but these physicians have struggled to access the capital investments and enhanced payment needed to pay for electronic health records and to expand services for larger patient populations.

Also, under the current system of healthcare financing, vertically integrated models have become more lucrative (Centers for Medicare & Medicaid Services Medical Learning Network, 2017). For the reasons stated above, an important distinction has developed between the terms "collaborative care" and "integrated care," which reflects financial and service delivery realities (American Psychological Association, 2017). In turn, the practice of caring for individuals through these models suggests that the face of a vertically integrated care delivery system could be a bachelor-level provider who will address more simplistic population-based behavioral health challenges under the supervision of a licensed psychiatric provider. The horizontal model's face is that of an independently licensed behavioral health provider who shares an alliance with a medical team in terms of both providing services to individuals and working within the same walls and consulting with one another. This provider, as an

[1] Patient Center Medical Home.

independently licensed professional, is also able to entertain and respond to more complex and varied clinical situations by virtue of breadth of experience and the model of care employed (Peek, Baird, & Coleman, 2009). Obviously, in reality, not all systems of care at either end of the continuum function in these ways, and the examples above are offered to provide distinctions. There are hybrids, too, and of late Raney has suggested that a "blended model" of Collaborative Care and PCBH may best serve primary care panels (2017, p. 5): "An ideal approach might be to use a 'blended' method that combines the PCBH model and the CoCM.[2]"

There are still other considerations to address by expanding the scope of practice in integrated behavioral healthcare to those not familiar with the intricacies beyond these models of care and the providers whom individuals encounter. For example, universal screening in primary care means that the number of people seen will be larger. This is regardless of whether or not healthcare organizations wish to screen for smoking cessation, substance use, treatment maintenance of a disease process or more, and seemingly common pathologies such as anxiety and depression. By definition, opening up a healthcare population to behavioral healthcare services means that in reality the whole spectrum of pathology (Bütz, 1997) will likely be presented to these behavioral specialists in primary care settings, regardless of when and if more sophisticated pathologies are recognized by these providers.

Who Continues Coming Through the Door, The Whole Spectrum…

It has long been known that (Luoma, Martin, & Pearson, 2002), "On average 45% of suicide victims had contact with primary care providers within 1 month of suicide." Accordingly, with the integration of behavioral healthcare into primary care, the capacity of providers and the acuity of their skills become critical considerations. A population health model suggesting that behavioral specialists in primary care only need to screen for a specific lower level pathology is, therefore, problematic in many ways. Behavioral health intervention at this end of the continuum requires just as much integrity and vigilance as at any other place along the continuum. Irrespective of what a healthcare organization or a payer may want to screen for, probabilistic models suggest that the whole of the spectrum of pathology likely has, and will, continue to work its way through primary care clinics as it has for some time (Brody, Khaliq, & Thompson, 1997; Hemmings, 2000; Smith, Kendall, & Keefe, 2002). It would seem that in the rush to implement models of care and bring non-licensed behavioral specialists forward as clinicians, this fundamental reality continues to be overlooked when considering how to set up models of care and, moreover, what kind of provider will see these individuals after a warm-handoff or referral.

These considerations include such often-discussed populations as veterans, who present at Veterans Affairs primary care clinics with an incidence of Post-traumatic Stress Disorder as high as 39% and problematic drinking at 26% (McDevitt-Murphy et al., 2010). It stands to reason that if organizations serve similar populations with known risk factors, and fail to screen for these factors, on average one-third of these individuals' most basic needs may well be overlooked. This would obviously apply to other populations as well (Foy, Kelleher, Laraque, & American Academy of Pediatrics Task Force on Mental Health, 2010). These are just a few poignant examples of the dangers should service provision not be up to standards and fail to consider those drawn to a clinic's door. The challenge is that the use of a few screening tools alone may produce a clinical focus that is too narrow, which potentially overlooks other important symptoms requiring care. Providing a screening tool for each malady is not the answer, either. Hence, the quandary healthcare organizations face about choosing a model of care that addresses the spectrum of needs presented by people walking through the doors of their clinics. At the same time, if healthcare organizations either see more individuals, or a more varied population of individuals, or both, then it is fundamentally to be expected that the organization will see a broadening spectrum of individuals with a wider array of pathology coming through those doors. This is not a novel concept, but, as with any enterprise, certain realities do get lost over time or sidestepped by some models of care not designed to address them.

In light of all of this, it also seems that, as a field, behavioral healthcare needs to question who has or will be addressing the care needs of those coming through the doors and how. Most in healthcare are familiar with the term physician or provider extender, professionals who are not doctoral or master-level healthcare providers but perform such activities under direct supervision. So what happens when this function is vertically integrated within the models being presented as a new way of performing behavioral healthcare? As noted before, there is the possibility of a bachelor-level provider becoming the face of integrated behavioral health, and, some have actually advocated for bachelor-level providers as sufficient (Schoenwald, Hoagwood, Atkins, Evans, & Ringeisen, 2010). Others, however, are concerned about these sorts of models (Serrano, Cordes, Cubic, & Daub, 2017), and still others are concerned about the potential shortage of graduate students in training and having enough independently licensed providers (Blount & Miller, 2009; Held, Mallory, & Cummings, 2017). Fundamentally, a number of organizations have viewed these needs

[2] Collaborative Care Model.

as so considerable that they have proposed guidelines or introductions to working in these environments (American Mental Health Counselor's Association, 2017; American Psychological Association, 2013; American Psychiatric Nurses Association, 2017; National Association of Social Workers, 2012). It is of primary importance to consider who could and does come through the doors of these clinics. More important, however, is the question of how well their behavioral healthcare needs will be served.

Conclusion: Models of Care and Providers are the Face of Integration

With the matters reviewed, there are some fundamental concerns raised about how the notion of integrated behavioral healthcare moves forward and how to raise awareness of the potential challenges and shortcomings that likely have been, and will continue to be, encountered. Generally, most would agree that the integration of behavioral healthcare into primary care and other medical settings is beneficial; and at the same time maintaining behavioral health's service diversity will remain crucial if the needs of those served are to be met.

There are naturally questions about the kind and quality of provider who serves as a point of contact with different integrated models of care, and how they meet the spectrum of needs individuals have when they come through the doors of these clinics. It has been emphasized that it is not sufficient for an organization to argue that they are only targeting simpler matters oriented toward population health goals. Rather, regardless of an organization's wishes or targeted efforts, individuals with the full spectrum of behavioral healthcare needs will enter these clinics. As such, provider organizations have offered guidance to their membership about appropriate levels of training, supervision, and experience necessary when working in these environments. Attending to these basic matters will ensure that the field of behavioral healthcare possesses an important degree of integrity up and down the continuum of treatment interventions as these integrated models and the field develops. To be sure, integrated behavioral healthcare will grow, and so will healthcare; but how, and with what qualities, are the critical questions that healthcare organizations, providers, and the public should be concerned about.

Compliance with Ethical Standards

Conflict of interest Michael R. Bütz and W. Douglas Tynan declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human participants or animals performed by any of the authors.

References

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (2014). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.

American Mental Health Counselor's Association. (December, 2017). *Specialist in integrated behavioral health care counseling*. Retrieved December 2017, from http://connections.amhca.org/Go.aspx?MicrositeGroupTypeRouteDesignKey=430fca37-b93a-492b-8d69-277eef72bd9b&NavigationKey=d6dfd417-94e1-4471-8f9d-3e8af36bfa69.

American Psychiatric Nurses Association. (2017). *Introduction to integrated physical and mental health care.* Retrieved December 2017, from https://www.apna.org/i4a/pages/index.cfm?pageid=4837.

American Psychological Association. (2013). Guidelines for psychological practice in health care delivery systems. *American Psychologist, 68*, 1–6.

American Psychological Association. (2017). Collaborative care and integrated care: What's the difference? *PracticeUpdate*. Retrieved October 26, 2017.

Bütz, M. R. (1997). *Chaos and complexity, the implications for psychological theory and practice*. Washington, DC: Taylor & Francis.

Bütz, M. R. (2018). *Integrating behavioral healthcare and primary care, and the necessity of breaking the glass to preserve the HIPAA Privacy Rule and 42 CFR.* The Montana Psychologist, 6–9 June, 2018.

Bütz, M. R. (2019). Integrating healthcare requires caution. *The National Psychologist*, *28*, 8–9.

Blount, F. A., & Miller, B. F. (2009). Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings, 16*, 113.

Brody, D. S., Khaliq, A. A., & Thompson, T. L. (1997). Patients' perspectives on the management of emotional distress in primary care settings. *Journal of General Internal Medicine, 12*, 403–406.

Bzdok, D., & Meyer-Lindenberg, A. (2017). Machine learning for precision psychiatry. http://arxiv.org/abs/1705.10553.

Centers for Medicare & Medicaid Services Medical Learning Network. (May, 2017). *Fact sheet: Behavioral health integration services.* ICN 909432, Retrieved July, 2017.

Crowley, R. A., & Kirschner, N. (2015). The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: Executive Summary of an American College of Physicians Position Paper: Integration of Behavioral Health into Primary Care. *Annals of Internal Medicine, 163*, 298–299.

Davis, M., Balasubramanian, B. A., Waller, E., Miller, B. F., Green, L. A., & Cohen, D. J. (2013). Integrating behavioral and physical health care in the real world: Early lessons from advancing care together. *The Journal of the American Board of Family Medicine, 26*, 588–602.

Department of Public Health and Human Services. (2018). *HIPAA Privacy Rule and Sharing Information Related to Mental Health*. Department of Public Health and Human Services, Office of Civil Rights. Retrieved March 19, 2018, from https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf.

Federal Register. (2017). Confidentiality of substance use disorder patient records: A Rule by the Health and Human Services Department on 01/18/2017. Federal Register. Retrieved March 19, 2018, from https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records.

Foy, J. M., Kelleher, K. J., Laraque, D., & American Academy of Pediatrics Task Force on Mental Health. (2010). Enhancing pediatric mental health care: strategies for preparing a primary care practice. *Pediatrics, 125*, S87–S108.

Glenn, J. K., & Goldman, J. (1976). Task delegation to physician extenders-some comparisons. *American Journal of Public Health, 66*, 64–66.

Green, A. R., Carrillo, J. E., & Betancourt, J. R. (2002). Why the disease-based model of medicine fails our patients. *Western Journal of Medicine, 176*, 141.

Havernkamp, R. (2017). *HRSA nurse-led safety net clinics*. Washington: AIMS Center University of Washington Psychiatry and Behavioral Sciences.

Held, M. L., Mallory, K. C., & Cummings, S. (2017). Preparing social work students for integrated health care: Results from a National Study. *Journal of Social Work Education, 53,* 435–448.

Hemmings, A. (2000). A systematic review of the effectiveness of brief psychological therapies in primary health care. *Families, Systems, & Health, 18*, 279.

Hickey, P. (August, 2013). *Medical model vs. psychosocial/behavioral model*. http://behaviorismandmentalhealth.com/2013/08/01/medical-model-vs-psychosocialbehavioral-model.

Hodgson, J., Mendenhall, T., & Lamson, A. (2013). Patient and provider relationships: Consent, confidentiality, and managing mistakes in integrated primary care settings. *Families, Systems, & Health, 31*, 28.

Hudgins, C., Rose, S., Fifield, P. Y., & Arnault, S. (2013). Navigating the legal and ethical foundations of informed consent and confidentiality in integrated primary care. *Families, Systems, & Health, 31*, 9.

Hudgins, C., Rose, S., Fifield, P., & Arnault, S. (2014). The ethics of integration: Where policy and practice collide. In J. Hodgson, A. Lamson, T. Mendenhall, & D. R. Crane (Eds.), *Medical family therapy* (pp. 381–401). Cham: Springer.

Integrated Health Care Alliance/American Psychological Association. (August, 2017). *Psychologists in Integrated Health Care*. Retrieved August, 2017, from http://www.apa.org/health/psychologists-integrated-care.aspx.

Kinderman, P. (2014). Why we need to abandon the disease-model of mental health care. *Scientific American [Guest blog].* Retrieved January, 2017.

Kolko, D. J., & Perrin, E. (2014). The integration of behavioral health interventions in children's health care: Services, science, and suggestions. *Journal of Clinical Child & Adolescent Psychology, 43*, 216–228.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32*, 509–515.

Kwan, B. M., & Nease, D. E. (2013). The state of the evidence for integrated behavioral health in primary care. In M. R. Talen & A. Burke Valeras (Eds.), *Integrated behavioral health in primary care*. New York: Springer.

Little, V. (2018). *Implementing utilizing virtual health solutions to address behavioral health specialty care in primary care settings (Grant)*. Billings, MT: Consultation with National Council for Behavioral Health Representatives at St. Vincent Healthcare.

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*, 909–916.

Maragakis, A., Siddharthan, R., RachBeisel, J., & Snipes, C. (2016). Creating a 'reverse' integrated primary and mental healthcare clinic for those with serious mental illness. *Primary Health Care Research & Development, 17*, 421–427.

McDevitt-Murphy, M. E., Williams, J. L., Bracken, K. L., Fields, J. A., Monahan, C. J., & Murphy, J. G. (2010). PTSD symptoms, hazardous drinking, and health functioning among US OEF and OIF veterans presenting to primary care. *Journal of Traumatic Stress, 23*, 108–111.

Morris, S. B., & Smith, D. B. (1977). The distribution of physician extenders. *Medical Care, 15,* 1045–1057.

Muse, A. R., Lamson, A. L., Didericksen, K. W., & Hodgson, J. L. (2017). A systematic review of evaluation research in integrated behavioral health care: Operational and financial characteristics. *Families, Systems, & Health, 35*, 136.

National Association of Social Workers. (2012). *Social work in healthcare and behavioral healthcare*. Washington, DC: Critical Conversation in Brief, Social Work Policy Institute.

National Register of Health Service Psychologists. (January, 2017). *The National Register's Integrated Healthcare Training Series*. Retrieved January, 2017, from https://www.nationalregister.org/ihts/

Peek, C. J., Baird, M. A., & Coleman, E. (2009). Primary care for patient complexity, not only disease. *Families, Systems, & Health, 27*, 287.

Raney, L. E. (2017). Elements of effective design and implementation. In L. E. Raney, G. B. Lasky, & C. Scott (Eds.), *Integrated care: A guide for effective implementation*. Arlington, VA: American Psychiatric Association Publishing.

Robinson, P. J., & Reiter, J. T. (2007). *Behavioral consultation and primary care: A guide to integrating services*. New York, NY: Springer Science Business Media.

SAMHSA-HRSA Center for Integrated Healthcare Solutions. (January, 2017). *Integrated care models*. Retrieved January, 2017, from https://www.integration.samhsa.gov/integrated-care-models/list

Saultz, J. W., Jones, S. M., McDaniel, S. H., Bagley, B., McCormally, T., Marker, J. E., … et al. (2015). A new foundation for the delivery and financing of American health care. *Family Medicine, 47*, 612–619.

Schildkrout, B., Benjamin, S., & Lauterbach, M. D. (2016). Integrating neuroscience knowledge and neuropsychiatric skills into psychiatry: The way forward. *Academic Medicine, 91*, 650–656.

Schneider, D. P., & Foley, W. J. (1977). A systems analysis of the impact of physician extenders on medical cost and manpower requirements. *Medical Care, 15,* 277–297.

Schoenwald, S. K., Hoagwood, K. E., Atkins, M. S., Evans, M. E., & Ringeisen, H. (2010). Workforce development and the organization of work: The science we need. *Administration and Policy in Mental Health and Mental Health Services Research, 37*, 71–80.

Serrano, N., Cordes, C., Cubic, B., & Daub, S. (2017). The state and future of the primary care behavioral health model of service delivery workforce. *Journal of Clinical Psychology in Medical Settings, 25,* 157–168.

Shackelford, J. R., Sirna, M., Mangurian, C., Dilley, J. W., & Shumway, M. (2013). Descriptive analysis of a novel health care approach: Reverse colocation—Primary Care in a Community Mental Health "Home". *The Primary Care Companion for CNS Disorders*. https://doi.org/10.4088/PCC.13m01530.

Silbersweig, D. (2017). Integrating models of neurologic and psychiatric disease. *JAMA Neurology, 74,* 759–760.

Smith, T. W., Kendall, P. C., & Keefe, F. J. (2002). Behavioral medicine and clinical health psychology: Introduction to the special issue, a view from the decade of behavior. *Journal of Consulting and Clinical Psychology, 70*, 459.

Smolyansky, B. H., Stark, L. J., Pendley, J. S., Robins, P. M., & Price, K. (2013). Confidentiality and electronic medical records for behavioral health records: The experience of pediatric psychologists at four children's hospitals. *Clinical Practice in Pediatric Psychology, 1*, 18–27.

Society for Personality Assessment. (2006). Standards for education and training in psychological assessment: Position of the society for personality assessment. *Journal of Personality Assessment, 87*, 355–357.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*, 1092–1097.

Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Jr., Hunkeler, E., Harpole, L., … et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA, 288*, 2836–2845.

Vogel, M., Malcore, S., Illes, R., & Kirkpatrick, H. (2014). Integrated primary care: Why you should care and how to get started. *Journal of Mental Health Counseling, 36*, 130–144.

Wade, D. T., & Halligan, P. W. (2004). Do biomedical models of illness make for good healthcare systems? *BMJ: British Medical Journal, 329*, 1398.

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic review and meta-analysis. *American Journal of Psychiatry, 169*, 790–804.