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Review Article

Behavioral Healthcare and Primary Care, Models of Integration, and this Modality's Place in the Continuum of Services

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ABSTRACT

Integrating behavioral health services into primary care has been viewed by most positively. It is important to consider how far this integration goes, such as the extent the model of healthcare has been, and will be, modified. Just integrating behavioral healthcare into primary care alone does not encompass the whole continuum of these services, nor the implicit limitations the adaptation of these services brings considering the spectrum of integration models. To emphasize the difference between integrated models of care, screening tools (GAD-7, PHQ-9) will be distinguished from psychological assessment measures and the theoretical grounding for models like Motivational Interviewing will be discussed. It is argued the model chosen for integration supplies a particular spectrum of services from limited to broad in nature, with unique interventions, skill sets, and tools. Successful integration, therefore, calls for appropriate vigilance in practice and scholarship for behavioral healthcare's integrity to be maintained across the larger continuum of services as well as those represented by models of integration.

Keywords: Integrated, Behavioral, Health, Continuum, Primary.

IBH, a Good Development Generally Speaking

Integrating behavioral health services has been viewed by most positively and holds the potential of righting those philosophical wrongs that Descartes and others put into motion. For decades, centuries, or even a millennium, there has been an uneasy struggle among providers to care for people's health in an integrated fashion [1,2]. The struggle has been long, one in which many a theorist and philosopher has struggled to find an even ground wherein the work of behavioral health providers was respected and seen as an equal.

"The fact that the mind rules the body is, in spite of its neglect by biology and medicine, the most fundamental fact which we know about the process of life."

Franz Alexander

"…would any physiologist assert that the body is simple? Or that a living molecule of albumen is simple? If the human psyche is anything, it must be of unimaginable complexity and diversity…"

C. G. Jung

There have been improvements since the early '1900s and with the welcome integration of behavioral healthcare it is important to consider how far this goes. To what extent has, or will, healthcare be modified? Certain modalities within behavioral healthcare require extensive specialty training, akin to those in other areas of healthcare, with a refined body of knowledge, more precise examinations and interventions. Others may be more simplistic, educational, and focused on matters like prevention. Those integrating behavioral healthcare would do well to consider the scope of this larger continuum of care, and the implicit limitations associated with models adapted for integration.

Certain compromises come with bringing behavioral healthcare to the masses, such as brief sessions of fifteen or thirty minutes, the use of screening tools, the orientation to the work, as well as the training providers receive as part of a larger team [3]. One model of integration is aimed at addressing a population model that tends to basic challenges such as depression, anxiety, smoking cessation, substance abuse, and maintenance of certain maladies. At the other end of the spectrum lies an adapted amalgam of specialized services, which includes examining a broad range of pathology, brief consultations and time-limited therapeutic approaches. Still, integrating behavioral healthcare simply cannot supplant, nor set aside, the broader continuum of modalities since there is a need for the whole of these services including highly specialized services. The broader continuum of behavioral health models and the spectrum of integration models have their own inherent limitations, and still each is needed for successful integration.

A certain watchfulness is required that understands and values the continuum of services in behavioral healthcare as well as those in integrated models for the field's integrity to be maintained. The spectrum of integrated models does have different

emphases with horizontal and vertical integration as but one marker for differentiation [4].

"There are the Collaborative Care and IMPACT Models that represent one end of the continuum [5] and then reverse integration seemingly on the other end, or the Primary Care Mental Health (PCBH) Model that holds the more middle ground."

There has also been much work on the notion of evidence-based practices discussed in these circles, and there has been a growing recognition that not all such practices are held to the same standard of rigor. Further, many times practitioners go off protocol as well. There has also been reasonable attention to best practices that do not comport with the confines of evidence-based models. The debate about these approaches has reportedly been based on science. But the sciences have also been filled with biases [6], and inaccurate notions about certain theoretical models [7,8]. In many respects, the debate had previously overlooked the reality that if behavioral health had evidence-based treatments for all maladies its providers would certainly use them. Experienced providers and researcher readily acknowledge the limitations of the evidence-based movement for these reasons. As scholars or scientists in behavioral health we are called to not only acknowledge our limitations, but fairly gauge the quality of the scientific endeavor when looking at new models of care and considering them among the existing behavioral health care literature, research, and theoretical constructs.

In light of these kinds of currents in healthcare and science a cautious approach is suggested while integrating behavioral healthcare, and what follows are a few examples that represent certain dangers to the field when it is opened up to a wider healthcare community of providers. A community that is not so steeped in the field's literature, procedures, research and traditions [9]. It is agreed that the integration of behavioral healthcare is a positive move forward, and that fully integrated models of care are the ideal. However, there needs to be clarity about terminology, the quality of research and services, setting apart different levels of care as well as what kind and quality of psychopathology is addressed by integrated models.

Scientific Advances, Caution and Humility

Proposing scientific advances such as models of integration is an enterprise that would ideally give one pause. With all the hypotheses, ideas, pieces, thoughts, and theories that have gone before, surely someone has considered the topic under study in some way, shape, or form… Accounting for the work of those that have gone before may well prove to be a difficult task. No matter how much work one may do, there are material omissions because of the limitations in the literature, how the literature has been organized, or even cultural or historical omissions. During undergraduate and graduate training likely, many readers may recall iconic representations that described scientific foundations where one scientist stood on the shoulders of another, and another, etcetera. This was likely daunting to many, if contemplating contributing to the field and the literature, no less the larger enterprise of scientific scholarship. In turn, many colleagues treaded carefully when presenting what was hoped to be an original contribution to the field.

There have, however, been a group of individuals in the field more recently whose training was seemingly not so similar, or, apparently were not so beholding to the conventions of scholarship as those that have gone before. Those who have pronounced that their material came from the so-called data in a 'bottom up' fashion, or, these notions came from independent thoughts, 'top down' and, that these experiences alone were sufficient for scholarly purposes. It is likely self-evident that making such claims are not sufficient, and sidesteps the hard work involved with what has historically been regarded as scientific scholarship. In fact, many can probably recall having an original thought themselves, only to find that others had already thought about, wrote about, and published on such matters.

Careful scientific scholarship, for example, has been characterized through the bedrock work done developing psychological assessment measures, and embodied the fundamental guidance involved with the construction of these instruments. There are, nowadays, a number of models of integrated care to consider and screening tools that accompany them, which are presented as if they are comparable to such psychological measures. These are tools with attractive acronyms that have drawn attention in integrated care even after limited foundational work. Some models of integrated care tend to have similar shortcomings by employing measures that may look like, but are not like, standardized psychological measures.

Screening Tools: GAD-7 and PHQ-9

For providers who have been through a semester long graduate course on psychometric measurement, the challenges with developing and improving an instrument's utility is self-evident. Years of additional study on assessment instruments and research design deepen these appreciations. Considerations about experimental and control groups, placebo effects, inherent biases held by researchers, and the limitations that all research suffers from are just a smattering of the topics addressed. Based on these understandings, most psychological measures come with manuals that explain extensively why it was developed, the research on it, sample size and population limitations, its reliability, as well as various considerations about validity. Ultimately, the measurement's general use and limitations are provided. The fashion in which screening tools are presented create the impression that they are akin to these more robust measures because they sound similar. The sound of the titles may be misleading to those who have not been through the aforementioned rigors [10,12]. It follows that though these titles sound similar to psychological measures that does not mean that they hold similar scientific weight, fidelity to research design, reliability and validity, among other such factors.

There are, for example, basic instruments such as the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory – Second Edition (BDI-2). These self-report inventories are accompanied by detailed booklets specifying the instrument's development, purpose, history, and clinical utility [11]. Then there are more sophisticated tests such as the Trauma Symptom Checklist for Children (TSCC) or the Trauma Symptom Inventory-Second Edition (TSI-2) that have more rigorous research on their validity and scope of clinical examination. Still further, there are instruments like the Millon Clinical Multiaxial Inventory – Fourth Edition (MCMI-IV) and the Minnesota Multiphasic Personality Inventory – Second Edition (MMPI-2) that have extensive scales to address reliability, validity, clinical outcomes and supplemental findings. These instruments are accompanied by books and are buttressed/supported by thousands of pieces of literature, which have described multiple facets of these instruments and how they perform in describing an individual's characteristics and state. Those in behavioral health care who are facile with the use of these instruments understand that conducting these instruments require reading its reference, literature, and knowing the research.

While the vast majority of behavioral health care providers who have training and licensure beyond a master's level broadly understand the distinctions between these instruments through at least a survey course in graduate school, many outside the field may not understand the distinctions [12]. In fact, those with only a cursory knowledge of behavioral healthcare may mistakenly believe that the three different categories of measurements supplied above all have the same value. In reality, they each have very different tasks, substance, and limitations. Though each assessment instrument is meant to address pathology, one set has no reliability or validity scales to mitigate findings (BAI, BDI-2), another set has not been so thoroughly researched as the other (TSCC, TSI-2), and yet another set has a whole body of literature built up around them that very carefully considers a wide variety of psychometric and research design challenges coupled with clinical outcomes (MCMI-IV and MMPI-2).

Then, we have screening tools like the GAD-7 and the PHQ-9, which actually sound like these psychological measures. But that is where the comparison between these screening tools and psychological measurements end. The GAD-7 is actually the Generalized Anxiety Disorder – Seven, and it is labelled seven dues to the fact that it just has seven questions. This convention is unlike those of psychological measures, wherein the numbers represent the iteration and/or its revision number. Rather than being accompanied by a twenty to forty-page booklet like the BAI or BDI-2, often those using this instrument only are supplied with a series of seven questions which are in the public domain. Essentially, many practitioners make use of this instrument based on its face validity. That is, simply put, the fashion in which a screening tool appears to be effective. There is the six-page article [13], and it does describe the instrument's development, the patient sample of five hundred and ninety-one (591) individuals, and that it is a self-report instrument. The authors of this instrument have indicated there are limitations, such as its design for addressing one anxiety disorder, secondly that it offers only a probabilistic diagnosis, and that, "… our study was cross-sectional, prospective observational and treatment studies are needed to determine the responsiveness of the GAD-7 and assessing change across time." Therefore, this screening tool is nothing like the psychological measurements described above in terms of psychometrics, research design, or scientific rigor.

Likewise, the PHQ-9 was developed by the same authors, and it is a screen for depression, though PHQ stands for Patient Health Questionnaire. Like the GAD-7 nine represents the number of questions and it too has an article that describes its name, its precursor, its use as a screen, and its use gauging depression severity [14]. Thus, the instrument is used to measure depression, and as the authors have described:

"The PHQ-9 is the 9-item depression module from the full PHQ (sidebar, page xx). Major depression is diagnosed if five or more of the nine depressive symptom criteria have been present at least 'more than half the days' in the past 2 weeks, and one of the symptoms is depressed mood or anhedonia."

This article, or others similar to it, are often not read by providers who tend to simply accept its face validity and then make use of its cutoff scores. This is obviously not sufficient, and this screening tool is not the same as the psychological measurements above.

If those trained in primary care or other aspects of healthcare outside of behavioral health are employing these measures, then it would make sense to supply at the least the basic level of distinctions and understanding suggested within this section. Healthcare providers new to these measures need to understand that these are screening tools, and not equivalent to psychological measures which require far more training, supervision, and experience to be employed correctly. In fact, several of these instruments can only be purchased by qualified providers who have, as alluded to earlier, foundational training in these measurements [12].

Motivational Interviewing, Ambivalence and Systemic Considerations

There are a number of models that have been folded into integrated behavioral health, models such as IMPACT, MI, or SBIRT, which sound impressive. Yet, the tenets of these models are rather easy to comprehend since they rely on a few key concepts. For example, one model of care, IMPACT, involves the use of a register, a PHQ-9 administered regularly, and a physician extender [5]. Or, there, is Screening, Brief Interventions, Referral to Treatment (SBIRT), which is basically, stepwise, just what it sounds like [15]. Then, we have the somewhat more complex concept of Motivational Interviewing (MI), and like these other models discussed enthusiastically within the integration community. At the same time, it is a

fairly simple model of care grounded in what appears to be an academic framework [16]. What these models of care all hold in common is that providers are required to be trained in each one's particulars, through a certain course offered by an associated agency (AIMS Center, Clinical Tools, Inc., or MINT).

Although any one of these models could be addressed, MI will be reviewed for purposes of simplicity. To begin with, the critique offered is not intended to limit the utility of any particular model. Rather, the hope is that such a review will provide the impetus for the kind of scholarly depth and integrity that has been established in behavioral healthcare. So, we have the notion of ambivalence in MI, an experience that has been around since the dawn of philosophical thought. The authors of MI have situated it squarely in the middle of their theory and use it as a pivot point, with repeated references to approach and avoidance dynamics. There were, however, limited references to any other descriptions or theories on ambivalence [16]. There are philosophical references, that do exist and are worthy of mention. There was also a considerable number of references within social science that also should be acknowledged. Specifically, Lewin, [17] and then Dollard, et al [18], who did extensive work on these dynamics, especially research focused on addressing the relationship between ambivalence and approach-avoidance conflicts. Others have described similar concerns about scholarship, both with regard to MI and the concepts of ambivalence and approach-avoidance [19].

Simply omitting references to more long-standing philosophical references is one thing; but overlooking extensive works by others is another. There is the need to address major treatments of such issues within this body of literature, and then to clarify what is similar or different about an author's usage of the concept or theory. Many, if not all, of those who have worked on their dissertations have been queried, if not hounded, about what is original about their proposal… Thus, one is left with an open question about what was original about the use of the concept of ambivalence in MI?

There was also material within MI that was beholding to systems theory. Change, managing change, that is seemingly MI's purported focus. The language used in MI described systems and transformation. Much of the systems theory in behavioral health came through the literature on family therapy. The language used within MI has a focus on sustaining versus changing talk-both basic systems topics. Further, patterns of change are altered or created by feedback, which amounts to another basic systems concept, positive and negative feedback.

Von Bertalannffy, [20] and Weiner, [21] articulated larger systems concepts via General Systems Theory (GST) and Cybernetic Theory (CT), wherein GST shifted systems descriptions from homeostasis to steady states, while CT made explicit how systems change through feedback. Thus, the behavior of a system, its steady state, could be sustained or transformed through negative and positive feedback. States and feedback were, therefore, a critical consideration in the larger change process described by theorists in family systems.

In turn, the markers for changing versus sustaining behavior in MI have not recognized, nor described these earlier contributions or dynamics at any length. In addition, these concepts do not address the significance of state, nor the import of the exchange of negative and positive feedback in the process of transformation. This body of literature is considerable [22-24], and ongoing, as manifested in the discussions about chaos, complexity, emergence, and nonlinearity from two decades ago [25-28], no less the present. All of these older and more recent pieces of literature describe important considerations in changing and sustaining behavior. Likewise, we have Lewin as well as Dollard and Miller who were giants in the field. Systems theorists and practitioners made significant contributions and their work has been applied to a whole variety of matters including the community health care movement of the '60's [29].

IBH, Considered in Perspective

Provided the matters above, those working in integrated care are encouraged to review the measures described and be clear about how sound each of these screening tools are in comparison with psychological measures. Further, it may well be time to review methods like MI and expect a more scholarly emphasis within the guardrails of existing behavioral health literature. Basic matters, such as acknowledging the work of others who had gone before and then differentiating what is unique, original, about the proposed contribution. A considerable literature lies beneath the concepts assumed under MI. It is an example of a situation that needs to be righted for behavioral healthcare to have integrity up and down the continuum of treatment modalities as this model and others are integrated. There is much to be excited about with behavioral healthcare's more focused integration into primary care. There are, however, needed clarifications and adjustments in coming years that are necessary to ensure that this is a successful venture.

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