Training Psychology Interns in Primary Behavioral Health Care

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This article describes a training program for primary behavioral health care (PBHC) for clinical psychology interns. The authors discuss the rationale for integrating mental health into primary care and the need for additional training programs at the predoctoral internship level. A review of relevant literature suggests that effective functioning in primary care requires competence in (a) generalist psychology, (b) health psychology, (c) interdisciplinary team functioning, and (d) skills specific to primary care. The authors advocate for a relatively intensive training program to address these areas. Common intern training difficulties observed during 3 years of program implementation are discussed. Practical, lessons-learned recommendations that address these problem areas provide guidance for others seeking to develop a PBHC training program.

A growing body of literature recognizes the potential value of integrating behavioral health services into the primary care arena. Researchers have found that approximately 60% of primary care visits involve some behavioral health need (Cummings, Cummings, & Johnson, 1997). Furthermore, epidemiological research suggests that although 28% of Americans in any given year meet diagnostic criteria for a mental disorder, half of these individuals do not receive any form of treatment. Of those who are treated, approximately half receive specialized mental health treatment, whereas the remaining half receive services solely through their general medical providers (Narrow, Regier, Rae, Manderscheid, & Locke, 1993; Regier et al., 1993). Thus, the existing mental health system provides specialized, intensive services to a minority of individuals with behavioral health problems. The rest receive treatment solely from their physician or receive no behavioral health services whatsoever.

Traditional models of mental health care cannot adequately provide services to the large numbers of individuals presenting to primary care clinics with a host of biopsychosocial problems. Consequently, innovative service delivery models capable of providing more comprehensive behavioral health interventions to primary care populations have been developed (Blount, 1998; Cummings, 1997; McDaniel, Hepworth, & Doherty, 1993; Pruitt, Klapow, Epping-Jordan, & Dresselhaus, 1998; Strosahl, 1998). These models all espouse some form of behavioral health service integration into primary care. Basic levels of collaboration involve increased communication between specialty mental health and primary care (through special referral relationships, increased exchanges of information, etc.). Greater integration occurs when mental health providers are placed directly in primary care clinics, which occurs in both co-located specialist approaches and in consultative models.

In the co-located specialist approach, psychologists work in primary care clinics providing traditional specialty mental health services. Collaboration with medical providers may occur through interdisciplinary case conferences and, in some cases, joint appointments (physician and psychologist meeting together with the patient). Benefits of this approach include easier patient access to behavioral health services, decreased stigma, and improved communication across disciplines. Additionally, because the psychologist continues to provide traditional specialty assessment and treatment, fewer practice modifications are required. A main drawback, however, is the relatively small number of patients who can receive services, because assessment and treatment are still provided in a time-intensive specialty approach. This can hinder accessibility and limit the benefits that integration can have for the behavioral health of the enrolled population. Furthermore, busy medical providers may not accept some aspects of the co-located specialist approach (e.g., joint visits and frequent case conferences may be viewed as too time-consuming).

The consultative model (Strosahl, 1998) also places mental health providers in the primary care setting. Rather than practicing specialty mental health care within the primary care clinic, however, behavioral health consultants (BHCs) serve as consultants to the medical providers and provide primary behavioral health care (PBHC). BHCs assist primary care managers (PCMs; physicians, physician assistants, advanced nurse practitioners) in managing the
care of individuals who have emotional or behavioral factors that affect health outcomes or functioning. Emphasis is placed on providing early intervention for patients with lifestyle and stress-related disorders as well as chronic illnesses. BHCs provide behavioral health assessments and brief interventions, as well as related disorders and chronic illnesses. BHCs provide early intervention for patients with lifestyle and stress-affect health outcomes or functioning. Emphasis is placed on care of individuals who have emotional or behavioral factors that affect health outcomes or functioning. Emphasis is placed on providing early intervention for patients with lifestyle and stress-related disorders as well as chronic illnesses. BHCs provide behavioral health assessments and brief interventions, as well as related disorders and chronic illnesses. BHCs provide early intervention for patients with lifestyle and stress-

This consultative model of PBHC differs substantially on multiple dimensions from traditional specialty mental health care (SMHC) services. The most obvious difference involves the location in which services are provided (e.g., primary care office vs. outpatient mental health clinic); however, more important differences are found in the service modality, mission and philosophy of care, identity of primary provider and primary customers, and service goals. The fundamentally distinct aims and objectives of PBHC lead to substantial differences in format, content, and style of services (e.g., consultation vs. psychotherapy, shorter appointment length, fewer number of appointments, different standards of informed consent and documentation, etc.). Specifically, PBHC appointments are shorter (15- or 30-min appointments) than those in SMHC, and intervals between appointments tend to be longer. For example, a one-month follow-up appointment for a patient with insomnia may be scheduled to give the patient time to implement recommended changes in sleep hygiene and monitor improvements in sleep patterns over time. Most patients are seen for one to four PBHC appointments (averaging approximately two visits). One of the main barriers to implementation of this model, however, is the need for mental health providers to learn to substantially alter their practice from a specialty to primary care approach.

After comparing the different models of integration, the United States Air Force (USAF) Medical Service adopted Strosahl’s (1998) consultative model of PBHC. This approach appeared the most likely to have a population health impact, to gain high levels of acceptance from practicing physicians, and to be compatible with the culture and goals of primary care. The co-located specialist model was rejected because of the time-intensive nature of specialty interventions, which would reduce capacity and have a much more limited population health impact.

Need for Training

Most traditionally trained psychologists are unprepared to integrate behavioral health services into primary care given the substantial differences between specialty and primary behavioral health care. Fortunately, there has been a growing recognition of the need for educational and training programs designed to prepare psychologists to work in the primary care setting. For example, the American Psychological Association’s (APA) recent report on training psychologists to provide services in primary care settings noted the following:

Given the nature of problems presented in primary care, psychologists need to be an essential part of that interprofessional primary health-care team. They need training; however, specific to primary care settings and services... in addition to the breadth of scientific and clinical training they receive in their doctoral preparation. (APA, 1998, p. 5)

The panel report also stated that “among (more than 500) internship training programs for psychologists, about 36% presently offer training in behavioral medicine, while only 2% offer a major rotation in primary care. Thus there is a critical need for more training in relation to primary care services for psychologists” (APA, 1998, p. 10).

In an effort to fill this gap, a small number of psychology doctoral graduate programs have initiated training in integrated primary care services (e.g., Brantley & Applegate, 1998; Sears, Evans, & Perry, 1998). The University of Florida Rural Psychology Program (Sears et al., 1998) trains graduate students to provide behavioral health services across the continuum, from primary prevention through tertiary care. Students develop skills in primary care consultation and “brief problem-focused therapeutic contact” (p. 506) in primary care. Others have recommended increased undergraduate and graduate course work in areas such as biology, sociology, neuroanatomy, and neurology (Cummings, 1997; McDaniel, Belar, Schroeder, Hargrove, & Freeman, 2002). However, Cummings (1997) noted that “because of the already overloaded curriculum in both medical schools and graduate psychology and social work programs, there is tremendous opposition from academia [to increasing required course work], necessitating postgraduate training” (p. 30).

Filling this postgraduate training gap are a small but growing number of predoctoral internships and postdoctoral fellowships offering training in primary care psychology (e.g., Hunter & Peterson, 2001; Pruitt et al., 1998; Sears et al., 1998). Furthermore, training guidelines and recommendations, summarized in the following section, have been published by several sources. Little has been written, however, on how such recommendations can be successfully translated into specific training programs and curricula. Most authors have provided brief (if any) descriptions of the nature and content of their training. Practical training issues, tips, and lessons learned have been noticeably absent from the literature. We seek to begin filling this gap by discussing the practical implementation of one such training program. We describe the USAF predoctoral internship rotation at Malcolm Grow Medical Center (MGMC) at Andrews Air Force Base, designed to prepare psychology interns to successfully work in integrated primary care settings using a consultative model. We discuss this training program in relation to the published educational and training recommendations, and we provide specific “lessons learned” during training.

Summary of Education and Training Recommendations

Three guidelines concerning core knowledge and skill areas necessary for successful practice as a primary care psychologist have been published, from which a core set of education and training recommendations can be drawn (APA, 1998; McDaniel et al., 2002; Strosahl, in press). These references provide helpful direction regarding the key components of a training program, regardless of the type or modality of training (graduate vs. predoctoral, postdoctoral, or on-the-job training). Despite differences in the models of integration, common themes emerged in these three descriptions of knowledge and skills needed to provide effective behavioral health services in primary care. The authors noted the importance of foundational knowledge and skills in (a) generalist psychology; (b) health psychology (e.g., biological, social, cultural, affective, and cognitive factors affecting health and disease); and (c) effective interdisciplinary functioning.
Furthermore, each set of guidelines emphasizes the importance of specific primary care mental health knowledge and skills. These include (a) knowledge of broad health care systems and administrative issues (e.g., understanding hospital practices and economics of health care; primary care policies and procedures; ethical, legal, and professional issues relevant to practicing in the primary care setting), as well as (b) specific assessment, intervention, and consultation skills appropriate for the primary care environment (e.g., assessment and treatment of problems commonly seen in primary care; allocation of time and resources; practice management skills; collaborative assessment and treatment; behavioral health consultation skills). These training guidelines and recommendations from the three sources provide a broad overview of competencies needed to effectively provide integrated PBHC services.

Malcolm Grow Medical Center’s Primary Care Training

The MGMC predoctoral psychology internship’s long-standing emphasis on developing proficiency in both generalist and health psychology skills provided an excellent foundation from which to build an integrated primary care training rotation. Using the training guidelines and competencies described above, we describe in the following sections the specific MGMC internship training elements and rotations that are relevant to developing core competencies as primary care psychologists.

Foundational Internship Components

Interns spend 6 months primarily focusing on gaining skills and experience in generalist psychology, including adult outpatient mental health, substance use disorders, and family violence. The primary setting for this experience is an outpatient mental health clinic for eligible military beneficiaries (e.g., active duty members, military retirees, and family members). Presenting problems cover a wide array of mental health diagnoses, and the client population is diverse in terms of gender, race, and age. Training goals for this rotation share substantial overlap with a number of recommended primary care psychology competencies: (a) effectively assessing and treating a wide spectrum of mental health problems consistent with a generalist psychology model; (b) providing mental health services to individuals across the life span; and (c) developing competency in identifying and intervening with problems appearing in high-frequency at primary care clinics, such as depression, anxiety, domestic violence, and substance abuse.

Interns spend another 6 months of the internship in the Behavioral Medicine Services (BMS) clinic, where they focus on adult and pediatric clinical health psychology. Here interns learn to identify biopsychosocial influences on patients’ overall health or disease status and to help modify such factors in order to enhance patients’ health and/or functioning. Patients with a wide variety of chronic medical conditions and psychophysiological problems across the life span are seen in BMS. This training provides interns with the foundational knowledge and skills in health psychology recommended by all three sets of primary care training guidelines (developing competency in addressing the biopsychosocial factors affecting health and disease).

Throughout the training year, interns receive a strong emphasis on effective interdisciplinary team functioning, a third core skill recommended for effective primary care psychology training. Specifically, the outpatient mental health rotation provides interns with regular collaboration with various mental health professionals through weekly interdisciplinary treatment team meetings and monthly interdisciplinary case conferences. During their health psychology rotation, interns participate in several interdisciplinary treatment programs (e.g., tobacco cessation, weight management, diabetes management, chronic pain treatment) where they learn skills in effectively providing services through collaborative work with other disciplines (e.g., dietitians, physicians, nurses). Additionally, on the health psychology rotation, interns evaluate and treat patients referred to the BMS clinic by a variety of primary care and specialty medical clinics, resulting in routine interaction with the patients’ medical providers.

Primary Care Rotation

The primary care rotation is embedded within the 6-month health psychology rotation. Initial exposure to integrated primary care occurs through a 4-hr didactic instruction period that includes discussions of directed readings of relevant integrated primary care literature as well as viewing and analyzing videotapes of model PBHC assessments and interventions. Trainees also read and discuss the 150-page USAF Primary Behavioral Health Care Services Practice Manual (Office for Prevention and Health Services Assessment, 2002). This manual includes a broad historical and conceptual background for integrated care in the USAF, followed by detailed descriptions and examples of clinical and administrative procedures.

The goals of this initial phase of primary care education are to promote an understanding of broad system-level issues related to integrated primary care, as well as issues related to practical implementation of PBHC at the local clinic level. Interns are expected to gain an understanding of the rationale behind integration of behavioral health and primary care, the potential benefits of integration (in clinical outcomes and medical cost savings), the foundations of integrated primary care within a population health framework, and the key distinctions between SMHC and PBHC. Interns and staff discuss issues related to differences in the informed-consent process, confidentiality, and standard of care.

The clinical and practical aspects of PBHC are introduced by discussing the following: strategies for managing a 30-min visit, conducting an initial assessment consistent with a primary care consultation model, and potential interventions for common behavioral health problems seen in primary care. Managing patients in crisis and indications for alternative treatment are discussed. Focus is also given to procedural issues, such as accessing and scheduling PBHC services, preparing documentation, giving feedback to PCMs, completing coding and billing procedures, and becoming familiar with staffing guidelines. Finally, because interns are likely to initiate integrated care programs at their first assignment after their internship, training also includes strategies for implementing a new program in a primary care clinic. A core competency scale is used on a regular basis to assess and provide feedback on interns’ proficiency in essential primary care skills. This form operationalizes specific primary care core competencies in several domains: clinical practice, practice management, con-

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1 Electronic copies of the manual may be obtained from Anne C. Dobmeyer.
consultation, documentation, and administrative skills. The form is useful as a feedback instrument as well as a concrete description of what an effective PBHC practice looks like. Interns rate themselves near the beginning of training, and they receive formal feedback, utilizing this instrument, at varying intervals thereafter (e.g., monthly). (For an example of this core competency form and a further description of its use, see Strosahl, in press.)

After completing the initial phase of training, interns begin their “on site” clinical training in the primary care clinics. For 6 months interns spend 12 hr per week working as BHCs in primary care: two half-days (8 hr) at one of several adult clinics (primary care, flight medicine, or internal medicine), and one half-day (4 hr) at a pediatric primary care clinic. PBHC schedules are set up in 30-min increments (of which approximately 20–25 min are spent in clinical assessment and intervention, and the remaining 5–10 min are spent on documentation, coding/billing, and PCM feedback). New and follow-up appointment slots are available for 75% of the BHC’s time; the remaining 25% is left open to see same-day walk-in appointments, catch up on note writing, provide PCM consultative feedback, make phone calls to patients, and discuss cases with supervisors.

Demographic and diagnostic data collected over approximately 19 months in two of the adult clinics with integrated programs (primary care and internal medicine) and in the first 9 months of the pediatric clinic’s integrated program demonstrate that interns are exposed to a variety of presenting problems and to patients who are diverse in terms of gender and age. The most frequent behavioral health problems seen in the adult primary care clinics are presented in Table 1. As expected, interns work with a large number of patients with typical “mental health” problems (e.g., depression and anxiety), as well as with problems related to medical or “primarily physical” conditions. In fact, PBHC appointments related to health problems (e.g., diabetes, obesity, chronic pain, headache, insomnia, etc.) constituted approximately 20% of total PBHC visits. This underscores the importance of embedding the primary care rotation within a broader program that helps

<table>
<thead>
<tr>
<th>Problem area</th>
<th>Frequency</th>
<th>%</th>
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<tbody>
<tr>
<td>Depression</td>
<td>304</td>
<td>26.2</td>
</tr>
<tr>
<td>Health problems</td>
<td>237</td>
<td>20.4</td>
</tr>
<tr>
<td>Anxiety</td>
<td>197</td>
<td>17.0</td>
</tr>
<tr>
<td>Stress</td>
<td>113</td>
<td>9.7</td>
</tr>
<tr>
<td>Marital problems</td>
<td>84</td>
<td>7.2</td>
</tr>
<tr>
<td>Insomnia</td>
<td>51</td>
<td>4.4</td>
</tr>
<tr>
<td>Occupational problems</td>
<td>50</td>
<td>4.3</td>
</tr>
<tr>
<td>Bereavement</td>
<td>42</td>
<td>3.6</td>
</tr>
<tr>
<td>Other</td>
<td>83</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Note. PBHC = primary behavioral health care. Data were gathered from two adult primary care clinics for 19 months (the 6th through 24th months in which integrated services were provided). Depression includes diagnoses of major depression, dysthymia, and adjustment disorders with depressed mood. Health problems include a variety of medical problems with behavioral health components (e.g., diabetes, fibromyalgia, hypertension, obesity, chronic pain, eating disorders, etc.). Anxiety includes all anxiety disorders as well as adjustment disorder with anxiety. The Other category includes sexual disorders, substance abuse, interpersonal problems, psychosis, and personality disorder (all less than 2%).

Interns develop skills in health psychology assessment and intervention methods.

The age distribution, as expected, differed significantly by clinic. The adult internal medicine clinic had a larger proportion of PBHC patients over the age of 60 (53%), whereas the adult primary care clinic had more PBHC patients in their 20s and 30s (58%). A summary of the age breakdown by clinic is presented in Table 2. In both adult clinics, more women were seen than men (74% female, 26% men). During their work in the pediatric primary care clinic, interns also saw a wide variety of common behavioral health problems in children (see Table 3). Ages of PBHC pediatric patients ranged from 1 to 17 years, with a mean and median of 8 years (SD = 3 years). This age distribution is similar to that found in other pediatric PBHC practices (Evers-Szostak, 1998; Schroeder, 1996). Interns worked with children of both sexes (42.5% female, 57.5% male).

The clinical training approach heavily emphasizes observational learning at the beginning of the rotation. Interns observe, or “shadow,” their supervisor while he or she is assessing and intervening with the patients, providing written and verbal feedback to PCMs, developing collaborative treatment approaches, and completing coding/billing and documentation activities. Although the timing of the transition from observation to active participation varies depending on the skill level of each intern, it is fairly typical for this transition to occur around the end of the first month of training. This next phase involves interns taking the lead in all PBHC activities. Roles are essentially reversed, with the supervisor now shadowing the intern. Early in this period the supervisor frequently “jumps in” to clarify or redirect the assessment or focus of the intervention. Verbal feedback on interns’ progress occurs throughout the day, as the primary care schedule allows (e.g., in between patients). Intermittently, feedback is given more formally, using the core competencies checklist.

As interns’ competencies gradually increase, the supervisor assumes a less prominent role. Once the supervisor believes that the intern is fully competent to provide PBHC services independently (as reflected by satisfactory ratings on the core competencies checklist), the intern essentially takes over the running of all aspects of the practice independently, with cases being discussed in supervision. This shift often occurs within the last 2 months of the 6-month rotation in the adult clinics. The transition typically occurs later in the pediatric primary care clinic, reflecting the lower level of experience our interns have with child clinical populations upon entering the MGMC internship.

Recommendations and Lessons Learned

Eighteen interns have been trained in PBHC since we began this rotation 3 years ago. During this time, the supervising psychologists have spent over 2,500 hr in face-to-face observation of interns’ progress in providing integrated care. This experience has highlighted a number of frequently occurring difficulties experienced by interns who are learning this model for the first time. In this section we describe common difficulties interns experience in doing PBHC work and how we have addressed some of these difficulties. These issues are summarized in Table 4.

Attempting Specialty Assessment in Primary Care Setting

The most significant challenge facing new interns involves time management (i.e., getting through an initial appointment, including
assessment and recommendations) within 20–30 min. Many interns initially try to conduct the same type of assessment that they would use in a specialty mental health setting but attempt to rush through it more quickly. Interns quickly discover, however, that it is impossible to assess patients in the same breadth and depth in this limited time frame. We have found it helpful to emphasize that given the goals of integrated care, such an in-depth assessment is neither necessary nor desired. Rather, a different framework is needed for structuring the initial assessment. This framework involves (a) providing introductions and obtaining informed consent, (b) rapidly identifying the main problem area/referral question, (c) focusing on symptoms related to the consultation question and a scan of major relevant diagnostic symptoms when relevant, (d) assessing functional impairment, (e) verbally summarizing and conceptualizing the problem(s), and (f) collaboratively developing a behavior change plan that evolves logically from the conceptualization. Rowan and Russ (in press) provide more details of the PBHC assessment and intervention process.

Overuse of Relationship-Building Strategies

Another common obstacle to effectively managing time involves the overuse of strategies designed to build a therapeutic relationship. Frequent empathic statements and reflective summarizations, considered essential to building a strong patient–therapist relationship in SMHC, are less important within this model of integrated care. Rather, patients and BHCs develop collaborative working relationships that are enhanced by the trust and confidence that already (it is hoped) exists between patients and their PCMs. Moreover, there is often an implicit norm in the primary care milieu to “get to the problem” quickly, with a corresponding decreased focus on relationship factors (i.e., patients may not expect the same type of therapeutic relationship within the primary care context that they would in a specialty mental health clinic). This does not imply that empathy has no place within integrated care. The BHC’s solid summary and conceptualization offered as feedback to patients, after the BHC has gone through the assessment phase rather rapidly, does communicate to patients that they have been understood. This approach allows for reduction in the number of reflective and summary statements during the initial assessment, thereby saving valuable time in a busy primary care environment. This shift may be particularly challenging for interns whose theoretical orientation involves less directive approaches.

Inappropriate Selection of Interventions

The task of selecting appropriate, “bite-sized” interventions that are supportable by the PCM and can be effectively taught within a limited time frame can prove challenging, particularly for interns with less knowledge and experience with behavioral approaches. Ideally, BHCs and patients collaboratively develop behavioral change plans that are individually tailored to the patient’s functioning and specific symptom pattern. Unfortunately, interns often use a “cookie cutter” approach (i.e., one solution fits all). For example, a novice BHC might recommend the same one or two behavioral strategies for all depressed patients, regardless of their individual manifestation of depressive symptoms. Distinguishing between patients who might initially benefit from increasing rewarding activities or physical exercise and those who might see more improvement from increasing balanced thinking requires close attention to the results of the functional analysis and symptom assessment. Helping interns refrain from prematurely selecting an intervention early in the appointment (often done because of a sense of time urgency) until they have fully completed their assessment often leads to interventions that flow more closely and naturally from the functional assessment.

Finally, we guide interns in the appropriate and selective use of written psychoeducational materials. Although these materials can be essential to successful work in PBHC, interns may overrely on these handouts at the expense of an intervention tailored for a particular individual.

Unclear Conceptualization and Premature Recommendations

Effectively communicating a clear biopsychosocial conceptualization to patients can increase their understanding of the rationale for particular recommendations. Many interns, however, rapidly move directly from assessment into a discussion of specific behavioral changes without first providing a clear summary and conceptualization of the problem. This omission may occur as a result of attempts to finish an appointment on schedule and send the patient away with a specific plan in place. This often leads to

<table>
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<tr>
<th>Problem area</th>
<th>Frequency</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Behavior difficulties &amp; oppositionality</td>
<td>65</td>
<td>27.2</td>
</tr>
<tr>
<td>Attention-deficit/hyperactivity disorder</td>
<td>58</td>
<td>24.3</td>
</tr>
<tr>
<td>Elimination disorders</td>
<td>34</td>
<td>14.2</td>
</tr>
<tr>
<td>Acute psychosocial stressors &amp; mood disorders</td>
<td>28</td>
<td>11.7</td>
</tr>
<tr>
<td>Physical/health problems</td>
<td>22</td>
<td>9.2</td>
</tr>
<tr>
<td>Anxiety</td>
<td>12</td>
<td>5.0</td>
</tr>
<tr>
<td>Developmental disorders</td>
<td>10</td>
<td>4.2</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Note. PBHC = primary behavioral health care. Data were gathered from one pediatric clinic during the first 9 months in which integrated services were provided.
resistance from patients who do not understand the rationale underlying the proposed plan (e.g., how it will help with their particular problem) or who have not been involved in developing a plan that they believe is feasible and desirable. A series of “yes, but” exchanges may ensue, or patients may simply fail to implement the plan or return for a follow-up appointment. For example, a patient may be referred by his or her PCM because of “sleep problems.” The BHC may conclude that the patient’s early-morning awakening appears secondary to depression. If the BHC jumps directly into recommending that the patient learn one of several mood-management strategies, the patient may not understand the connection between these plans and his or her initial

<table>
<thead>
<tr>
<th>Problem</th>
<th>Corrective strategy</th>
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<tbody>
<tr>
<td>Time management (i.e., implementing assessment and interventions in 30 min or less)</td>
<td>Provide model of sequenced phases of initial appointment with associated time frames (e.g., 5 min introduction and problem identification, 15–20 min assessment, 5–10 min summary and recommendations)</td>
</tr>
<tr>
<td>Attempting to implement specialty care assessment/ intervention processes in primary care setting</td>
<td>Provide model of sequenced phases; model PBHC techniques/processes</td>
</tr>
<tr>
<td>Overreliance/focus on relationship-building strategies</td>
<td>Focus on summary stage as an alternate way to communicate empathy for problem</td>
</tr>
<tr>
<td>Lack of individualized assessment/intervention and corresponding overreliance on handouts or “cookie cutter” interventions</td>
<td>Emphasize and demonstrate how interventions should flow logically from the individualized functional assessment and how to collaborate with the patient during the summary/ intervention phase to obtain agreement on problem conceptualization and recommendations</td>
</tr>
<tr>
<td>Overly complex (vs. “bite sized,” PCM-supportable) recommendations</td>
<td>Provide experiential base so that trainee can witness effectiveness of “bite-sized” interventions</td>
</tr>
<tr>
<td>Premature/rushed recommendations (before sufficient understanding of presenting problem or before patient understands rationale for recommendations)</td>
<td>Model and emphasize need to summarize conceptualization for the patient and provide rationale for particular interventions</td>
</tr>
<tr>
<td>Deficient skills in rapid identification of core problem area and conceptualization</td>
<td>Model rapid problem identification and conceptualization skills, build in strategy of “stepping out” of the room to discuss conceptualization before trainee provides summary and recommendations</td>
</tr>
<tr>
<td>Lack of appreciation for the efficacy of PBHC interventions and consequent tendency to overrefer to SMHC</td>
<td>Provide exposure to PBHC efficacy literature and provide sufficiently lengthy training (e.g., six months) to allow witnessing course of care</td>
</tr>
<tr>
<td>Overdocumentation of patient information</td>
<td>Educate interns about primary care standard (versus SMHC standard) of documentation; review typical PCM notes for examples of content, amount of detail, and length</td>
</tr>
<tr>
<td>Verbal feedback to PCM is too lengthy and/or contains mental health jargon</td>
<td>Teach and model structure for concise consultative feedback</td>
</tr>
<tr>
<td>Failure to interrupt PCM to provide feedback</td>
<td>Identify and discuss indications for interrupting PCMs when they are “behind closed doors” with patients; model open-door policy</td>
</tr>
<tr>
<td>Hesitancy to recommend that PCMs modify a behavior</td>
<td>Model honest but tactful communication; remind interns of goal to increase PCM’s competence in treating patients with behavioral health problems</td>
</tr>
<tr>
<td>Training responsibilities pull staff trainer away from practice-building and sustaining activities</td>
<td>Staff trainer builds in extra time in clinic to focus on such activities (e.g., attending staff clinic meetings, touching base with providers over lunch, etc.)</td>
</tr>
</tbody>
</table>

Note. PCM = primary care manager; PBHC = primary behavioral health care; SMHC = specialty mental health care.
Inappropriate Level of Care Determinations

Interns’ ability to formulate an appropriate plan also heavily relies on their determination of the appropriate level of care, particularly in differentiating between indications for PBHC versus SMHC. Limited research exists regarding patient predictors for response to PBHC interventions (for a recent exception, see Hegel, Barrett, Cornell, & Oxman, 2002). Additionally, because interns typically have not worked in primary care settings before, they have not developed their own experiential knowledge base about which patients with problems tend to improve with which types of minimal interventions. With little to guide their decision making, the tendency among most interns has been to err on the side of conservatism by referring greater numbers of patients for specialty care. This skill—being able to rapidly conceptualize a patient’s problem and discuss it on the spot in terms that the patient will understand—is often underdeveloped in interns. If problems with this skill remain, even after extensive modeling and feedback, we often employ mid-appointment discussion of the case with the supervisor. Here, after interns conduct the assessment, the intern and supervisor step out of the exam room to discuss the intern’s conceptualization and possible interventions before returning to the patient and proceeding with the appointment. Although this approach typically adds 2 to 3 min to the appointment, it appears to decrease the likelihood that the intern and patient will become involved in a more time-consuming discussion when the goals of each party conflict.

PBHC outcomes that interns might initially have thought needed SMHC.

Of particular value has been initiating discussions related to standard of care to help interns shift their perspective from viewing primary care interventions as “care that is less than” what patients would get in an outpatient mental health clinic to “care that is more than” what they would typically receive in the primary care setting. We encourage interns to attempt primary care interventions with most patients and assess responses over time before recommending that the PCM initiate a referral for specialty care. This strategy is consistent with the zeitgeist of primary or managed care generally (i.e., PCMs typically implement primary care interventions that are commonly effective before referring to more expensive specialty care).

Additionally, supervisors demonstrate structuring interventions in ways that are consistent with a consultative model (i.e., how to translate “what works” in specialty clinics to “what works” in primary care) and how to implement the intervention in a few minutes. For example, a supervisor might model helping a depressed patient make changes in unhealthy thinking patterns in a manner consistent with a consultative role (e.g., using more streamlined concepts and simplified practice assignments; relying more heavily on patient psychoeducational materials).

Finally, structuring the rotation so that interns spend some time each week in primary care over an extended period of time (6 months) allows interns to see change in patients over time and to develop a sense of what kinds of improvements patients can make within an integrated consultation model. Shorter but more intensive rotations (e.g., full time for one month) do not allow this experiential learning, because interns usually do not see most patients back for a follow-up appointment.

Overdocumentation

Because PBHC services are conceptualized as part of standard primary care services (rather than as SMHC), documentation adheres to primary care standards and norms. PBHC documentation consists of brief consultation notes to the PCM. Interns are encouraged to make these notes appear similar to those written by other primary care providers (e.g., one-half to one page in length, handwritten, no psychological jargon). Notes are placed directly in the medical record rather than in a separate specialty mental health chart, and no separate treatment-planning documents or termination notes are written.

Interns’ main difficulty in adhering to this primary care standard of documentation is a tendency to overdocument information on background and presenting problem, leading to overly lengthy notes. This creates problems in two ways. First, long notes are time-consuming to write and typically cannot be completed within the fast-paced primary care environment. Second, such lengthy notes often contain more detail than is appropriate for a primary care setting, given the large number of medical personnel who may view primary care medical records. Hence, we instruct interns to include the minimum amount of information that will allow the PCM to understand the results of the assessment and rationale for the recommendations. Encouraging interns to periodically review notes written by PCMs also helps shift their framework from specialty to primary care documentation.
Inappropriate Consultative Feedback to the PCM

BHCs provide same-day feedback to PCMs on all new patients seen, as well as any follow-up patient with a significant change in functioning or recommendations. Whenever possible this information is provided in face-to-face verbal feedback. If the PCM is not available, BHCs may provide written feedback (typically a copy of the PBHC consultation note), or verbal feedback through voice mail.

Some interns show hesitance in interrupting PCMs to provide consultative feedback. This makes effective and timely communication difficult, given the busy schedules within the primary care clinic. To address this problem, we emphasize that the culture of primary care includes frequent interruptions, and we model a willingness to be interrupted ourselves (by encouraging PCMs to knock when our door is closed). We also help interns differentiate between situations that require interrupting the PCM during patient care (even when they are behind closed doors) and those that can wait until the provider is not engaged in direct patient care. Examples of more urgent issues that may require interruption include medication issues or medical concerns that need to be addressed before the PBHC patient leaves the clinic.

Verbal consultative feedback to PCMs typically should not take more than a couple of minutes. To help interns modify this tendency to provide lengthy feedback, we model a succinct consultative feedback structure, including brief identifying information and referral question, main assessment results and conceptualization, and follow-up recommendations (for both the PCM and the patient). Interns are encouraged to avoid the use of psychological jargon and to retain a focus on functional outcomes.

Finally, some interns struggle with directly recommending that PCMs modify their own behavior. Interns may be hesitant to suggest that the PCM initiate a new behavior (e.g., recommending that the next time the PCM sees the patient, the PCM should ask if the patient is continuing to practice a particular skill and to review the rationale for this strategy). Interns may also not address concerns about a PCM’s approach to treating a particular problem (e.g., prescribing practices related to insomnia or adjustment disorders). To address this avoidance, we rely heavily on modeling and feedback. We also review one of the main goals of our primary care work: increasing the PCM’s competence in treating patients with behavioral health problems. This can only be accomplished through tactful but direct communication.

Failure to Maintain the Health of the PBHC Service

In addition to helping interns develop PBHC skills in the aforementioned areas, supervisors must also attend to the broader functioning of the integrated care program. Placing a training program within an integrated care setting can present additional challenges to the integrated care service itself. Frequently rotating interns in and out of a clinic has the potential to result in confusion among primary care staff as well as in scheduling problems and decreased referrals. We have addressed this by attempting to keep staff changes minimal (e.g., interns rotate primary care clinics either every 3 or 6 months; supervisors remain consistent) and to simplify booking procedures so that staff members do not have to decide “which” BHC the patient should see.

The extra time that the supervisor spends providing supervision to interns (e.g., feedback, teaching, reviewing chart notes) takes time away from other service-building activities, such as strengthening relationships with primary care staff, talking with providers about concerns with the service in general, and encouraging providers to refer a broad spectrum of patients. Because supervision of interns pulls staff members away from these practice-building activities, it is important for supervisors to build in extra time for these types of activities to maintain the health of the consultation service itself. This may involve spending some extra time each week in the primary care clinic without interns, attending provider and staff meetings, or staying over lunchtime to meet informally with staff. We also encourage and expect the interns to take an active part in these informal interactions, particularly as they become more efficient with their use of time.

Future Directions

The MGMC predoctoral internship provides interns with the knowledge and skills necessary to function effectively as primary care psychologists and is consistent with most of the published recommendations for training discussed earlier. Through major rotations in outpatient mental health and behavioral medicine, interns develop competency in generalist psychology and in assessment and intervention with factors affecting health and disease. Effective interdisciplinary team functioning is emphasized throughout the year. During the primary care rotation itself, interns develop an understanding of the population health model, administrative and health care systems issues, primary care procedures, and ethical/legal issues related to integrated primary care. Didactic and clinical training builds competence in assessment, intervention, consultation, and practice management skills consistent with the primary care consultation model. The range of patients with whom interns work in the primary care settings helps interns develop skills in working with patients across the life span (pediatric through geriatric patients) and with the wide variety of problems seen in primary care settings.

In summary, for readers who are considering beginning their own PBHC internship training program, we recommend that they design programs to foster “foundational” knowledge and skills (in generalist psychology, health psychology, and interdisciplinary functioning), and “specific primary care” knowledge and skills. Furthermore, we recommend that they be aware of the common difficulties that trainees are likely to experience (e.g., deficient time-management skills, excessive referrals to specialty care, etc.) and potential ways of addressing these problems.

References


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**Call for Nominations: Health Psychology**

Division 38 (Health Psychology) has opened nominations for the editorship of *Health Psychology* for the years 2006–2011. Arthur A. Stone, PhD, is the incumbent editor.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2005 to prepare for issues published in 2006. Please note that Division 38 encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations also are encouraged.

Jerry Suls, PhD, has been appointed as chair for this search.

To nominate candidates, prepare a statement of one page or less in support of each candidate. Address all nominations to

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