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Integrated Behavioral Health Manual

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Introduction

This manual is intended to provide support for behavioral health clinicians engaged in the complex work of practicing in an integrated setting, as well as offer guidance for the necessary operational, leadership and cultural aspects of a whole-person care system.

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Introduction

Background and Purpose

For a long time, it has been universally recognized that mental illness and substance use have significant impacts on one's overall health and wellness. However, over the last decade, integrated, person-centered, care approaches that treat the full spectrum of one's health needs, including mental health and substance use issues, have become increasingly popular. There is an abundance of research demonstrating integrated care's positive effects on clinical outcomes, patient experience, and healthcare costs. It reduces the stigma of receiving behavioral health services for individuals who would not normally have sought treatment outside of the primary care setting, simultaneously addresses co-occurring behavioral and physical health disorders, and saves organizations and health plans money. In this sense, integrating behavioral health services and primary care is no longer thought of as a new or innovative model, but instead, considered to be a standard of care.

While some form of integration has been happening in health centers since the 1960s, the last 12 years have seen a significant acceleration in the field. In 2006, the California Endowment and the Tides Foundation launched the Integrated Behavioral Health Project (IBHP), the first statewide effort in California to advance integrated care. Since that time there have been numerous federal, state, and philanthropic grants aimed at advancing integration in the safety net, primarily funding "bi-directional" integration that integrates primary care into traditionally mental health and/or substance abuse organizations. However, the most robust integration continues to occur in community clinics. This manual is written, specifically, with this (and clinicians practicing in this setting) in mind.

Still, it is important to note that integrating behavioral health and primary care poses many challenges. Beyond issues with funding, systemic or organizational change, and healthcare policy, working within the culture of a traditional primary care setting can feel alienating for behavioral health providers because behavioral health practices are founded on principles that sometimes seem to be at odds with the culture of primary care. Primary care can appear to be a system that supports overwork and burnout, lacks person-centered care or partnership with patients, and has an absence of empathy as a primary component of treatment. Some behavioral health providers fear that integration in these settings can threaten to subsume the behavioral health culture and leave them feeling chronically overwhelmed and concerned about the quality of care they are providing. However, integration should not be avoided for these reasons. Instead these points should only point to the importance of consciously integrating behavioral health AND primary care, as opposed to integrating behavioral health INTO primary care. This manual hopes to guide practicing behavioral health clinicians who wish to understand how to provide services in an integrated setting or are preparing to implement integrated care in their workplace. In addition, it aims to serve as a comprehensive overview of the philosophical, clinical, administrative, and operational

characteristics of an effective integrated care model.

Some of the writings here come from my own 11 years (and counting) of experience working as a clinician in primary care settings, some comes from being a Director of Behavioral Health in the same settings for a decade, and much comes from the experiences shared with me by my many wise integrated behavioral health colleagues. This manual was composed to reflect a "point in time" in the field of integrated behavioral health, as it is one that is dynamic and constantly changing and evolving. In this spirit, I would invite and encourage readers to provide suggestions and feedback to any parts of this manual. Lastly, it is my hope that this manual is not interpreted as directive in any sense. I hope that it is only supportive and reflective of the complex work we are all engaged in.

- Elizabeth Morrison

What Makes Integrated Behavioral Health Unique?

There are many different definitions of Integrated Behavioral Health and even more definitions of "Integrated Care". This is likely due to the newness of the terminology, as it only just a decade old, and because the terminology is often used to describe very different models of care. However, for the purpose of this manual, it can be helpful to consider the definition provided by The Agency for Healthcare Research and Quality (AHRQ). AHRQ defines Integrated Behavioral Health as:

> "The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population".

In essence, it is the attempt to address the multiple social, psychological and physical health care needs of patients in a comprehensive and collaborative manner. It involves the treatment of mental health, substance abuse, and health behavior conditions (such as depression, obesity, smoking, anxiety, etc. and their contribution to and interaction with other chronic medical illnesses), while simultaneously considering the patient's life stressors and social contexts, the psychological effects of physical health symptoms, and the barriers to effectively utilizing the services made available to them. Most importantly, however, it involves a diverse team of health care professionals, who work together with the patient to provide person-centered, holistic, care.

This might seem complicated, idealistic, or even unrealistic, given the historically narrow definition of "healthcare" (which usually excluded services beyond medical care) and the traditionally siloed operation, financing, and delivery of healthcare services. However, integrating behavioral health and medical services has now become the accepted philosophy of care due to its compatibility with the Triple Aim, the plethora of research regarding its effectiveness, and clear data on patient preference.

In comparing Integrated Behavioral Health settings to more traditional mental health settings, there are a number of characteristics that make it unique.

PRACTICE DIFFERENCES:

More time is spent in direct patient care. In integrated settings, 5-7 hours of the day are spent in direct patient care. This is in distinct contrast to many traditional mental health settings where only about 2-4 hours a day are spent in direct patient care. Not surprisingly, in integrated settings, less time is also spent on documentation, paperwork, and case management activities. Much of this is due to differences in assessments procedures (Screening and Assessment), insurance and payer driven reports (such as discharge summaries, burdensome assessment and referral procedures, etc.), scheduling, and the workplace's culture of collaboration between mental health and primary care providers.

Providers operate at a quicker pace. In integrated settings, the pace of work is generally quicker than that of more traditional mental health settings. Therapy sessions usually range between 25-45

minutes, sometimes without longer first visits. With this, some systems schedule time for paperwork between sessions, while others require clinicians to rely on no-shows appointments or the end of the day to complete their documentation. In integrated settings, it is not uncommon for a clinician to go directly from one patient to the next with no more than just a few minutes of break in between.

Schedules are less predictable. In integrated settings, schedules are not always predictable. Many systems overbook or double book appointment slots to compensate for no-shows, encourage "warm hand-offs" between clinicians, and ask providers to take walk-ins. This minimizes a clinician's downtime and maximizes resources. However, not surprisingly, if most scheduled patients do show up or if a clinician falls behind because they are challenged to make clinical decisions within the 25-45 minute appointment slot, it can also lead to waves of time when the clinician feels swamped. While the degree to which clinics adopt these scheduling strategies varies, generally speaking, working in integrated systems calls for a high amount of flexibility, rapid decision making skills, and superior levels of adaptability to meet the needs of both the patients and the healthcare team on any given day.

Providers see patients who would not normally have sought behavioral health services. In integrated settings, many of the patients that the behavioral health clinician sees are referred to them from primary care providers or other members of the healthcare team. This referral can come about in many different ways. A patient may have indicated a need or a desire to see a behavioral health professional on a screening form, they may have expressed it verbally to a primary care provider, or the health team may have assessed that a patient would benefit from behavioral health services or a real-time assessment in order to make a pharmacology decision that day. The fact that these patients have not directly sought behavioral health services, but rather, were identified to have a behavioral health need after coming into the clinic to receive primary care, poses one of the greatest practice differences between integrated settings and traditional mental health settings. Many of the patients have neither met a behavioral health provider nor obtained counseling services before. This requires the clinician to establish what therapy is, how it may be helpful to the patient, and develop a strong therapeutic alliance with them from the very beginning of the intervention.

Providers often use the "warm hand-off" technique. Related to the above, many organizations utilize what is often called the "warm hand-off" technique to help patients move smoothly between providers of different disciplines on the same day. This means that when a patient comes in for one service (usually a medical visit) and is identified to have another need (such as a behavioral health need), the original provider directly introduces the patient to the new provider on that same day. This face-to-face introduction is beneficial for a multitude of reasons. It allows the patient to be seen while they are already in the clinic, increases the likelihood that they will return for their next appointment, and allows for intervention to occur at a time when a patient has expressed a need or desire for the new services. In considering behavioral health services specifically, the meeting allows for the patient to alleviate some of the fears of what therapy will entail and enables the clinician to provide immediate feedback to the medical team about any diagnosis or treatment directions.

(Warm Hand-Offs: Philosophy, Procedures, and Related Communication)

PHILOSOPHICAL DIFFERENCES:

Care is coordinated between providers. SAMHSA/HRSA states that care coordination "involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care". There is research to show that this not only increases efficiency and efficacy, but that it also produces superior clinical outcomes in patient care and improves patient satisfaction. It is important to note that care coordination is related to, but also distinct from, working on a team. The larger philosophy and practice of care coordination is to establish entire systems that strive to meet the goals of shared patient care plans, which are patient-driven, individualized, and grounded in the patient's belief system, values, preferences and strengths. Integrated systems are designed to facilitate consistent and effective communication between all members of the healthcare team, including, most importantly, the patient.

Behavioral health clinicians work a "team" with primary care providers. While many behavioral health clinicians have worked on treatment teams in the past with psychiatrists, substance abuse specialists, school personnel, and the like, traditionally, these teams have not included primary care providers. In integrated settings, the behavioral health clinician works with medical professionals and support staff to simultaneously address the behavioral and physical health needs of their patients. On these teams, the medical professionals are the "specialists" on physical health, the behavioral health clinicians are the "specialists" on behavioral health, and all other members of the team are responsible for seeing and responding to the patient's whole health (Communicating with Medical Professionals and the Healthcare Team). This approach allows the behavioral health provider to actively include the patient's physical wellness into assessment and treatment from the beginning of intervention, something that has been traditionally overlooked in the field of behavioral health up until this point (Common Intersections of Behavioral Health and Physical Health).

There is a concurrent focus on individuals and whole populations. This means that in addition to a focus on individual treatment for patients, there is a focus on developing systems of care that utilize population management tools in order to intervene effectively with particular populations. For example, the implementation of tools that screen whole populations (such as screening all children between the ages of 4-16 for behavioral health concerns, all post-partum women for depression, or all patients 13 and up for addictive disorders) and designed standardized treatment pathways for specific groups of patients (such as referring all chronic pain patients to behavioral health for assessment of substance abuse and other behavioral health issues or referring all patients who score over 12 on a PHQ-9 to behavioral health for services). With this, integrated systems work to increase their capacity to track progress and outcomes of specific populations and ultimately aim to design preventative health interventions for targeted conditions or populations.

Common Concerns of Behavioral Health Clinicians in Integrated Settings

Integrated Behavioral Health is not "real" mental health treatment. In some cases, this could very well be true. Different people and different organizations define "Integrated Behavioral Health" in different ways and because the term is so broadly used, it is important to clarify what an organization exactly means when they say "Integrated Behavioral Health". Originally the term did refer to a model of mental health care that was very different from what behavioral health clinicians would normally think of as mental health treatment. In this model, sessions were no longer than 20 minutes and were more consistent with "health coaching" than therapy. The visits focused on intervening on a targeted behavior, for example, daily exercise, and there was no psychosocial assessment, history taking, eliciting of past trauma, or other techniques considered to be standard in traditional therapy. Under such systems, a behavioral health clinician might have seen 15-20 patients a day, most of which were referred directly from the primary care provider. Examples of this model can be seen in Cherokee health systems (www.cherokeehealth.com) and in parts of Kaiser Permanente. As the field has developed and matured, integrated behavioral health has taken on a new meaning. Today, it has become a term that no longer describes one rigid model but rather refers to any type of integration of behavioral health and medical services. Many organizations use the term to simply describe the co-location of mental health and medical services while others use it to describe the provision of behavioral health services that include therapy but shorter sessions with an absence of payer-driven procedures such as lengthy written assessments on the first visit.

Integrating behavioral health into the primary care setting will mean that behavioral health becomes "medicalized". This is a possibility. It is true that most integrated systems at this time focus on providing medical care to patients. Some have as many as 10 times the amount of primary care providers as behavioral health providers. Moreover, primary care providers and other medical staff usually have little to no knowledge of mental health and mental health treatment. They may assume and expect that behavioral health clinicians will subscribe to their norms but fail to understand how this might compromise the ability of the behavioral health clinician to provide effective services. For example, they may be resistant to providing the behavioral health clinician with an office that is comfortable and therapeutic. They may fail to provide funds for a clinician to buy toys to be used in therapy, reference books, or other critical office supplies. Further, they may not understand the need for regular supervision, consent to treat and Releases of Information (ROI) forms, or even the differing mandated reporting requirements of behavioral health clinicians and primary care providers. For these reasons, it is important for behavioral health to preserve the tenets of their culture within the primary care setting. Behavioral health clinicians should be integrated into the leadership of primary care organizations, should help to reflect the importance of a patient's relationship with their therapist, articulate all of the necessary factors that go into building a strong therapeutic alliance, and ensure that important legal and ethical principles are upheld. Moreover, having a behavioral health leader, in title, to sit at the table with the executive team ensures that behavioral health services are not thought of as "extra" or "auxiliary" to primary care. If the leadership believes that the behavioral health clinician's only job is to intervene on patients who are

presenting as "problematic" for the primary care provider, behavioral health will likely be absorbed by the medical culture. However, if the leadership maintains a vision of healthcare as something that treats the whole-person and does not separate the mind and the body, they will have a strong foundation for truly integrating the two cultures.

30 minute visits?! My patients will hate that! This is a very common fear. For clinicians who are used to doing hour-long sessions or even 90-minute assessments, it is hard to imagine how to squeeze therapy into a 30-minute visit. They don't see how they will be able to perform well as a therapist and believe it will leave their patients feeling unsatisfied. However, in reality, the great majority of patients are very satisfied with receiving behavioral health services within a shorter time frame. Their satisfaction tends to vary more based on their connection with their therapist and their larger experience at the clinic, as opposed to the length of the appointment. Moreover, a high percentage of behavioral health patients in the primary care setting have never received therapy before and therefore have nothing to compare a shorter visit to. When patients do express concern or anger over the length of the session, the therapist can simply convey their confidence in their ability to build a partnership and provide assistance to the patient, regardless of the timeframe.

Still, it is important to note that there is no "rule" about 30 minute visits in integrated behavioral health settings. Even when scheduling templates have been developed with 2 appointments an hour, this doesn't mean the appointments each have to be 30 minutes long. For example, think about a doctor who may have 4 patients scheduled in an hour. They don't necessarily see each patient for exactly 15 minutes. They may have a "no-show" or only need 10 minutes with one patient but 20 minutes with another. It depends on the patient's needs within the context of how much time the doctor has. While it can initially feel stressful to be flexible about how long patients are in session, with practice it becomes easier for the clinician and can even be liberating. For example, a clinician may embrace the process of seeing a patient in an exam room for 15 minutes to make a therapeutic connection and then have a longer session with the patient the following week. They may also begin to appreciate the unpredictability of their schedule. They may enjoy that on some days, only 7 patients show up but they have 2-3 warm hand-offs and on other days, 3 patients come in, but they have 2 warm hand-offs and end up spending 50 minutes with another patient in an exam room. Moreover, many clinicians begin to find that working within shorter time periods actually makes them better clinicians. They are better able to build rapport, convey empathy, elicit disclosures, and provide interventions more efficiently.

Patient Experience

Environment of Care

Given the enormously personal nature of health care and its supreme importance in all of our lives, one might expect that maintaining high quality interactions between providers and patients would be a top priority for healthcare professionals, clinics, organizations, and health plans. However, research tells us that these intensely human encounters that take place in the healthcare setting every day are often marked by a lack of connection, compassion, and respect. While other industries have long understood the value of skilled, kind, authentic exchanges, the healthcare field has been slow to acknowledge the importance of focusing on the human experience of patients.

For many, a trip to a healthcare organization is like a trip to the DMV, only that it is made worse by the significantly more personal nature of the visit. Patients may feel fear, pain, or dread even at the thought of going to the clinic. The customary greeting of "do you have an appointment", spoken without a smile or even eye contact, and a directive "have a seat" in the cold, silent, interminable waiting area while being largely ignored until their name is bellowed from the door, contributes to the horribly dehumanizing experience that many have come to accept as normal. However, the cost of this sort of indifferent environment for health care organizations is high. The uncomfortable and cold setting lessens a patient's confidence in their care, increases their anxiety, and decreases their satisfaction.

Placing value on the whole patient experience is particularly important for behavioral health leaders and clinicians. They understand that a patient's experience in the reception and waiting room areas are essentially an extension of the therapeutic relationship. If sufficient goodwill is not established from the first points of contact in an organization, the therapist will have to "repair" and "catch up" to develop the adequate therapeutic alliance.

The behavioral health field has a long history of placing value on the patient's appraisal of care and a deep understanding of its impact on treatment outcomes. With this, the field has identified empathy conveyance as the core of patient experience. Research on empathy and its effect on patient experience originated in the field of psychology during the 1950s with the work of Carl Rogers, however the past 15 years have seen an explosion of interest in studying the connection between empathy and healing. The literature has consistently demonstrated the impact of the medical providers' empathy on patient adherence and, subsequently, health outcomes, including its ability to lower HbAIC levels, improve success in weight loss, and even lessen the duration and severity of the common cold. Of particular interest to the behavioral health field, research reveals that motivational interviewing and behavior change strategies grounded in the practice of successfully conveying empathy produce significant results. Overall, more than 70 clinical trials have demonstrated that these techniques produce a positive impact on patient satisfaction and healthcare outcomes. As a result, the American Psychological Association Task Force on Evidence-

Based Therapy Relationships has even designated empathy as an evidence-based element of the therapeutic relationship.

It is also important to note that it is not only the empathy of medical providers that impacts a patient's health, but that it is also the empathy conveyed by the entire organization. Improving patient experience involves great customer service and skilled communication at all levels of the organization but also a clean and organized waiting room and warm patient care offices. With this, there are a multitude of stakeholders that have an interest in improving patient experience in healthcare. Direct care providers can improve patient health outcomes by utilizing evidenced-based communication practices that improve patient adherence, and therefore, lead to more positive health outcomes. Concurrently, payers benefit from the cost savings that these improved health outcomes bring. Human Resources benefits from staff developing empathy conveyance skills, as it not only impacts relationships with patients, but it also improves staff morale and alleviates personnel problems. Clinics benefit from focusing on empathy and customer service in a world where patients have a wider range of choice in healthcare. Today, clinics have to compete for patients. Positive patient experiences help them retain existing patients and attract new ones, as well. In practical terms, if the receptionist at clinic is perceived by the patient as warm, caring, and friendly, down the line, that patient will be more likely to adhere to physician recommendations and ultimately experience more positive health outcomes. Plainly stated, patients who are treated better become healthier.

Most importantly however, it is imperative to remember that fundamentally, everyone wants to be treated with kindness and respect at their doctors or therapists office, especially those who have been historically judged and stigmatized. Providers working with those who experience a severe mental illness, addictive disorder, chronic pain, or who are homeless must remember that these are the folks who have commonly been mistreated, dismissed, and given poor care in the past. They are the most vulnerable in systems of care that have substandard customer service and suffer more from a lack of empathy and understanding in healthcare organizations. Therefore, building organizational climates where skilled empathy conveyance is expected and practiced, especially with the most vulnerable patients, ensures that everyone in our community receives the highest quality of care.

Improving Patient Experience

Improving patient experience begins with customer service. While the term "customer service" often times brings scripted phrases and robotic employees to mind, excellent customer service aligns closely with the practice of successfully conveying empathy. Both customer service and conveying empathy rely on the same skills sets - communicating a sense of warmth and goodwill, skilled listening, acknowledging the perspective and feelings of customers and patients, and preserving their sense of dignity and respect.

Much of the current patient experience field focuses on access to services (next available appointments) and fast service (decreasing wait times). While both of these are certainly important and all of us have been frustrated by endless phone system loops and long waits, it is really the patient's *perception or interpretation* of wait times or poor access that is important. Many times long wait times and poor phone access *convey* a lack of caring and respect. Patients who wait in cold, brightly lit, crowded waiting rooms after being "greeted" with a grim face and are not spoken to again during their hour-long wait, are going to *interpret and experience* this wait very differently than the patient who is warmly greeted, informed apologetically that the wait is over 45 minutes, offered water and snacks, as well as crayons and coloring papers for their children, and kept informed during their wait by employees who come around to check-in with them.

In summary, if we decrease wait times and improve phone access without improving how we *convey* warmth and kindness to patients, their overall experience will be much the same. By contrast, even when wait times or access to care does not change, improving skilled communication with patients has a dramatically positive impact on the patient's experience. Admittedly, the great difficulty with this model is that an organization must focus on how their employees treat patients *interpersonally*. This demands a *whole-scale culture change on all levels* and this is much more difficult to change than a adding a phone or a few more appointment slots.

The development of integrated behavioral health services is a prime opportunity for organizations to fully embrace empathy as a care value, and concurrently develop policies, procedures and workflows that support and enhance skilled interpersonal connections between employees and patients. Behavioral health providers can lead organizations in developing skilled communication learning and training activities, for both medical providers and staff, as well as assist human resources in developing recruitment and hiring practices with a bias toward those who are skilled communicators and who understand the primary importance of communication.

Comfort and Accommodation for Patients With Mental Health Conditions: How to increase mental health cultural competency in the traditional medical setting

As stated in the documents above, behavioral health providers do not provide services in a vacuum and patient sessions do not start when the patient walks into the provider's office. Instead, the patient's experience of behavioral health (and other clinic services) is much broader. It encompasses all contact the patient has with the organization's staff, including making appointments, phone interactions, and most significantly, the waiting room experience. Behavioral health providers have a unique responsibility to lead the organization in patient experience and more specifically, in cultural competency for those who have mental health issues and addictive disorders. Below are some important considerations for accommodating patients with these conditions.

- Ensure that the organization's written policy on disability accommodation specifically includes those with mental illnesses.
- Provide orientation for all staff and providers on basic mental health information, such as:
    - The organization's mission and how it supports treating those who have mental health conditions
    - The organization's values and how they support treating those with mental health conditions
    - The prevalence of mental health conditions to address the tendency to think in "us and them" terms. More resources for mental health prevalence data can be found in the Resources for Further Exploration section.
    - Empathy activating and stigma reducing information, such as effective patient stories and historical information about the poor treatment of those who have mental health conditions.
- More in depth training of the receptionists, as they are the ones who spend the most time with patients and set the tone of the organization. Training should cover mental health conditions, specifically thought disorders, personality disorders and anxiety, and how these conditions might present on the phone or in the waiting room, as well as how to best comfort and accommodate those who have these conditions during the wait time
- Written protocols should exist for providing alternative appointment times and/or alternative waiting areas when a patient desires (for example, to accommodate severe social anxiety). These protocols should follow the spirit of reasonable accommodation, with the understanding that most organizations do not have extra space. Protocols can include:

- Alternative options available to patients for waiting, when they desire (such as, in their car, outside, in an empty exam room, in an empty office, in an office with a staff member, etc)
- Examples of when to offer these options to patients
- How to let patients know that they can ask for alternative waiting options when they come in
- When and how to intervene with patients who are having visible symptoms in the waiting room
- How and when to offer appointment times that lessen the chance of waiting (first appointment of the morning, or after lunch, etc.)

- Have therapists not only co-located to provide treatment, but on-site to provide education and support to other staff and providers. Having therapists as on-site experts to provide education and support to other staff and providers tends to lower fear, judgment and stigma of patients with mental health conditions, which results in better care.

Sample Waiting Room Environment Policy and Procedures for Accommodating Persons with Mental Health Conditions

- Efforts should be made to avoid florescent lighting, which increases the institutional feel of a clinic and decreases feelings of emotional warmth. In addition, florescent lighting has been shown to increase stress, migraines, and anxiety.
- Screening tools that include mental health symptoms, if administered in the waiting room, should be given universally so that those with mental health conditions do not feel singled out. Moreover, universal screenings also show organizations the patients who want to hear and know about the psychological difficulties they are experiencing, but did not come into the clinic to receive behavioral health services. With this, the universal screenings increase the probability that those with these conditions will feel welcome.
- If patients are having visible symptoms, such as talking to themselves, talking to other patients about delusional content, anxiously pacing, etc. a staff member should go up them and quietly offer a private area for them to wait. Ideally the behavioral health provider or another skilled staff member can talk with the patient to elicit where and how they might be most comfortable. This is done for the patients' comfort as well as others'. If space does not allow for a separate private area, other options include having the patients wait in an empty exam room, an empty office or, if the patient's condition warrants, in an office with a staff member. If patients are comfortable waiting outside, that can be an option also. Receptionists can let the team know where the patient will be when it is time for their appointment.

- Patients should be informed that they can ask for alternative waiting options when they come in, such as waiting in their car, at outdoor tables, or an empty exam room or office.
- Patients should be informed of the estimated wait time when they check in and periodic updates should be given as they wait.
- Water should be available or offered to patients when they check in, in the spirit of demonstrating concern and care for the patient's comfort.
- Staff members should regularly visit the waiting room to tidy up, interact with patients warmly, offer parents crayons and papers for children, etc. This sense of attending/befriending patients in the waiting room not only decreases the chance of behavioral escalations, but it also provides a comforting presence for all who have come for care.

Patient Care Offices in Integrated Behavioral Health Settings

Behavioral health offices are the "exam rooms" of therapists. Research indicates that the patient's level of comfort in the office has a direct impact on their level of disclosures and how much empathy they feel. This, in turn, impacts how effective an assessment is, the accuracy of a diagnosis, their adherence to recommendations, and subsequently, their overall health outcomes. While all offices vary in size and layout and are influenced by the individual clinician's preferences or the organization's norms, all offices should have standard minimum furnishings and configurations to ensure that the patient has the best experience possible.

Configuration: There should not be any barriers, even desks, between the therapist and the patient. Desks should instead border a wall, allowing the therapist to face patients and family members without anything in between them. There should be open seating with enough room for a patient and a minimum of 1-2 family members. Ideally, there should also be a small space for children to play. This can be a table with some coloring supplies or even just a clean spot on a carpeted floor with appropriate toys.

Privacy: Offices should be and should feel, private. If the office's walls are thin, the therapist may use sound machines, such as a white noise machine (either inside the room or outside of the room) to muffle noise both ways.

Furnishings: When furnishing an office, maximizing the patient's comfort should always be the priority. Whenever space permits, small loveseats or upholstered chairs should be used in place of hard office chairs. Research has also shown that overhead lighting has impacts on migraines, anxiety, general stress, and inhibits patient disclosure. Because of this, overhead fluorescent lighting should be replaced with floor or desk lamps and wall lighting. Art should be placed on two walls in the office and be consistent with the organization's standards. With this, it is important to note that therapy rooms usually avoid abstract art, which is more apt to be interpreted as frightening or threatening by individuals who may be suffering from active psychosis. In most offices, personal trinkets and photos are also minimized, but discussions about what sorts of art or photographs are appropriate to display should be had with a clinical supervisor. Lastly, books, papers, and file folders should be neatly tucked away on a shelf or in a cabinet.

Appearance: Generally, as stated above, it is important that offices are clean and organized. As research indicates, the patient's perception of the office as a comfortable, private, orderly, environment instills confidence in the given organization and the specific clinician, which subsequently has great impacts on their health outcomes. Clutter, storage, boxes, piles of paper, bare walls, and papers tacked or taped to the walls are often interpreted by patients to be neglectful and even disrespectful, as an "uncared" for environment can indicate a lack of care for a patient's comfort. Still, organizations should remember that the clinician's comfort is important, as well. Behavioral health providers work in their offices for 8-9 hours a day and the effectiveness of a clinician can vary considerably depending on how comfortable they perceive their immediate

environment. Organizations should remember that "the self" is the only "tool" behavioral health providers use. For this reason, creating and maintain environments that supports the clinician's work and facilitates the calibration of the self is important because it has direct impacts on how effective a clinician will be with their patients.

Computers and Electronic Health Records in the Behavioral Health Visit

The widespread adoption of the Electronic Health Record (EHR) and the presence of computers in both exam rooms and behavioral health offices has brought about new questions surrounding how to best use the technology in the integrated behavioral health setting. As we all know, computers are useful. Healthcare professionals have used them as their "clipboards" and "notepads" for more than a decade. However, many behavioral health clinicians differ in how often and in what ways they prefer to use computers.

Some more traditional therapists tend to be hesitant to use computers during sessions for documentation. They may be used to taking notes on paper (or not taking notes at all) or feel that computers negatively affect their ability to fully focus on the patient, prevent them from skillfully listening, and inhibit their ability to form a strong therapeutic alliance. Likewise other therapists embrace using computers during sessions. They may feel that it has no real impact on the therapeutic alliance or even more, they may have received feedback that it inspires confidence in care from patients. They may see that using computers during the session allows them to consistently refer back to the patient's whole-health information. They can look at notes from other team members and process with the patient in real time.

Either way, it is important to note that there is no "right" way for a behavioral health clinician to use a computer. Each should make their own decisions about what works best for them, their patients, and their organization. For example, some clinics have their own standards for the use of computers in sessions. They may require clinicians to enter screening tool scores or other notes about the patient directly into the EHR during the session. Others may choose to administer screening tools during other points of care and thereby preclude the behavioral health clinician from having to do this work on a computer themselves.

However, in spite of whatever technique is ultimately chosen by the practitioner and their organization, generally speaking, a computer should always be readily accessible to the clinician. This is because there are times when consulting with a computer during a session is necessary for patient care. For example, a behavioral health clinician might find it necessary to consult with a patient's EHR to answer their questions about a care plan or to print patient education materials. Regardless of when or how much the computer is used, here are some guidelines that can be helpful.

Tips for Using Computers in the Behavioral Health Visit

1. Clearly refer to the computer as "the patient's chart" or "health record". This helps frame the computer as being related to and benefiting the patient.

2. Apologize for using the computer during a session. This can help to acknowledge any intrusiveness the patient might perceive. The therapist might say something like, "I

apologize - if you can give me a moment, I am just going to look quickly at your chart to answer your question".

3. Narrate the use of the computer to clearly identify when the clinician is using it and when the clinician is attending directly to the patient. This can mitigate any potential damage to the therapeutic alliance. The therapist might say something like, "I am going to document your depression assessment right now on the computer so that we can have it in the record to refer back to later (*typing, looking at computer…)* Okay, thank you for waiting. *(Eye contact, listening, and no typing)* Tell me more about how your depression has impacted you?"

4. Avoid having a desk between the clinician and the patient (Patient Care Offices in Integrated Behavioral Health Settings). Using a computer on a desk between the clinician and the patient will further compound the difficulty.

5. Avoid typing while "listening". Regardless of how skilled a clinician might feel they are at typing and listening at the same time, attention is, by default, split between these two tasks. Often times, the result is substandard listening.

Collaboration and Teamwork

The Many Roles of a Clinician in Integrated Behavioral Health Settings

Psychotherapist - has excellent assessment and diagnostic skills and is competent in evidence-based, briefer, therapy for everyone from children to adults with mild-severe behavioral health conditions.

Geriatric Social Worker - has the ability to discern mental health conditions from neurological conditions and has the ability to do basic assessments (MMSE) for the healthcare team in addition to designing treatment plans for the patient and family members of those with dementia and other cognitive impairments.

Supportive Co-Worker - assists employees and the system in managing patients who can be heavy on time and resources, such as those with cluster B personality disorders.

Consultant - provides knowledge and support directly to the primary care providers, nurses, and other medical staff.

Case Manager - is skilled in comprehensive bio-psychosocial assessment and knows how to guide referrals to community services in an effective manner.

System Navigator and Advocate - helps patients navigate complex health systems to ensure their needs are met.

Educator - provides formal and informal skills training to providers and staff on evidence-based interventions.

Medical Social Worker - engages in care and has a working knowledge of medical conditions and their symptom overlap with behavioral health conditions.

De-escalation Specialist - is skilled in basic de-escalation techniques and is willing to intervene with upset, agitated, or angry patients.

Family Interventionist – is skilled in family assessments and interventions to be used when working with children and adolescent patients.

The Role of the Psychiatrist and the Behavioral Health Clinician

Due to the shortage of psychiatric services in the United States, California, and above all, communities serving safety net populations, the main goal of having a psychiatrist in an integrated setting is to enhance the medical provider's skill and comfort with psychoactive medication management. Particularly with complicated patients, psychiatrists increase the health team's understanding of behavioral health conditions and help to lower anxiety, fear, or bias that may come with caring for individuals experiencing issues with mental health. Having psychiatrists, in addition to behavioral health clinicians within an integrated system can, therefore, have a dramatic impact on how staff and medical providers think about and care for those with severe mental health issues.

To this end, the psychiatrist's role on the integrated health care team is just as much about teaching and consulting with medical providers, as it is about seeing and treating patients face to face. Ideally, a psychiatrist's time will be allocated to both accordingly.

ROLES OF THE PSYCHIATRIST

Consultant: Providing telephone, text, email, or "curbside" consultations directly to medical providers. These contacts are typically in response to requests from primary care providers for specific information or advice about patient medication decisions and management.

Teacher: Facilitating the learning and development of the health care team (in both formal and informal ways) surrounding issues regarding pharmacological treatment of complex psychiatric conditions, such as treating those who are pregnant or have other co-morbid medical complexities.

Clinical Mentor: Providing both formal and informal teaching and supervision for behavioral health clinicians in assessment, diagnosis, and treatment.

Clinical Provider: Administering direct care to patients. This involves performing assessments that determine the appropriate medication(s) for a patient and identify any changes that need to be made in pharmacological treatment. In integrated systems, psychiatrists rarely continue to follow stable patients or manage their refills. Primary care providers are typically responsible for these tasks. This reserves the psychiatrist's time for initial assessments and treatment decisions. Psychiatrists also almost never provide therapy. Instead the behavioral health clinicians are responsible for this course of treatment. The Director of Behavioral Heath, the CMO, and the psychiatrist typically develop flexible referral protocols that establish the appropriate use of psychiatry. For example, they may decide that for someone with ADHD, but no co-morbidities, the primary care provider will take the lead in treatment. However, with more complex mood disorders or when treating someone who has a history of pharmacological treatment failures, pregnancy, or psychosis, the psychiatrist will play a much larger role. While every system is different, most systems will have developed written guidelines for appropriate referrals to psychiatry.

Preceptor: Providing follow-up support. In most cases, psychiatrists will see patients 1-3 times or until they are somewhat stable on their medication regimen. After that, psychiatrists usually provide support to medical providers through email, text, and phone when they have questions or concerns.

ROLE OF BEHAVIORAL HEALTH CLINICIANS WITH PSYCHIATRY

Different clinic systems have different practices and protocols about the role of behavioral health clinicians within psychiatry services. The following are common roles of behavioral health clinicians when interacting with psychiatrists in integrated systems.

Primary Referrer: In many integrated systems, the behavioral health clinicians are the only referral pathways to psychiatric services. This is usually because behavioral health clinicians are asked to do the assessments before referring patients to the psychiatrist, direct referrals from primary care providers are sometimes inaccurate or inappropriate, it facilitates greater communication between the behavioral health clinicians and the psychiatrists about what is working and what needs to be changed in the referral pathway, and it ensures that those who are referred to psychiatry are concurrently in therapy, or have at least been assessed for a need and desire for therapy.

Shape and Frame Expectations for Patients: Psychiatry tends to have an archetypical reputation to patients. It brings to mind a "super therapist" who is all knowing, has unlimited insight, and a couch to lie down on. It is important that behavioral health clinicians shape the patient's expectations of the psychiatrist. They should reiterate that the psychiatrist is a doctor who they will be consulting with about medication and treatment, but that the patient will likely see them only a few times. If the shaping of expectations is not done sufficiently, patients typically expect therapy from the psychiatrist and are irritable or disappointed with their visit. Their unhappiness with the visit can subsequently impact their confidence in the treatment recommendations and thus their adherence to the treatment plan, so it is important to frame expectations during the first visit.

Liaison and Relationship Facilitator: Behavioral health clinicians are instrumental in facilitating trusting and communicative relationship development between the psychiatrists and other medical providers, as they tend to have strong relationships with both. For example, a primary care provider might consult with a behavioral health clinician about a patient who continues to have audio hallucination after the initiation of an anti-psychotic and they may want to quickly refer back to psychiatry. A behavioral health clinician may encourage the primary care provider to text, email, or call the psychiatrist first and ask for their advice directly, thereby helping to establish direct communication. Likewise, sometimes a behavioral health clinician might present a case to the psychiatrist on behalf of a primary care provider and share the psychiatrist's response with the primary care provider. Either way, behavioral health clinicians are incredibly important to supporting psychiatric services. They attend brown bags and other in-services, encourage other team members to do so as well, are particularly skilled at understanding the primary care provider's needs when it comes to psychotropics, and can guide the psychiatrist's teachings to meet these needs.

Common Intersections of Behavioral Health and Physical Health

Behavioral health clinicians are readily aware of how physical health conditions intersect with behavioral health conditions. They understand how depression, anxiety, and substance abuse affect one's adherence to medical recommendations, how obesity affects one's emotional or psychological state, and how childhood trauma impacts one's health throughout the life course. They recognize that the distinction between the mind and the body is somewhat artificial and see integrated care as the pathway that can reunite the two. In fact, behavioral health clinicians working in integrated settings often say that 99% of patients being seen by the primary care provider could be also be referred to them and vise versa!

Although the overlap of physical health and mental health conditions is broad, it is possible to identify some specific conditions that are more commonly treated by both physical and behavioral health providers in integrated settings. Although coordinating care between providers for these conditions can sometimes be complicated, when teams work together to enhance the care they give to a patient, they are working to achieve the goal of providing whole-person care and ultimately see more long lasting, positive, health outcomes.

Insomnia: Insomnia is a condition that commonly presents itself in the medical settings and is addressed by both primary care providers and behavioral health clinicians. Primary care providers typically take the lead with completing a medical evaluation that would identify whether there is a physical health condition that is contributing to or causing the insomnia. Conversely, behavioral health clinicians will usually complete an assessment that would identify whether there is a behavioral health condition that is contributing to or causing the insomnia. More specifically, the behavioral health clinician will usually assess the patient for depression symptoms, uncontrollable worrying or General Anxiety Disorder, and substance abuse issues. But even if the patient doesn't meet the standards for a diagnosis of a mental health condition, the therapist may find that the patient feels the insomnia is having adverse impacts on their mental health. The patient may feel fearful or even angry about their lack of sleep and they might blame themselves or others for their cycle of poor sleep hygiene. Regardless of the causes of insomnia, behavioral health and physical health providers work together, communicating with each other along the way, to increase a patient's tolerance and coping with the condition.

Depression and Anxiety: Most behavioral health clinicians are very comfortable and skilled with treating depression and anxiety that is the result of past or current life events such as loss, trauma, and faulty cognitive patters. However, it is important to remember that physical health conditions can also contribute to or cause depression and anxiety. For example, physical conditions from thyroid problems to hormone problems can cause depression and plenty of physical health conditions can manifest into anxiety. For this reason, it is important for the patient to have a thorough medical evaluation by their primary care provider when they present with symptoms of anxiety or depression. When it comes to treatment, the most important factor to consider is the patient's preference. Each patient will likely have an opinion about what sort of treatment they

want. Some may be perfectly fine with taking first line medications for depression and anxiety such as Xanax and Valium while others may wish to avoid medications completely. Fundamentally, working with patients to assess their beliefs about different types of treatment is important because preference, autonomy, and choice in treatment decisions correlate with adherence and subsequently better health outcomes. Behavioral health clinicians can work with the patient to advocate for themselves around treatment decisions and collaborate with the primary care provider to prescribe medication in an empathetic fashion that validates any of the patient's difficult feelings.

Obesity: If obesity was as simple as eating less and exercising more, it is unlikely that it would be the epidemic that it is. Many times, the primary care provider takes the lead in treating obesity. He or she may evaluate the patient to rule out any medical conditions that are contributing to the obesity and maintain regular appointments with the patient to monitor their overall health and track their weight loss progress. In treating obesity in integrated settings, the behavioral health clinician will usually come in and begin by assessing the patient for a history of trauma, co-occurring anxiety, depression or other behavioral health conditions, and whether they have a binge eating disorder, or more broadly, addictive food behavior. The behavioral health clinician will also elicit and help the patient examine and explore their personal thoughts, beliefs, and experiences about/with food, eating, and body image. Engaging patients in exploring and understanding how their culture, both familial and ethnic, might influence their ideas and behavior with eating and weight is also important. Health outcomes ultimately depend on creating a treatment plan that aligns with the patient's preferences and beliefs about what they want and need. To this end, clinicians should partner with patients to elicit and assess their perceptions of their weight. A motivational interviewing framework can be helpful to do this, as it can assess where a patient is in the stages of change concerning their eating/weight and individualize interventions accordingly.

ADHD: ADHD is the most common behavioral health condition seen in pediatric populations in the primary care setting. The role of the behavioral health clinician is particularly important because differential diagnosis for behavioral health conditions is complex with ADHD. PTSD, lack of sleep, poor nutrition, abuse, problems at school such as bullying or a shaming teacher, and the like can all contribute to ADHD symptoms. In addition to the behavioral health clinician's initial interview and assessment, patients typically also need a medical evaluation to rule out any other conditions that might be causing the ADHD symptoms before anyone considers pharmacological treatment. As with all conditions that have multiple treatment options, the patient and their family's beliefs and preferences should be of primary importance. Behavioral health clinicians, primary care providers, and the patient and their family should continue to work together to monitor the response to intervention and adjust or change it as necessary along the way.

Chronic Pain: There might not be a better example of a condition that requires the support of the entire health care team in an integrated setting than chronic pain. Chronic pain is complex. There is often overlap between severe physical pain and histories of trauma, mood disorders, substance abuse conditions, and the like. Moreover, most behavioral health clinicians and primary care

providers receive little to no training about chronic pain in graduate school and often only develop experience in assisting people who have the condition while working in a primary care setting. With this, most of what taught in graduate school is about the dangers of treating chronic pain. Providers hear case studies about accidental overdoses, the dangers of opioid medications, and "drug seekers" who are hoping to sell their medication for profit or feed and addiction. For this reason, people with chronic pain are highly stigmatized and treated very poorly. Therefore, perhaps one of the most important roles of the behavioral health clinician in treating chronic pain is to model compassion and professionalism in interactions with patients. Beyond this, the behavioral health clinician will use a clinical interview and other assessment tools to evaluate patients for mental health and substance abuse issues, functional abilities, and risk for developing addiction. They will then work with primary care providers to determine the best treatment plan that also takes into consideration the patient's preferences and beliefs. From there, the behavioral health clinician will work with patients to increase their acceptance of chronic pain, connect them with pain programs and support groups, and continue to provide clarification about treatment decisions such as a regular urinary analysis or a discontinuation of alcohol or other drug use. Throughout the process of treating someone with chronic pain, it is important for the health care team to maintain communication and adhere (with kindness) to any limits or boundaries in order to ensure the safety of the patient and avoid the "lenient then resentful" cycle that sometimes occurs with helping professionals.

Communication and the Healthcare Team

Communicating with Medical Professionals and the Healthcare Team

Genuine relationships on the healthcare team are the foundation of an effectively functioning integrated behavioral health system. When team members understand and trust each other, they create an environment where everyone is motivated to mutually learn from one another, adopt a common belief system, and embrace practice change. Face-to-face interactions about patient care issues increase communication between team members, however it is the more "informal" conversations (both work related and non-work related) that allow co-workers to gradually begin self-disclosing and engaging in vulnerable questioning and affective expression. These interactions build quality relationships, which in turn have a direct impact on patient safety and care outcomes, not to mention, employee job satisfaction.

Generally speaking, the difference in communication styles between medical providers and behavioral health clinicians stems from the fact that medical providers are usually "task driven" while behavioral health clinicians are usually "relationship driven". This means that, in general, medical providers value conclusions and solutions to tasks and problems. They prefer short and straightforward answers and recommendations as opposed to longer discussions concerning what is clinically compelling about a patient. On the other hand, behavioral health clinicians tend to prefer to focus on problems as they stem from the complexity of human behavior. This involves the curious exploration of a person's problems through longer discussions and relationship building.

In an integrated environment with employees who are comfortable communicating with one another, each style can be valuable and compliment the other. Below are some general tips about how to facilitate productive and positive communication within the healthcare team.

Modeling Evidenced-Based Skilled Communication Techniques

In order to begin building quality relationships within the healthcare team, the behavioral health clinician can model the very evidence-based communication skills they use with their patients. Although they may not be used as extensively by medical providers, these communication practices are also considered to be the "gold standard" in the medical field, since they are proven to yield superior treatment outcomes, increase provider satisfaction, and improve patient experience. While there are many evidenced-based communication techniques, a brief list of some is below:

1. Open-ended questions
2. Reflective listening

3. Feelings validation
4. Empathy conveyance

Consciously practicing these techniques with colleagues will not only increases the behavioral health provider's skill, but it will also allow for other team members to acquire the skill, as well.

Maximizing Provider Focused Consultation

Maximizing provider-focused consultation is the ability of the behavioral health clinician to respond to the provider's feelings, needs, and beliefs when they are asking about a patient. Properly attending to the provider's feelings in the short term will yield larger gains for patients in the future, as it can help shape how they think about patients with behavioral health conditions and even shape their entire belief system. Behavioral health clinicians may do this by pausing before responding to a question about a patient, taking stock of the provider's emotional state, and then attending to their feelings. From there, the behavior health clinician can elicit thoughts and opinions about the patient's condition from the provider. This will facilitate information sharing and mutual learning, which will subsequently enhance their relationship.

For example, a medical provider may come to a behavioral health clinician and express that they are very frustrated because a patient is demanding medication, referrals, and testing that the provider believes are unnecessary. Perhaps the patient has a diagnosis of depression, is nicotine dependent, and has a history of polysubstance dependence. The primary care provider may ask the behavioral health clinician to go talk to the patient, which the behavioral health clinician will ultimately do. However, before they do so, they would address and validate the provider's feelings by saying something like "yea that sounds very frustrating, I can understand why you feel that way". The behavioral health clinician may follow by asking open-ended questions about the provider's experience to get more information, such as "can you tell me more about how it feels when you are in the exam room?" and then continue by probing for the provider's opinions by saying "what do you think you would like to do with this situation?". After the behavioral health clinician has heard the thoughts and feelings of the providers, they can ask to give information respectfully by saying something like, "can I give you a thought on this?". The behavioral health clinician can then give them any relevant information about how to proceed with the patient.

Providing Information Through Skilled Communication

One of the most rewarding parts of working on a team is the personal and professional growth that occurs as a result of learning from other team members. The osmosis of knowledge between team members can significantly affect how one practices individually and collectively. Behavioral health clinicians can provide information on a variety of important topics and specifically demonstrate that *the way* in which information is communicated is just as important as the information itself. The following are examples of areas in which a behavioral health clinician's expertise and communication skills might be particularly valuable to the team.

- Many medical providers are not particularly knowledgeable about therapy. They may not know what happens in therapy sessions or know that it is a first line treatment for the most common behavioral health conditions, many of which intersect with medical conditions. As it comes up in patient care conversations, it is important for the behavioral health clinician to educate other providers about therapy as an evidenced-based treatment. To do this, the therapist might ask the provider what they already know about therapy, validate and reinforce what they already know, and then provide new information. Beyond educating their co-workers, this also allows the therapist to model effective communication strategies. For helpful "tips" sheets directly addressing primary care givers' knowledge and perceptions of behavioral health clinicians and services, see "What Does a Therapist Actually Do?" and "Tips for Medical Providers Working on a Team With Behavioral Health Providers" in the appendix.

- Many medical providers are not aware of how traumatic childhood experiences can lead to chronic diseases and generally poor health outcomes as adults. Although many of the medical professions are now teaching Adverse Childhood Experiences (ACES) and related research in their curriculums, the behavioral health provider might be the first line of knowledge for information about the social determinants of health. Whenever appropriate, the behavioral health clinician should share this expertise, as it can enrich the other provider's insight and empathy in patient care. A therapist might do this by first empathizing and acknowledging a provider's frustration with a patient who has multiple chronic conditions and then use skilled communication strategies to provide them with new information about the possible social determinants of that person's health condition.

- Many times, addictive disorders are misunderstood as problems of willpower, character, parental failings, and the like. Moreover, there are many myths about the drugs themselves, such as illicit drugs having more addictive potential than alcohol or tobacco. Behavioral health clinicians can provide meaningful, research-based, information to the medical team about addictive disorders as it comes up in patient care conversations. The behavioral health clinician might do this by first asking the provider open-ended questions to elicit their thoughts and beliefs are about addictive disorders and then provide them with new information.

- Related to the above, many primary care providers have had experiences with mental health issues or addictive disorders within their own families, or perhaps, themselves. When providers disclose this to the behavioral health clinician, they can respond with compassion, skilled empathy, and respectfully share any helpful information that would appropriate.

- It is not uncommon for primary care providers to ask the behavioral health clinician for advice about what psychotropics to prescribe. It is important for the behavioral health clinician to stay within their scope of work and refrain from making medical or medication

recommendations. To this end, it can be helpful for the behavioral health clinician to educate the medical team about their responsibilities and limits. When discussing medication however, it can be helpful for the behavioral health clinician to provide information about the patient's belief system surrounding medication, what they may have tried in the past, what they may want to try now, and what other family members may have used successfully. To do this, the behavioral health provider might start by acknowledging the provider's willingness to collaborate (affirmation of strengths) and then provide their insights.

COMMUNICATION WITHIN THE ELECTRONIC HEALTH RECORD

For most behavioral health clinicians, face-to-face interactions tend to be limited to the healthcare team they work with on a daily basis. However, even these face-to-face interactions can be limited in time or an inefficient way to communicating about a patient's care. The Electronic Health Record (EHR) subsequently becomes the primary way for a team to communicate about the vast majority of patient-related issues and care decisions. Although it can be seen as a convenient and easy way to communicate, clinicians should be particularly careful and thoughtful about what is written in the EHR. This is because whatever is written in the EHR has direct impacts on the readers' understanding of behavioral health, patient safety, and the quality of care. To this end, it is important to avoid the use of high judgment and stigmatizing phrases such as "drug seeking", "lying", "non-compliant", "unreliable reporter", "resistant", etc. Conversely, the EHR can be a way to consciously communicate empathy, understanding, and promote whole-person care. Behavioral health clinicians can continue to lead the advancement of this culture change by taking care to chart the patient's values, strengths, and successes, within the EHR. With this, every clinician should also remember that whatever is written in the EHR is essentially permanent, could potentially be seen by the patient, and could even be subpoenaed in court. Most organizations will have some level of standardization or training about their specific charting guidelines, but the following are some general standards for using the EHR.

- Behavioral health records should be integrated with medical and substance abuse records whenever the services are being offered at the same organization. While this challenges some individuals' and organizations' historical belief systems about sharing information, there are no legal or ethical reasons for records not to be integrated. Moreover, when there are legal or ethical concerns, they can be addressed through reasonable system changes, such as including behavioral health and substance abuse services in consent to treat documents, as well as on Releases of Information (ROI).
- When records are integrated, it is important for the organization to clearly communicate this to the patient on the first visit. By doing this the clinician can address any of the patient's concerns, discuss charting norms, and remind them about HIPPA's "need to know" mandate. There may be times when a patient will prefer to receive behavioral

health services elsewhere as a result. Although this is rare, it is important that patients are given all appropriate information about how their records will be shared.

- A behavioral health clinician's diagnosis of a patient should appear on any shared problem or diagnosis list. This means that a diagnosis of panic disorder would appear alongside a diagnosis of COPD or diabetes. This is the most basic way of patient care communication. While most EHR software make creating shared self-management goals or care plans very difficult, creating shared problem or diagnosis lists is usually quite simple.
- Actual narrative charting should be respectful of a patient's privacy. Documentation of counter transference, extensive details about a patient's marital difficulties, sexual history, childhood trauma, or any other delicate subjects are rarely necessary to include in the EHR. The EHR should be reserved for only the clinical information necessary to keep a patient safe or enhance their quality of care.
- There should be an established, standardized, system, within the organization, for communicating health information that might be urgent or impact the patient's safety. For example, when a patient discloses severe alcohol dependence to the behavioral health clinician and the clinician realizes that the patient is also being prescribed benzodiazepines and opioids, there should be a system that "alerts" or "flags" this to the prescribing provider.

COMMUNICATING WITH RECEPTIONISTS AND MEDICAL ASSISTANTS

Receptionists tend to be the "right hand" of behavioral health clinicians. For many, the receptionist is the only support staff the behavioral health clinician has and are the staff member that the behavioral health clinician interacts with the most (sometimes as often as between every patient they see). Medical Assistants are also often particularly important members of the team for behavioral health clinicians. At some organizations the Medical Assistants, although not explicitly working with the behavioral health clinician, provide the warm hand-offs, clinical communication, interpretation, and other general support that the behavioral health provider needs. Both the receptionist and medical assistants are seen as true "health team members" to the behavioral health clinician and for this reason, communication with them takes particular thoughtfulness and care.

- Modeling skilled communication when interacting with receptionists and Medical Assistants is as important as it is with medical providers. Not only is it kind and respectful, it also models the very skills behavioral health providers want them to use with patients.
- Staff-focused consultation is similar to provider-focused consultation. When receptionists come to the behavioral health clinician with concerns about a patient, perhaps a patient's behavior, rudeness, eccentricities, flirtations, or other behavior, the behavioral health clinician can begin by exploring their needs and wants by providing validation,

empathy, and reflective listening before moving on to focus on the particular patient at hand. Particularly with support staff, focusing on their strengths and encouraging confidence will build their interpersonal skills and ability to communicate with an increasingly wider variety of patients.

- Behavioral health clinicians are sometimes the first therapists a Medical Assistant or receptionist has ever met. Subsequently how a behavioral health provider talks about behavioral health concerns will have a significant impact on how other staff will perceive patients with behavioral health conditions and the field of behavioral health at large. For this reason, it is the responsibility of the behavioral health clinician to model empathy, compassion, understanding, and the very skills taught to patients in therapy (feelings identification and expression, self acceptance and self care, etc.).

- Workplace culture is different in each organization, however it is not uncommon for healthcare organizations to allow little autonomy for staff to make their own decisions, treating them more like robotic taskers than empowered team members. While behavioral health providers may not be able change the whole culture of an organization (or at least not quickly!), they can explicitly encourage the autonomous decision making of staff and thereby treat them as an important member of the healthcare team. The behavioral health clinician may facilitate this by saying something like, "When you call this patient back, go ahead and make whatever decision you think is best after you talk to her. If you think she needs to be squeezed in, just let me know." or "What do you think works best for no-shows? I know it affects your work and you are probably the one who deals with this the most, so I'd be curious to hear your opinion." The benefit of having empowered, autonomous, decision makers cannot be overestimated. When it is welcomed in the organization's environment, it builds trust, communication, and quality relationships, which all ultimately effect patient care outcomes.

Warm Hand Offs: Philosophy, Procedures, and Related Communication

PHILOSOPHY

The "warm hand-off", simply put, is the practice of one health care provider introducing a patient to another healthcare provider with the hopes of connecting them to a new service. While the warm hand-off is most often used in reference to a medical provider "handing off" a patient to a behavioral health clinician, warm hand-offs can occur between anyone at a given organization or even between providers at different organizations. The "hand off" occurs during the course of the visit and usually involves the original provider walking the patient over to the new provider (or bringing the new provider over to the patient), allowing them to meet face-to-face before beginning care. There is no time requirement for the length of the "hand off" – it could consist of a 15-20 minute consultation or an official "first session" but it could also simply be a 5 minute "introduction" that leads to another appointment being set up in the future.

The warm hand-off seeks to address many of the barriers that patients face in obtaining behavioral health services. No show rates for first appointments can be as high as 60% for behavioral health services, reflecting the stigma around receiving mental health care, transportation and childcare issues, and apprehension or fear of a therapist. The warm hand-off, therefore, becomes a skillful way to connect the patient with the new provider when they are already in the clinic. This not only eliminates any barriers that might prevent the patient from being able to return at a different time for a new appointment but it also builds comfort, trust, and rapport between the patient and the therapist. With this, it can be an efficient and effective way to provide services in real-time, when a patient is ready and willing to receive care, and/or when the medical team needs assistance with the patient.

PROCEDURES

When an organization chooses to embrace the warm hand-off as a standard practice, they must take care to consider how it will work with their existing procedures and scheduling. This is because warm hand-offs are, by nature, unpredictable and unscheduled, their frequency varies between organizations and providers, and there isn't a "one size fits all" template for scheduling them into care visits. Some questions to consider before developing procedures about warm hand-offs are:

Is there sufficient behavioral health staffing to sustain warm hand-offs (re: the ratio of behavioral health clinicians to primary care providers)? If the staffing is insufficient, utilizing the warm hand-off technique becomes almost impossible, as the behavioral health clinician receiving the warm hand-off, will be overwhelmed with referrals from multiple medical providers and staff. This will leave them with insufficient time to respond to all of the inquiries while also doing their scheduled therapy sessions with existing patients. When staffing is insufficient (generally, less than 1 behavioral health clinician to every 2-3 medical providers), it may be worth considering not adopting the warm hand-

off practice or pairing the behavioral health provider with a single healthcare team (such as only one primary care provider and their staff), until sufficient behavioral health staffing is achieved.

How will interruptions to the behavioral health provider and the patient they are currently seeing be handled? Some behavioral health clinicians do not want any interruptions at all and may instead schedule some time in-between each session for warm hand-offs. In this case, the medical team may ask the patient to wait a bit longer in order to meet the behavioral health provider. Other behavioral health clinicians manage interruptions well (providing that there aren't so many that it makes focused therapy impossible), developing skills to minimize their impact on the current patient, while communicating briefly to the medical team when they will be available.

How will the health care team communicate that they need the behavioral health clinician for a warm hand-off? Will the providers text each other, knock on doors, use pagers, flags on exam room doors? There are many different options and health teams can develop the strategies that work best for them.

What happens after the behavioral health clinician is notified about the need for a warm hand-off? Will the provider respond immediately or will they finish their current session with another patient? Organizations and individual therapists (in collaboration with their healthcare team) can decide what works best for them. Some therapists may choose to let the medical assistant or primary care provider know how much longer they will be in their current session and ask if the warm hand-off patient can wait until they are done. Other therapists may choose to leave their current session briefly to complete an introduction with the warm hand-off patient. With this, organizations, therapists, and healthcare teams will also need to be flexible and make different decisions for each situation, depending on the time available, the urgency, the patients schedule, etc.

Who will actually do the warm hand-off? In some organizations, the medical provider introduces the patient to the behavioral health provider. In other organizations, other staff members might regularly engage in the warm hand-off. Generally speaking, patients are more likely to get the behavioral health services they need if organizations encourage all staff to utilize the warm hand-off technique.

What are the protocols around billing and documentation? Billing and documentation for warm hand-offs bring a distinct level complexity. As stated above, warm hand-offs happen, by definition, on the same day as another medical appointment and vary in length from a quick introduction to a full session. This not only poses issues with billing in the state of California but it also poses issues with the EHR, where documentation is usually tied to billing. It can be hard to document in the EHR without billing, but when a warm hand-off involves some level of assessment or intervention (even if it is only 10 minutes long) documenting what happened is important. Organizations will likely need to develop their own protocols for when to document and bill for warm hand-offs.

Related Communication

Primary care providers typically have their own style of communicating and have different relationships with different patients. These, among other factors (especially cultural considerations), make each warm hand-off different, individualized to best help a particular patient overcome any barriers to accessing behavioral health services. However, some general principles can be articulated:

- A primary care provider's referral to a behavioral health clinician should be the same as any other referral they would normally make to another service. For example, there should be no discernable difference in the content or tone of a referral made to a behavioral health clinician and a referral made to a cardiologist. Patients can pick up on the implied level of importance a provider is placing on a referral and will respond accordingly.
- Unless a patient has used a diagnostic term themselves such as, "I feel depressed", "I had a panic attack", or "I'm addicted", it is more effective to use general terms like "stress" to refer to a behavioral health problem. Later on, the behavioral health clinician will have the time to skillfully assess a patient's readiness to identify themselves as having particular problems and can work with them to de-stigmatize these terms whenever necessary.
- Similarly, it can be more effective to use general terms such as "colleague" or "someone who specializes in" instead of "counselor", "therapist", or "social worker". For many patients these terms evoke stigma, fear, and misunderstanding, especially patients who have not received behavioral health services in the past. Beyond threatening the therapeutic alliance, they may even keep a patient from seeing a behavioral health clinician at all. Skilled behavioral health clinicians are able to appropriately identify themselves and intervene to address any issues the patient may have with their professional background. Along the same lines, a primary care provider is generally more effective at referring a patient who does not have a history of accessing behavioral health services or did not request behavioral health services, when they ask or offer a patient "education", "ideas", or even "support" instead of "counseling".

Script 1- Primary Care Provider Referring Patient to Behavioral Health Services

PRIMARY CARE PROVIDER: "It sounds like you might be experiencing a lot of stress right now. That can be so difficult. I work with someone who specializes in helping with these issues and I would like you to speak with them today to better help me help you. Is it alright with you if I introduce you to her/him?" (*Waits for response from patient*). "Great, let me go see if they are available to pop in right now."

SCRIPT 2 - MEDICAL ASSISTANT REFERRING PATIENT TO BEHAVIORAL HEALTH SERVICES

> ***MEDICAL ASSISTANT:*** "From some of your answers on this questionnaire, it looks as if you may be feeling down lately. We have someone here who can give you some ideas of ways to help with this. [Her/His] office is just down the hall, would you be interested in meeting with [him/her]? *(Waits for response)*. Great, let me go see if [he/she] is available to meet you."

The following are two sample scripts for behavioral health clinicians or primary care providers who are referring patients to a psychiatrist. Both address the major barriers of achieving a successful psychiatric consultation - stigma and fear regarding the implications of seeing a psychiatrist and misunderstandings about the role of a psychiatrist. Because of how they have been documented in history, patients commonly assume psychiatrists are super competent, specialized analysts, who will engage with them in intensive therapy. Many patients feel disgruntled, ignored, and even angry by very competent and kind psychiatrists, when they feel they "only" received an assessment and a prescription.

SCRIPT 1 - PRIMARY CARE PROVIDER REFERRING A PATIENT TO PSYCHIATRY - HIGH LEVELS OF STIGMA

> ***PRIMARY CARE PROVIDER:*** "We have already tried 3 medications that have not seemed to work for you and I know that has been very frustrating. We have a specialist here who is a doctor for [anxiety/depression/voices] and may be able to change your medicine or find something that works better for you. [He/She] is right here and could see you next week. Is that okay?" *(Waits for agreement from patient)*. "Great, if you would like, I can walk you up to reception and they can help you make an appointment."

EXAMPLE 2 - PRIMARY CARE PROVIDER REFERRING A PATIENT TO PSYCHIATRY – LONG HISTORY WITH MENTAL HEALTH SERVICES

> ***PRIMARY CARE PROVIDER:*** "You have a long history of struggles with this problem and since you are a new patient to me, I am wondering if you would be willing to see our specialist to make some recommendations about medicine. [She/He] is just a doctor, so they don't do counseling, they will only be assessing and addressing your medications. I do have a colleague that is a counselor and I think [he/she] could be helpful to you, as well. Is it okay with you if I make two appointments for you, one that is for medications and one that is for counseling? (*Waits for agreement from patient*) "Great, I'll go ahead and do that and then I can follow up with you in about two weeks. How does that sound?"

Sample Scripts for Behavioral Health Clinicians Referring Patients to Primary Care

In many integrated systems, behavioral health services are only made available to patients who are also receiving primary care from the organization. Much of the time, this is due to a lack of behavioral health resources. Organizations are frequently unable to accommodate the behavioral health needs of current patients, let alone those of people who are not concurrently receiving medical care at the organization. Other times, clinicians simply feel that patients should be receiving medical care and behavioral health services under the same roof, as the quality of care is generally higher when care plans are managed by a team of health care professionals who are communicating about a patient's multiple, competing, needs.

However, it is important to note that many times, the behavioral health provider is the first person to have contact with a patient. When this happens it becomes the behavioral health clinician's responsibility to successfully refer the patient to a primary care provider, either to establish care or for a consult. The following are sample scripts for behavioral health clinicians and other front office staff who are making referrals to primary care providers in an integrated setting.

SCRIPT 1: BEHAVIORAL HEALTH CLINICIAN ESTABLISHING CARE WITH A PRIMARY CARE PROVIDER

(Towards the end of session unless an appropriate opening is shown earlier in the visit)

BEHAVIORAL HEALTH CLINICIAN: "Can we change course for a minute so I can give you some important information?" (*Clinician waits for agreement from patient*) "I know the call center/receptionist let you know that all patients who obtain behavioral health services here also receive medical care here. I wanted to ask you if you have thoughts about your preferences for doctors. I can make some recommendations if you would like." (*Patient responds about any preferences they may have in regards to gender, age, location, or specialties*) "Thank you for telling me that. I will walk you up to reception and they can help you make an appointment with a [*female*] primary care provider who works at this clinic. They will have access to my notes and I will make sure to write what you and I talked about – *[that you need refills for your medications and an EKG to make sure there are no heart problems they need to follow up on since your recent ER visit]*.

SCRIPT 2: BEHAVIORAL HEALTH CLINICIAN REFERRING AN EXISTING PATIENT BACK TO PRIMARY CARE

(Towards the end of session unless an appropriate opening is shown earlier in the visit)

BEHVIORAL HEALTH CLINICIAN: "Can we change course just for a minute so that we can talk about our plan for next steps?" *(Clinician waits for agreement)*. "You shared with me that *[reiterate the medical problems the patient expressed, such as the medication not being effective or producing unwanted side effects, etc.*]. It sounds like you would like to discuss this with your physician and, in that case, we can make an appointment for you to see *[him/her]* when you leave here today. How does that sound? *(Clinician waits for agreement)*.

Great, if you would like, I can walk you up to reception and they can help you make an appointment.

SCRIPT 3: BEHAVIORAL HEALTH CLINICIAN REFERRING AN EXISTING PATIENT BACK TO PRIMARY CARE - ALTERNATE REASON FOR REFERRING

(Towards the end of session unless an appropriate opening is shown earlier in the visit)

BEHVIORAL HEALTH CLINICIAN: "When I look at your health record it looks like it has been over six months since you have seen your primary care provider. As we continue to work together on your [*whatever their issues are*], I think I would recommend that you see your primary care provider soon for a regular physical - just to make sure your problem [*specify*] is not being caused by another medical condition. What are your thoughts about this? (*Clinician waits for agreement*). Great, if you would like, I can walk you up to reception and they can help you make an appointment.

SCRIPT 4: FRONT OFFICE, RECEPTION, OR CALL CENTER REFERRING A PATIENT TO PRIMARY CARE

(Client calls inquiring about making an appointment with a behavioral health provider)

FRONT OFFICE, RECEPTION, OR CALL CENTER: "I would be happy to make you an appointment with one of our behavioral health clinicians. Have you heard about also receiving medical care at our clinic? (*Wait for patient's response*). Can I give you some information about this? (*Wait for agreement*). At our organization, in order to see our behavioral health clinicians, patients actually also need to receive their medical care here. What are your thoughts about this? (*Wait for agreement*). Great! I would be happy to make you an appointment with one of our medical providers, as well.

Alternative for FRONT OFFICE, RECEPTION, OR CALL CENTER: "I would be happy to make an appointment with one of our behavioral health providers. I see you have not seen one of our medical providers. Have you heard about also receiving medical care at our clinic? (*Wait for patient's response)*. Can I give you some information about this? (*Wait for agreement*). At our organization, we are an integrated system, which means in order to continue to see our behavioral health providers, patients also need to obtain their medical care here. Can I make you an appointment to establish care with one of our medical providers as well?" *(Wait for agreement*). Great! I would be happy to make an appointment with one of our medical providers, as well.

Clinician Relationships with Employees

One of the most drastic differences between the medical healthcare culture and the behavioral healthcare culture concerns boundaries with patients and coworkers. While behavioral health clinicians are educated and trained to have rigid boundaries with their patients, medical providers are known to treat the family members of their co-workers, accept gifts from patients, and even attend their dinners, parties, and graduations. The National Association of Social Workers' and American Psychological Association's codes of ethics specifically speak to "dual relationships", prohibiting them whenever exploitation could be possible. Even behavioral health clinicians who interpret the codes of ethics very loosely, would still decline to provide therapy to a co-worker's family member and would never attend a patient's social engagement. The American Medical Association code of ethics, on the other hand, has no such prohibition, causing the differences in boundary norms between medical and behavioral health providers to be evident immediately upon walking into an integrated setting.

While there is not necessarily a "right" answer to how providers should develop relationships with their patients, it is important for an organization to agree on one set of guidelines that are the same for all professionals working in that given system. With an understanding of the major areas of divergence, organizations can develop standardized policies and protocols that address treating employees and family members of employees as patients, guidelines for accepting gifts, and standards for contact with patients outside of the provision of healthcare, including social media. Although behavioral health clinicians should **always** adhere to their code of ethics (NASW or APA) regardless of the protocols of their specific organization, it is important that each employee is educated about the organization's expected boundaries and limits of patient contact.

The Clinician's Informal Role as a Behavioral Health Expert

One of the greatest benefits of working in an integrated behavioral health setting is the impact behavioral health providers have on their co-workers. Through formal and informal interactions, behavioral health clinicians disseminate helpful knowledge to their co-workers and influence the culture of an organization. More specifically, behavioral health clinicians expand their co-workers' understanding of behavioral health issues. This is important because many medical providers and other staff have never had close contact with a behavioral health clinician and even fewer have utilized therapeutic services. In fact, research has proven that physicians have a much lower than average rate of utilization of therapy!

Behavioral health clinicians can answer questions about the causes and treatment of depression, addictive disorders, and chronic pain. They can help staff build greater compassion for those with personality disorders and schizophrenia. They can even give information about effective parenting strategies. Behavioral health clinicians who have an understanding of their role realize it as a huge

responsibility - they have the potential to do exponential good, above and beyond the services they provide to patients.

Developing quality relationships with other staff members is one of the most important parts of an integrated setting and it is important that behavioral health clinicians spend time creating these trusting relationships. But it is also important to remember that the behavioral health clinician is a colleague, not a member of the support staff. This is important to note because if the behavioral health clinician acts like support staff, others will not see them as someone who provides first line treatments. To this end, it is important for behavioral health clinicians to be as helpful as possible to medical providers without doing tasks that aren't within their scope of practice. For example, a willingness to be interrupted during a session, make therapeutic use of 10 minutes, or flexibility with taking a phone call when the receptionists tells you the patient sounds "super upset" are great qualities for a behavioral health clinician to have. However, administrative and operations support should look the same for you as it does for the other medical providers. Appointments should be scheduled in the same way, referrals should occur in the same way, and calendars should be respected in the same way. If this doesn't happen, it sends a message to both the behavioral health provider and the patient that the organization does not value therapy.

Seeing Employees and Their Family Members as Patients

Medical providers and staff are frequently unaware of the behavioral health clinician's guidelines and restrictions for who they can provide services to. Some may refer co-workers, family members, or even ask to be seen themselves. If there is a policy in place within the organization that all employees are educated about, this will likely happen less often. However, if there is not a policy in place, it is usually up to the behavioral health clinician to decline the request for services in a way that preserves the relationship and helps the other person to understand that it is a rule or barrier in place that is set up to protect them. Understanding that there are no perfect scripts and that all communication happens in the context of the relationship and the organization's policies, here are some examples:

Script 1: Employee Wants to Receive Services From the Behavioral Health Clinician

> ***BEHAVIORAL HEALTH CLINICIAN:*** "I'm honored that you trust me enough to want to see me for services. I wish I could. But we have a code of ethics that says we can't see people we know, which probably seems odd. It's because when we already know someone, we aren't as objective and helpful to them. Also having two different relationships with someone can get complicated. What you are describing to me sound really hard on you right now. Could I help you find another therapist that your insurance covers?"

SCRIPT 2: EMPLOYEE WANTS A FAMILY MEMBER TO RECEIVE SERVICES FROM THE BEHAVIORAL HEALTH CLINICIAN

> ***BEHAVIORAL HEALTH CLINICIAN:*** "I am touched that you trust me enough to see your *[spouse, son, mother*]. It sounds like what they are going through is really tough. Unfortunately, behavioral health clinicians normally don't see the immediate family members of people they have a relationship with. It probably seems odd since you would want your family member to see someone you know and trust, but it is just that things can get complicated in terms of confidentiality and even sometimes mandated reporting requirements. With that said, I would really like to help you find someone else they can talk to. Do you want me to help you find services elsewhere?"

You can see from the above examples that it is much easier to decline the provision of services to a co-worker or their family members when the organization has a standardized policy in place. While the behavioral health clinician may still want to help the employee understand, the declination is apt to be received less personally when they have an organization's guidelines backing them up.

Informatics, Information Sharing, and Billing

Documentation and Billing

DOCUMENTATION

Most clinicians have been well trained in the importance of documentation and have learned to use it as a part of the "Data, Assessment, Plan" or "Subjective, Objective, Assessment, Plan" format. Quality documentation is important in any given setting for multiple reasons:

1. ***For the patient -*** If and when they need it in order to support applications for benefits, such as SSDI or supportive housing, or if and when they need it as evidence for mandated treatment, such as with cases involving child protective services or the judicial system.

2. ***For the treating clinician -*** To assist them in remembering relevant disclosures and diagnostic formulations between visits. Additionally, for some clinicians, the process of writing and making decisions about the language and the wording of the documentation assists them in formulating clinical impressions and thoughts about treatment.

3. ***For the treatment team –*** To assist the team, especially the primary care provider, in communicating about treatment goals in order to facilitate safe and high quality care.

4. ***For the payer -*** To justify services and reimbursement.

Beyond this, there are some important differences in how documentation is approached in traditional behavioral health settings and how it is approached in integrated behavioral health settings:

Less time is spent on documentation, in general. In integrated settings, the vast majority of a clinician's time is spent on patients, not documentation. Generally speaking, 5-10 minutes is spent on documentation for each patient seen.

Documentation is focused where the patient is focused. In integrated settings, clinicians document where the patient is and what their presenting difficulties and goals are. Their bio-psycho-social history is only important in as much as it is helps the patient therapeutically or helps the clinician understand the patient's wants and needs. Another aspect of this is…

Documentation is "Treating to Target". This means that the clinician and the patient are clear on both what the goal of therapy is and how progress is going to be made to achieve that goal. Intake notes identify the goals for treatment, as they are collaboratively defined with the patient. Follow-up notes indicate if behavior change goals were adhered to and what the outcome was,

such as whether the behavior improved, worsened, or experienced no change. With this, any changes in the treatment plan, goals, or recommendations are noted in the follow-up notes.

Documentation is more general when it comes to trauma and other sensitive subjects. Because the EHR is shared extensively in integrated settings, care should be taken to protect the patient's privacy as much as possible. "Childhood Trauma is endorsed; sexual abuse by grandfather" is a sufficient note to put in the EHR, as opposed to a paragraph detailing the abuse's frequency or severity. Care should also be taken in documenting subjects such as infidelity, sexual conditions or concerns, and criminal behavior. Documentation should only consist of that which is medically necessary for the health team to know.

Radial buttons are utilized more. This is because integrated behavioral health focuses both on individual treatment and population based care. As the IT and QI people always tell us, only radial buttons can be made into a report! Not only is it quicker to use radial buttons to document a patient's functional impairments, risk factors, and even the interventions being used, it can also help with gathering potentially useful population or other quality data. In documenting a patient's information, radial buttons should be used in conjunction with articulate, well-crafted, sentences to convey important clinical information and impressions. Don't be afraid to use the radial buttons! Using them in combination with short narratives can make documentation even quicker and more effective.

BILLING

For better or for worse, today, documentation is driven primarily by EHR templates. Many of these templates were created with payer sources/ICD-10 in mind, not behavioral health specialists. For this reason, the behavioral health templates can often feel like they were created as afterthought. They tend to fall short of properly lending meaning to a patient's conditions or experiences and are usually pathology focused as opposed to strengths focused. However, they must be used for billing purposes. It is therefore the clinician's responsibility to find a way to document relevant clinical impressions, while attending to needs of the payer source.

While most documentation will meet the needs of both the clinician and the payer, it is of the utmost importance for clinicians to understand the difference between documentation that is good clinical practice and documentation that must be included for reimbursement (when these two are different). Just as therapist should be careful not over-disclose about a patient's condition in the EHR, therapists should also guard against the loss of quality clinical documentation, which can occur when one focuses on documenting solely to meet the payer's needs.

It is an unfortunate and common pitfall for clinicians to become absorbed by what must be documented for a given payer or grant. They may stress themselves to find out someone's veteran status, sexual orientation, or history of incarceration. However, at the same time, they may forget that asking patients these yes or no questions can be clinically damaging. They can indicate a lack of attention to the patient's needs and preferences and demonstrate an interest in "checking

boxes" as opposed to skilled listening. If clinicians can remain conscious and clear about good clinical practices, while also keeping in mind what "needs" to be entered in the EHR, it is more likely that both the system's and the patient's needs will be mutually met.

In integrated settings, billing is done within the EHR system. The following codes are the most commonly billed services and are in the Next Gen system already:

Psychiatric/Psychological Interview: 90791

Individual Psychotherapy, 30 min: 90832

Individual Psychotherapy, 45 min: 90834

Individual Psychotherapy, 60 min: 90837

Family Psychotherapy (patient present): 90847

Group Psychotherapy: 90853

However, there are services and diagnoses that are not billable by the major payers (Managed Care MediCal Healthplans and their behavioral health administrators). Some examples are:

- V codes
- Primary diagnosis of substance abuse (carved out to the County)
- Services for the SMI population (carved out to the County)

In other cases, some services are often partially paid. Some common examples are:

- Behavioral health visits on the same day as a primary care. These are typically paid by a partial fee from the Managed Care MediCal Healthplans and/or their behavioral health administrator
- Services by unlicensed MFTs and ASWs. These are typically partially reimbursed (in the $35 dollar range) by Managed Care MediCal Healthplans and/or their behavioral health administrator

These are just examples and are not meant to be a strict billing guideline, as there are always differences between health plans and frequent changes in what is reimbursable. In addition, organizations also frequently have multiple payers (MediCare and private insurance) and different funding streams (such as grants and contracts). This means that most integrated systems do not base their service structure and clinical decisions on what is billable and what is not. Instead, services are based on the organization's mission, ethical guidelines, and patient care needs. For example, although V codes and a primary diagnosis of substance abuse are not covered by most insurance plans, it is rare that an organization would not allow clinicians to see or treat patients for

these conditions. In another common example, although a primary diagnosis is needed to bill for services, clinicians should not just "find" a diagnosis where there is not one that meets the criteria. Many organizations have made executive decisions about seeing patients who need and want to be seen, regardless of whether the visits can be paid for or not. It is important for behavioral health providers to have clarity about their organization's billing practices and policies, including their protocols for providing services when they are not billable.

Patient Paperwork Guidelines for Behavioral Health Providers

PRINCIPLES:

- Patient paperwork that is health related (in the broadest definition) is considered to be a part of a patient's care.
- Guidelines for paperwork completion should be standardized throughout the organization to ensure that all providers (medical, behavioral, dental, ect) follow the same protocols and that the patient experience is consistent.
- Patient paperwork should be a part of a patient's healthcare record.
- Providers should only be responsible for filling out the clinical parts of paperwork. Any "non-clinical" parts should be filled out by other staff. Behavioral health providers often find this to be difficult. While medical providers typically have a "team" of people to handle non-clinical issues, behavioral health staff usually runs with very little administrative support. Initiatives such as "integration", "collaborative care", and "SBIRT" do offer some opportunities to fund support staff for behavioral health providers. Behavioral health providers should advocate for this kind of support and educate their workplace about how it will free up time so that they can be more productive clinicians.

PROTOCOLS:

- Behavioral health clinicians should fill out paperwork that is related to a patient's mental health condition or its symptoms, such as State Disability, SSDI, testing accommodations, or letters for independent study for school, since it is within their area of expertise.
- If a behavioral health clinician receives a request for paperwork to be filled out from a patient, primary care provider, or elsewhere in the system, and they have not seen the patient for a recent assessment, it is prudent to have the patient called in for a new assessment appointment before the paperwork can be completed.
- If a patient does not meet the criteria for the benefit that they are hoping for (for example, if a patient does not meet the criteria for depression that impairs their functioning enough to warrant State disability), it is important to let them know that, although the paperwork will be filled out, it may not meet their expectations or hopes. This allows the clinician to elicit any feelings or reactions the patient may have and repair any wounding that it may cause to the therapeutic relationship.
- Paperwork brought in during a visit can be filled out during the visit. It is a good idea to ask for the patient's permission to complete the paperwork during session, or in the last half of the visit, but this usually does not cause an issue as it not only meets their request to have it completed in a timely manner. It also allows for real-time assessment and

documenting. The clinicians should copy the paperwork and scan it into the patient's health record.

- If paperwork is particularly long or laborious, a behavioral health clinician may choose to complete it during time outside of the visit or let the patient know it may take 2-3 visits to get the paperwork done properly.

- When letters are requested from patients as "proof" or "evidence", it can be particularly difficult for providers. For example, a patient may ask for a letter stating that their ex-spouse is causing their daughter's anxiety or that their spouse's deportation would cause significant harm to their children. While, generally speaking, it is best to fulfill the patient's request for a letter, it is important to inform the patient that their diagnosis, treatment regiments, or other factual information might be recorded in the letter. The letter should avoid direct recommendations outside the scope of services, guessing, or conjecture. It should only include factual documentation about a patient's care at the organization. Although this sort of information is not always helpful to the patient's cause, it is important that clinicians stay within their purview. In a way, it also "frees" the clinician from having to make a difficult decision about either saying "no" to the patient's request and thereby wounding the therapeutic relationship or saying "yes" to the patient and making an inappropriate recommendation in the particular situation.

Confidentiality

In the early years of the integrated behavioral health field, confidentiality was a difficult issue for many organizations and for behavioral health clinicians specifically, as they had been trained in a very strict culture of confidentiality. As time went on and many organizations began to integrate substance abuse treatment and primary care, it became even more complicated due to the differing privacy laws around substance use treatment. In many ways, today, these concerns have not changed. It can still be difficult to distinguish between legal mandates, ethical guidelines, and common discipline specific norms and practices, while also considering one's own personal belief systems. This document is not intended to provide legal guidance to practitioners, but rather to help them explore the different confidentiality related issues that often come up in integrated settings. In general, it is important to consult with your specific supervisor or obtain guidance from your organization's legal counsel when faced with more complex decisions about confidentiality and privacy.

LEGAL ISSUES

HIPPA: All patient information is protected by HIPAA and HIPPA does not make distinctions between the different medical disciplines. Even though HIPAA requires health care providers to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care. This can seem to go against the culture of the behavioral health field, as clinicians are used to having patients sign releases of information (ROIs) in order to speak to family members or others involved in their care. Further, many clinicians who are newer to working in a primary care setting are shocked when they see a patient's information given out to pharmacies and specialists without first securing a signed ROI from the patient. Although this type of exchange of information and communication is allowed in integrated settings, providers should still only share that information which is necessary for medical treatment.

It is also important to remember that there are no legal barriers to integrating the behavioral health clinician's notes into the larger Electronic Health Record. Although HIPPA does say that "psychotherapy notes" must have specific protections, the law's definition of these sorts of "psychotherapy notes" is "notes that are written for the '*benefit of the provider*'". More broadly speaking this means that "personal notes" are those that do not have information about a patient's diagnosis, functional status, symptoms, or treatment interventions. They might, however, include information about a therapist's own counter transference, for example. For the therapist's own benefit, these notes would be kept separate from the patient's actual record. Here is the quote from HIPPA regarding "psychotherapy notes":

> *"Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date*".

42-CFR- Part 2: 42 CFR Part 2 is the federal government's regulations concerning the confidentiality of drug and alcohol abuse treatment and prevention records. 42-CFR is somewhat stricter than HIPPA, although most differences are not legal, but rather related to different practice norms between disciplines. Here is a summary of the few legal differences:

1. HIPPA allows disclosures of patient information to public health entities about communicable disease. 42-CFR does not allow this without a written patient consent form (a release of records). Substance abuse providers (those providing substance abuse treatment) must adhere to 42-CFR.

2. HIPPA mandates a provider to report when a patient makes a disclosure of domestic violence and there is an injury present at the time of the visit. 42-CFR does not allow this without a signed release form. Substance abuse providers must adhere to 42-CFR. This is one of the few differences between mental health providers and medical providers.

3. HIPPA allows patients to access their records. 42- CFR leaves it to the provider's discretion. All substance abuse providers must adhere to HIPPA on this one.

4. HIPPA allows patient information to be disclosed for payment. 42-CFR does not allow this without a signed release form. Substance abuse providers must follow 42-CFR.

5. HIPPA allows providers to disclose information pertinent to a patient's treatment to other organizations and healthcare providers (this is why doctors can call pharmacies about patients). 42-CFR doesn't allow this without a signed release form. Substance abuse providers must follow 42 CFR. Generally speaking, mental health providers adhere to 42-CFR on this one as well and opt to get a signed release form before talking to other providers.

6. HIPPA allows a patient representative (power of attorney, parent of adolescent, ect) to sign releases. 42-CFR does not.

7. HIPPA does not state that a Prohibition of Re-Disclosure of Information statement must accompany records that are released. 42-CFR does.

Mandated Reporting: Mandated reporting laws apply to both medical and behavioral health providers and are generally the same for both professional fields, but there is one significant legal difference between the two professions' standards. Medical providers are mandated to report suspected or disclosed domestic violence when the patient has a current injury from the violence and is being treated by the provider. Behavioral health providers are NOT mandated to report domestic violence, even when there is visible injury or the patient is being treated for the injury by a medical provider in the same setting. In these situations, the medical provider would be mandated to report, but not the behavioral health provider. In most integrated organizations, this difference is articulated to patients in a written document such as a Consent to Treat form or other informational material about behavioral health services. This difference in reporting requirements is important to

note, but does not usually cause any significant difficulties between employees or patients in integrated settings.

Ethical Issues: Most integrated care organizations create release of information and consent forms in addition to establishing policies and practices that adhere to the most restrictive laws (42-CFR). Releases of information forms typically have clearly delineated lines for the release of 1) Medical records 2) Behavioral health records and 3) Substance abuse records. This enables patients to make informed decisions about what communication and information exchange they would like to consent to.

Behavioral health providers who feel strongly about obtaining ROI's before speaking to family members or care providers at other organizations can continue to do so. There is rarely a downside or a difficulty with obtaining ROI's from patients – if anything, it conveys a level of care and concern for their personal preferences about how and what information is shared with others. Moreover, it may help the patient better understand what it means to be treated in an integrated setting. If they have not been treated in integrated settings before, they may not realize that their notes and diagnosis are being shared in the Electronic Health Record. Some organizations have developed formal ways of communicating how a patient's information will be shared with consent to treat forms but many behavioral health providers still like to inform patients of this verbally during the first session. When doing so, the provider should frame the information in a way that lets the patient know that the organization believes shared records help a treatment team to give the best care possible. With this, it can also be helpful to let patients know that their notes will be very general and only include information that is necessary for treatment. Even more, a clinician may give the patient the option to have their notes read back to them after the session to ensure they are comfortable with what is being written. Often, this builds trust in the therapeutic relationship and helps patients get a sense of what the documentation is like. If a patient takes issue with any important clinical information that is being written and it becomes difficult to agree on what should be included in the EHR through a quick discussion, it is a good idea to articulate that integrated setting (where notes are shared) might not be the best place for them to obtain services. From there, the patient can decide where they would like to receive care.

For more information on confidentiality, SAMHSA has a review of HIPPA and 42-CFR and the applications for practice settings: http://www.integration.samhsa.gov/operations-administration/the_confidentiality_of_alcohol_and_drug_abuse.pdf

Another helpful like is to SAMHSA's beta site http://beta.samhsa.gov/about-us/who-we-are/laws which has clarifying FAQ for all sorts of laws and regulations.

Screening and Assessment

Principles of Screening and Assessment

Principles of Screening: The definition of screening is to examine a large group of usually asymptomatic, or not known to be symptomatic, individuals in order to detect those with a high probability of having or developing a particular condition. Screening in integrated settings typically involves giving all patients a set of questions at a designated frequency. For example, giving the PHQ-2 or PHQ-9 (depression screening) to all patients 17 and over twice a year or giving the Pediatric Symptom Checklist (screening for emotional and behavioral difficulties) to all children between the ages of 4-16 once a year. While organizations will differ in their screening content or frequency, screenings are ideally evidenced-based, such as the US Preventative Task Force's recommendations on screenings for Nicotine use, alcohol use, and depression symptoms, among others. In integrated settings, screenings are not typically done by behavioral health providers since the number of patients who receive behavioral health services is usually only a small subset of all the patients coming into a clinic. For this reasons, screenings are typically done at the reception area or in an exam room with a Medical Assistant, where theoretically 100% of patients will receive it.

Principles of Assessment: Behavioral health providers have been educated, trained, and supervised on assessments extensively. However, the guiding principles of assessment in integrated behavioral health settings are different from those in traditional mental health settings. Traditional mental health settings typically separate assessment from treatment, using the first contact with patients to complete a formal assessment questionnaire before embarking on therapy. However, the drawbacks to this model are significant. Separating assessment from treatment proves to lead to higher dropout rates and generally worse health outcomes because it interferes with the therapeutic alliance. Traditional assessment forms don't allow for the therapist to "follow" the patient. Instead, they demand the therapist to "follow" a structure where they have to ask closed-ended questions that make the patient the passive recipient of a string of typically pathological and problem-focused inquiries. Moreover, research shows (and clinicians agree) that spending an hour having a patient answer these closed-end questions or only those questions that the organization decides are important, results in an insufficient amount of attention being paid to establishing goodwill, trust, and other aspects of the therapeutic alliance. All of this leads to lower return rates for a second visit to "start" treatment.

For these reasons, integrated behavioral health practices usually engage in assessments differently. Assessments are not separated from treatment, meaning that they occur concurrently in an ongoing fashion. Assessments usually begin with the patient disclosing what they are most concerned about. However, in the case that the patient does not disclose any concerns, the assessment might begin with the behavioral health provider introducing something that a primary care provider was concerned about (such as the reason for the referral) or something that has been endorsed on a screening tool. For example, if the patient was referred to behavioral health services

because they are diabetic and have an HBAIC over 9 and all diabetics with an HBAIC over 9 are referred to behavioral health services, but the patient doesn't disclose this as a concern, the behavioral health provider should still consider the reason for the referral as the beginning point of the assessment. However, the vast majority of the time, the patient will disclose a concern and express what they most wish to discuss. In this context, the next step is for the behavioral health provider to use their clinical judgment and communication skills to elicit more relevant and fruitful information about the patient. For example, a therapist may say "tell me more about your diabetes". In integrated settings it is expected that the therapist will not obtain all of the patient's biopsychosocial information in the first visit. Instead, equal attention is paid to what the patient most wants to address and building the therapeutic alliance. The therapist does, however, usually elicit enough information in the first visit to make a provisional diagnosis. This is considered to be sufficient for meeting clinical and operational needs.

Integrated behavioral health settings use this assessment method because assessments done in this way have proven to be more effective. Patients are more likely to return for their next appointment when they feel that the therapist has paid attention to them in a genuine way instead of firing off questions. Moreover, this method allows for the assessment to be based on self-disclosure. Self-disclosure, in turn, produces a higher quality assessment and strengthens the therapeutic alliance that will be so critically important throughout the rest of the therapeutic process. Therefore, assessments done in this way should always be considered to be more effective, even if they span multiple sessions.

Screening and Assessment Tools

Organizations need to consider many different factors when deciding which screening and assessment tools they will ultimately use. First, they should know their specific goals for the screenings they are hoping to implement and establish clear ways to measure if they are meeting their goals. Screenings in and of themselves are rarely beneficial to the patient. Rather, it is the organization's response to screenings that is. Organizations should have clearly established pathways for further assessment and treatment when a screening tool indicates that additional clinical action is required. Moreover, organizations should have ways of evaluating the strength of these screenings, assessments, and subsequent treatment outcomes for patients. Second, organizations should consider patient literacy levels, cultural competency, and the specificity or sensitivity of screenings. If any gaps exist, there should be supports in place to help patients complete the screening. This might include having someone available to read the questionnaire to patients who may need assistance and having copies of the screening tool in other languages. Efforts should also be made to elicit feedback from patients about whether they find the screenings to be burdensome or invasive. Lastly, it is also critically important for the organization to consider how and when the screening will be administered. A screening that is operationally infeasible or will significantly impact the schedules and time of providers and staff will be essentially ineffective.

While there are many different types of screening and assessment tools, the following is a list of ones more commonly used in integrated settings. It is very important to remember that these are screening tools (and a few assessment tools) and are not considered to be diagnostic without a clinical interview. Any positive or threshold score on any of the following tools indicates a need for further assessment.

ADULT SCREENINGS:

- PHQ-2, PHQ-9 (Depression)
- GAD-7 (Generalized Anxiety Disorder)
- MDQ (Bipolar Disorder)
- SHA (Alcohol pre-screen)
- CAGE-AID (Alcohol and other drugs)
- DAST (Drug abuse, does not include alcohol)
- AUDIT-C (Alcohol only)
- UNCOPE-Plus, etc. (Alcohol and other drugs)
- Edinburgh Postnatal Depression Scale (EPDS)

- Adverse Childhood Experiences (ACE)

PEDIATRIC SCREENINGS:

- Pediatric Symptom Checklist (Emotional and Behavioral issues)
- ASQ (Developmental issues)
- M-CHAT (Autism)
- PHQ-9 (13 and up)

PEDIATRIC ASSESSMENTS:

- Vanderbilt (ADHD; r/o on anxiety and conduct difficulties; self-administered by parent and teacher)
- SNAP IV (ADHD; r/o anxiety and conduct difficulties; self-administered by parent and teacher)
- ASQ-SE (Parent completes if they are concerned about infant – 5 year old behavior. It can also be used as screening tool but there are usually time constraints in primary care setting)

ASSESSMENTS FOR SPECIFIC POPULATIONS:

- Opioid Risk Tool (Assess risk for chronic pain patients abusing opioid medications)
- Montreal Cognitive Assessment (MOCA) (Cognitive functioning issues. Completed partly by patient, but mostly by the clinician asking questions with specific wording)
- Mini Mental Status Exam (MMSE) (Administered to assess cognitive impairment)

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Clinical Interventions

Establishing an Effective Therapeutic Alliance

The therapeutic alliance refers to the relationship between the clinician and the patient and it is characterized by empathy, collaboration, trust, genuineness, and affirmation. A strong therapeutic alliance is undeniably the most important predictor of positive care outcomes. It far outweighs any other variable in treatment, including a patient's specific diagnosis or impairment and the intervention method that is used.

This is because, in therapy, patients are sharing about and working through some of the most difficult parts of their lives. In order to make progress, they have to not only be able to trust their therapist, but they also have to be able to trust that no matter how difficult the therapy may get, the therapy will work. Fundamentally, they can't trust that the therapy will work without fully trusting their relationship with their therapist. With this, it is also important to consider that the vast majority of the time, patients are in therapy because of their difficulties with relationships with others. Without attention being paid to creating a trusting and empathetic relationship between the patient and the therapist, healing cannot occur. Research affirms these assertions, with studies consistently demonstrating that patients who rate their relationships with their therapist highly tend to be those who are most committed to the therapeutic process, sticking around long enough to reap its benefits and tolerate the sometimes very painful feelings that therapy can bring up.

Therefore, creating and maintaining a therapeutic alliance is a skill that most therapists continually work on throughout their career with education, training, and patient feedback. While it is a complex endeavor that requires skills that are built on over time and with experience, there are evidenced-based recommendations for how to establish a strong therapeutic alliance, most of which focus on the first impression and the first session.

First Impression

Maintain an orderly, comfortable, office space that demonstrates warmth and care for the patient. Although it might seem obvious that the ambiance of a treatment room would have a significant impact on how the patient feels, there is also research to support the assumption. Studies have indicated that an organized office with a "warm" feel increases a patient's feelings of confidence in their therapist, while a cluttered, cramped, or messy office decreases their sense of trust in their clinician. The individual preferences of the therapist and policies of the organization will vary, but in general, it is important to consider the lighting, the placement of supplies and books, the chairs and furniture, as well as the artwork on the walls (Patient Care Offices in Integrated Behavioral Health Settings)

Warmly greet the patient when gathering them from the waiting room or meeting them in an exam room. Greet patients verbally, with a genuine smile, and eye contact when first meeting them. This

greeting should consist of a salutation, the patient's name (whenever possible), and an official introduction to the clinician. This is the first impression a patient has of a clinician, whether they are literally meeting them for the first time or whether they are seeing them as the first interaction of a new session. It is of primary importance that clinicians connect with patients in the most basic of ways - looking them in the eye, greeting them with a smile, and showing them goodwill.

Greet the family members of the patient, including and especially children, in the same way you would great a patient. Maintain eye contact and a genuine smile to show empathy and respect for a patient's family. Not only does this reflect how they believe we feel about them, but it is also important social and relationship modeling.

Walk with the patient, not ahead of them or behind them, on the way to the office. How one chooses to walk with a patient can either indicate a partnership (shoulder to shoulder) or a power differential (leader/follower, teacher/student, etc).

Attend to the patient's (and any family member's) comfort. Offer them a comfortable place to sit, water, toys or coloring supplies for children, and when a patient (or one of their family members) appears to be in pain, inquire as to what you might do to make them feel more comfortable. For example, if a patient appears cold or hot, offer them an appropriate response, such as a blanket, cold water, to open a door, or close a window.

FIRST SESSION

Ask open-ended questions. Asking, "Tell me more about your family" as opposed to "How many children do you have and how long have you been with your boyfriend?" allows the patient to guide the clinician to the important aspects of their lives. It indicates that the clinician is following their lead, not imposing their own agenda on the visit. In general, open-ended questions are considered to be the gold standard of assessment and skilled interpersonal interaction.

Avoid standard assessment tools, especially during the first visit, and do not separate assessment from treatment. By nature of their design, standard assessment forms pose close-ended questions and reflect our own (or the system's) agenda. They tend to increase patient passivity and therefore decrease the amount of important disclosures. This negatively impacts both the assessment and the therapeutic alliance. Instead, the clinician should ask open-ended questions, use reflective listening, and guide the conversation to particular assessment topics. This places more attention on the therapeutic alliance than answering formulated questions. During this assessment process, the therapist should also be intervening clinically. Research indicates that when assessment is separated from treatment, it correlates with higher dropout rates and more negative patient outcomes. Assessments should instead be continual. When formal assessment forms must be completed due to system constraints, it is important to mitigate the damage to the therapeutic alliance by completing them at the end of session and explicitly "changing hats" - for example, the clinician can say "I do have a bit of business and paperwork to attend to in order for me to get some important

information. Since we have about 5-10 minutes left of our visit, could we do it now?". (Screening and Assessment)

Use reflective listening and avoid evaluative statements. Reflective listening is an evidenced-based strategy to convey empathy. It involves the clinician reflecting what they have heard back to the patient, using some of the exact words of the patient has expressed. It is a powerful tool in helping clinicians avoid evaluative statements, such as "That wasn't right for your mom to say that to you", or "Having someone close to you die is a horrible thing". These types of statements tend to interpret how a patient feels for them and are barriers to the therapeutic alliance. Reflective listening is a highly developed skill that typically involves many hours of continued practice. It can seem tricky to use reflective listening when a patient says things like "I'm so tired of coming here and never feeling any better". Reflecting back "You're tired of not feeling any better" or "You feel frustrated about coming here and not getting any better" can feel counterintuitive or even scary. But with an empathetic tone and facial expression (and lots of practice!) a skilled therapist will know how to proceed. Moreover, reflective listening gives the patient a chance to correct the therapist. If the therapist did not accurately capture the patient's sentiment, the patient can correct them by saying something like "No, not frustrated, just tired". The therapist can go from there.

Demonstrate empathy skillfully. There are many ways to demonstrate empathy, in addition to the ones outlined above. One of the most important ways is to avoid conveying judgment about the patient or their behaviors and beliefs. It is natural for this to be difficult, as each clinician holds their own biases and judgments, but is important to leave these comments and opinions out of the therapy session and save them for discussion during clinical supervision.

Elicit feedback from the patient. Ask the patient about their perceptions of the therapist, therapy, and therapeutic alliance throughout the treatment process. There is strong research to support that eliciting feedback from patients consistently and skillfully is related to the strength of the therapeutic alliance and therefore, positive treatment outcomes. Scott Miller (ScottdMiller.com) has spent his career developing tools and resources to assess the therapeutic alliance during the visit. Clinicians find his writings and tools to be very helpful for their practice. However, even without formal tools, clinicians can elicit feedback from the patient by asking things like "I wonder how it felt for you today to talk about *[x, y, or z]* with me?" or "I wonder if you can share with me how you feel this session went for you?"

Affirm the patient's strengths. Sometimes called the "strengths focus", affirming is the act of seeing and communicating a patient's strengths, as opposed to their pathologies, to them directly. For many therapists, this comes naturally, but for others it may take some practice, as it is sometimes hard to remember that the patient is more than a complicated diagnosis or series of problems. For example, a patient may have a diagnosis of bi-polar disorder but they may also be a person who gets their children to school every day, conveys deep care about their pet, makes therapy appointments regularly, or has a great sense of humor!

The Behavioral Health Clinician's Role in Chronic Disease Management

A chronic disease is a long-lasting condition that can be controlled but not cured. About half of all adults—117 million people—have one or more chronic health conditions. However, this number is probably conservative, as it does not specifically include mental illness and addiction as stand-alone chronic diseases or consider that 7 out of 10 primary care population visits are related to chronic disease. The Center for Disease Control states:

> "Chronic disease is the leading cause of death and disability in the United States. It accounts for 70% of all deaths in the U.S., which is 1.7 million each year. Data from the World Health Organization show that chronic disease is also the major cause of premature death around the world even in places where infectious disease is rampant."

In addition to what are typically thought of as chronic diseases, mental health conditions and addictive disorders also commonly meet the definition of chronic disease. Many are long lasting and can be controlled, but not cured. The American Society of Addictive Medicine even defines addictive disorders as a chronic disease. Moreover, the interaction between mental health conditions (such as depressive and anxious disorders) and addictive disorders (such as substance abuse, food addiction, process addictions) is profound and complex, with research demonstrating that any one of these diseases seemingly worsens the other.

Therefore, seeing patients with who have chronic disease is nothing new for mental health clinicians in any setting. However, for clinicians working in integrated settings, where the focus is on the whole-health of patients, a more active role is placed in addressing chronic conditions.

Fundamental Skills and Techniques for Chronic Disease Intervention

Assess and intervene based on the patient's acceptance level. When a patient has chronic depression, PTSD, diabetes, chronic pain, or another chronic condition, it is important for clinicians to understand how high their acceptance level is, or how aware they are of their disease and the attention it requires. Acceptance in this sense does not correspond with agreeing or liking their condition, but rather with how they feel about it and relate to it. For example, whether a patient is resentful (low acceptance), does not believe they have a chronic condition (very low acceptance), or believes it can be "cured" and that they won't have to manage it anymore (also low acceptance). Alternatively, those with higher acceptance are less angry, sad, and resentful. They generally believe that they have a condition that needs attention, but that it is manageable. Understanding a patient's acceptance level is important, as those with low acceptance levels are rarely motivated to care for their condition. Assessing a patient's acceptance level can be done skillfully with open-ended questions or a scale of 1-10 - with 1 being "you have no peace with your chronic pain, you frequently feel very angry about it, or forget to do the things that help it" and 10 being "you feel at peace with your condition and feel very good about the daily or weekly activities you engage in to manage it" (more resources about measuring patient acceptance level are included in the Resources for Further Exploration section. When a patient's acceptance level is very

low, various strategies can be employed in to increase it, from motivational interviewing, to CBT, PST and others intervention strategies found in this manual.

Work as a member of a team, not just a solo practitioner. Electronic health records allow team members to see how their patients are managing their chronic diseases. Primary care providers can see a behavioral health clinician's notes about whether a patient with schizophrenia is taking medications regularly, keeping appointments, continuing high levels of support with NAMI and family, and if their symptoms have stabilized. Likewise, behavioral health clinicians can see a primary care provider's notes about whether a patient who is diabetic is coming in regularly, losing weight, and managing to keep their blood sugar under 7. Whether clinicians are using the Electronic Health Record or communicating verbally, working as a team ensures that each provider has a fuller picture of how their patient is doing in different areas, and therefore can tailor their interventions appropriately.

Elicit the patient's goals, beliefs, preferences, and strengths. Deciding on patient goals is fairly easy when it comes to chronic diseases, as there are often distinct markers for what is healthy and what is not. However, patient empowerment, activation, and motivation only truly come from the patients setting their own goals, in the context of their beliefs and preferences, and in accordance with their strengths. Asking open-ended questions, reflective listening, and affirming strengths are core techniques that can be used to elicit these goals in practice.

Shape understandings and beliefs about the meaning of "chronic". Assisting patients in gaining an understanding of, and increasing motivation for, lifelong self-management is critical to intervention around chronic disease. Many patients with chronic conditions have misunderstandings, or sometimes complete misconceptions, about their condition. They may not know they have a chronic condition or they may believe that it can be cured and pursue extreme or unlivable treatments instead of developing sustainable, healthy, self-care habits. All of this leads to frequent relapses in self-care and a recurrence of symptoms. The goal is therefore to re-shape the patient's perception of their disease and help them understand that it can be managed.

Assist patients with health maintenance and relapse prevention. Research indicates that with most chronic diseases, the more relapses a person has, the more severe the relapses are, and the more apt they are to have relapses again in the future. Preventing relapse, then, becomes a primary goal of intervention with chronic disease patients. It involves practicing maintenance, identifying relapse warning signs, and developing relapse prevention plans. For example, it is not uncommon for a patient to believe that once they reach their goal weight or their blood sugar is controlled, they can stop their maintenance activities (taking insulin, exercising daily, ect). However, clinicians should work to help the patient identify the signs that they are moving away from their self-management activities and heading towards relapse. They can then assist them with developing an action plan to intervene on themselves, before a relapse occurs.

Help patients make healthy behavior changes to support the management of their condition. The behavior changes needed to live a full, healthy, life are different for every patient and based on

their specific values, goals, and strengths. They might range from weight loss or yelling at their kids less often to smoking cessation or increased church attendance. All of these behavior changes have impacts on their health and each small, sustainable, change contributes to larger ongoing changes. Intervening to facilitate these changes with techniques such as Motivational Interviewing and CBT is one of the most common responsibilities of behavioral health clinicians who are working with patients who have chronic diseases.

Addictive Disorders Intervention

Addictive disorders encompass everything from substance abuse, including Nicotine, to eating disorders, compulsive disorder conditions, and process addictions, such as gambling and sex. About 10% of the general population and between 20%-50% of those who end up coming into a health clinic setting suffers from an addictive disorder. However, historically, the treatment of addictive disorders and behavioral health conditions was kept separate. There were different treatment facilities for each and the disciplines and workforces were bifurcated. In integrated settings today, treating addictive disorders in conjunction with behavioral health and physical health conditions is a necessity. It is simply not feasible to rely on referrals to outside specialists for the number of patients who need treatment. Moreover, the majority of those with addictive disorders also have concomitant mental and physical health issues that need attention. Deferring treatment for disorders that require continuous, comprehensive, care, not just acute, specialist, treatment, can result in adverse outcomes in patient care.

Behavioral health clinicians, primary care providers, direct service staff, and organizational leadership all have strong opinions (informed and uninformed) about addictive disorders. The following section explains some of the common myths about intervening and treating addictive disorders in integrated settings.

Myths About Treating Addictive Disorders

Treating addiction requires a highly specialized and completely separate skill set than my own. Evidenced-based addiction intervention is comprised of many of the same skill sets used to treat other conditions. It involves building a therapeutic alliance, patient-centered listening, behavior therapies, motivational interviewing, skilled case management, and the like. While there is some additional specialized knowledge required to treat addictive disorders, it can be learned and implemented quite easily and efficiently.

It's not my job and I don't have the time. Due to the prevalence and overlap of mental health, addictive, and physical health conditions, it not feasible to place addictive disorder treatment outside of the mental health or primary care setting. Addictions are no different than any other chronic disease, such as severe anxiety, chronic depression, or diabetes. They all can feel overwhelming and time consuming to clinicians but providers in an integrated setting should consider treating any and all of these conditions as part of their job to achieve whole-person care. Moreover, many evidenced-based interventions can be used to treat addictive disorders within short periods of time, such as brief motivational enhancement strategies.

Addiction treatment must be done by someone who is in recovery themselves. This is a hotly debated topic, especially in California, which adopted the "social model" some years ago and relies on peer counselors to provide the majority of addiction treatment. However, there is ample evidence to show that there is no difference in the therapeutic effectiveness of someone who is in recovery and someone who is not. There are many more significant differences in the effectiveness

of a therapist based on their skill level, such as whether they have a MD, PhD, LCSW, or a lower-level counseling certificate.

It is just hopeless. They won't get better. There is still a pervasive social stigma around addictions. Many times, providers are held back by its socio-economic nature, characterizing "addicts" as lying and deceitful. Other times, providers believe it is the patient's "choice" and that they are "bad people" for having an addiction. These judgments often result in feelings of hopelessness and futility about intervening on addiction and overlook the other personal and environmental factors that are contributing to the disorder. The good news is that when evidence-based interventions are used, treatment outcomes for addiction are just as good, if not better, than the treatment outcomes for other chronic diseases and conditions.

Abstinence is the only appropriate treatment goal. While it is true that the majority of patients who have developed a severe addiction will not be able to use substances "normally" or "socially" again, some patients may be able return to "normal" drinking or continue using certain drugs, such as cannabis, without personal consequences. There are even community support groups that are congruent with this approach, such as Life Ring and Rational Recovery. Other times, a harm reduction model can be appropriate. The term "harm reduction" generally refers to a public health philosophy and set of practices that seek to minimize individual and societal harm from varied behaviors, such as drug use or sexual activity. Needle exchange programs that lower HIV transmission, designated driver campaigns that lower auto related casualties due to drunk driving, and non-abstinence based interventions such as Methadone or Suboxone maintenance treatments, are all examples of well-known harm reduction strategies. More broadly speaking, harm reduction can also be used to describe a goal of having someone "cut down" on the amount of cigarettes they smoke per day or lessen the amount of alcohol they drink. Harm reduction strategies are a bit controversial and polarizing in the addiction treatment field because there are many providers who are firmly in the "abstinence camp" and many just as firmly in the "cutting down" camp. Still, as with all beliefs, philosophies and techniques in treatment, it is imperative that the individual patient's needs, goals, and strengths are prioritized over the clinician's. With thoughtful assessment and an open mind, individualizing treatment is possible.

In addition to moving past many of the myths of treating addictive disorders in integrated settings, there are also some core skills necessary for behavioral health clinicians who are treating those with addictive disorders.

CORE SKILLS FOR INTERVENTION

Develop a strong therapeutic alliance and skillfully convey empathy. Although it this has been mentioned many times throughout the manual, developing a strong therapeutic alliance and knowing how to skillfully convey empathy cannot be overemphasized (Establishing an Effective Therapeutic Alliance). In considering addictive disorders specifically, empathy conveyance has been proven by research to be particularly important. Higher levels of empathy correlate with

positive outcomes for patients while lower levels of empathy correlate with poorer outcomes, even when compared to no treatment at all.

Use Motivational Interviewing. Motivational interviewing is defined by Stephen Rollnick and William Miller as "a directive, patient-centered, counseling style for eliciting behavior change by helping patients explore and resolve ambivalence". Compared with nondirective counseling, it is more focused and goal-directed. Its central purpose is to examine and resolve ambivalence and the counselor is intentionally directive in pursuing this goal. Motivational Interviewing was born out of the addiction field and its effectiveness has been studied extensively. For more information about Motivational Interviewing and further reading on the research surrounding its effectiveness, please see the Motivational Interviewing and Resources for Further Exploration sections, respectively (Motivational Interviewing, Resources for Further Exploration).

Develop an understanding of process addictions. The term "process addiction" is often used to describe behavioral addictions that do not involve alcohol or other drugs. A behavioral addiction could be a compulsive behavior, such as excessive gambling, a sexual addiction, eating disorder, spending addiction, or internet addiction (gaming or pornography). The field's understanding of process addictions is still in early development compared to substance-related addictions and for this reason there are some areas of disagreement. Still, one common area of agreement is that the chemical processes that occur in the brain during the behavior or "process" of the addiction are very similar to the chemical processes that occur during a use of a substance in a substance addiction. With this, the symptomology is very similar in both. Further, there is research that indicates the stigma (both self-stigma and societal stigma) surrounding process addictions is even higher than that of substance addictions. Process addictions are increasingly attributed to poor character and weak willpower. For clinicians, this indicates a special need to skillfully elicit the concerns about process addictions from patients, as they may be less apt to disclose them without some empathic prompting.

Know how to properly assess and diagnose addictive disorders. A thorough knowledge of the DSM-V symptoms and criteria for substance use disorders and related addictive conditions is necessary for clinicians working in any setting. However, clinicians should also be well aware of the appropriate screening tools to use and understand which patients need to be screened and assessed. Some organizations may have instituted screening tools for alcohol addiction or other drugs and have general protocols for who needs further assessment (such as when a patient has screened positive). However, other organizations may not utilize a set screening tool or engage in screening at all. When this happens, it can be difficult for a behavioral health clinician to determine who should be screened and assessed, but in general, every patient over 12 years of age should be assessed.

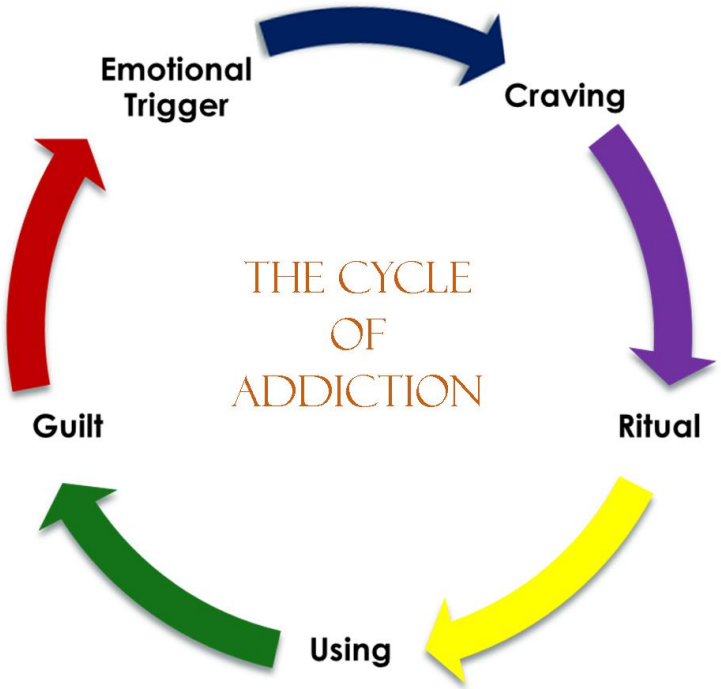
While there are many helpful standardized assessment tools, it is important to remember that they should always be used in conjunction with a clinical interview. Clinical interviews are particularly important because, when done in a skilled and empathetic way, they help build the therapeutic

alliance and thereby, help elicit more meaningful information from the patient. This is because clinical interviews use open-ended questions that better prompt the patient to self-disclose and give quality, detailed, and accurate information than formalized, close-ended, questionnaires do. For this reason, it is particularly important for behavioral health providers to learn how to conduct a good clinical interview. Sometimes it is hard to know what to ask, how to ask it, and how to respond to the patient's disclosures in a way that conveys non-judgment, but with practice and over time, it becomes easier.

It is also important for behavioral health clinicians to obtain knowledge and skills that allow them to effectively assess differential diagnoses. For example, the differences between ADHD, depression, anxiety, schizoaffective disorders, and sleep disorders. This can be particularly complex, especially when the patient is in active use, or acute, or post-acute, withdrawal.

As always, it is critical to remember that diagnosis and modifiers take on special importance in the shared medical record. For example, diagnosing someone with alcohol use disorder, severe, with a modifier that indicates long-term remission, may impact the primary care provider's treatment decisions. For this reason, clinicians should take particular care when imputing diagnosis information into the EHR.

Knowledge of the Addiction Cycle. When beginning to treat addictive disorders, it is important to understand the addiction cycle. Patrick Carnes, who is an expert in sex addiction, first developed this very useful conceptual model of the stages of compulsivity in addiction.



There are many different versions of the addiction cycle, but most see addiction as a process that begins with a trigger and is followed by a physical craving that includes fantasizing or obsessing. There is then some sort of ritual preparation, followed by the use of the substance or partaking in the behavior itself, and then ultimately a consequence, which at the least, usually includes feelings of guilt and shame.

Have a knowledge and understanding of mutual self-help groups. Having a working knowledge of mutual self-help groups can be a particularly useful resource for clinicians treating patients with addictive disorders. The breadth and depth of these peer support groups is truly stunning. There are 12-step groups such as Alcoholics Anonymous, church-based groups such as Celebrate Recovery, secular groups such as Life-Ring, and non-abstinence based groups such as Rational Recovery. Alcoholic Anonymous alone has about 2 million members and 100,000 regular meetings worldwide. Its model has also been adopted to create other 12-step groups for those with drug addictions, food addictions, gambling addictions, and even those who are affected by people with addictions, such as Al-anon and Adult Children of Alcoholics. Celebrate Recovery is a church-based peer support group for those with multiple addictive disorders and is in 20,000 churches across the US. Life-Ring and Rational Recovery have active groups in most cities, as well. Some programs, like 12-step groups, are explicitly spiritual (though not specifically Christian) while others are affiliated with one faith, or not affiliated with any faith at all. All of these groups are non-professional and free.

For clinicians who do not have personal contact with these types of groups, it might be a bit difficult or confusing to understand their potential value to patients. Moreover, they may have formed strong opinions or biases about particular self-help groups based on one or two patients' anecdotal reports that have kept them from effectively assisting their patients with utilizing them. However, the best thing for a clinician to do is make an effort to personally learn more about the groups. They can read the approved literature of the groups, including the Alcoholics Anonymous "Big Book" or group websites, attend "open meetings" ("open meetings" are open to anyone, while "closed meetings" are only for those who are members), or call hotlines and the groups directly to ask them more questions.

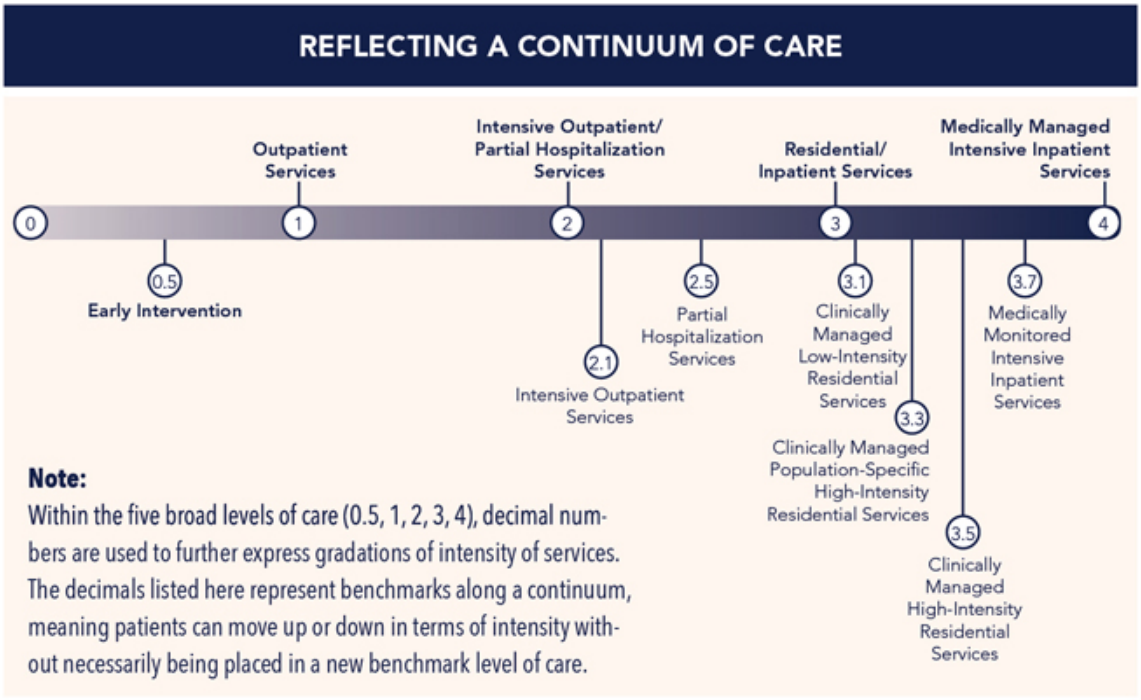
While these groups are not "treatment" or "therapy", there is research to prove that those who are involved in peer support groups have improved outcomes in their battles with addiction. When referring patients to any of the wide variety of groups, it is important to remind the patient that each group is different. There are some that are best for women, LBGT, those with dual diagnosis, and the like. Meetings have minimal structure and each group is autonomous from the larger program, allowing each community to develop its own unique culture. As always, when making referrals, it is always best practice to elicit the patient's motivation and, if they express interest, to make the initial phone call or referral to a group during that same session.

Develop the ability to assess the level of care needed for a patient, including recognizing the signs and symptoms of withdrawal from different addictive substances and behaviors. The American

Society of Addiction Medicine (ASAM) placement criteria is the most comprehensive and widely used tool for helping clinicians determine the appropriate place for the treatment of a patient.

The graphic above shows that the dimensions of assessment that inform placement decisions are complex and that the particular substance of use is not a decision making factor in placement.

The graphic below shows the ASAM numerical continuum of care. ASAM provides detailed criteria, which distinguishes each stage.



Integrated settings can generally offer .5-1 (early intervention/education to outpatient services) and some organizations offer 1-1.5 (out-patient services to intensive outpatient services).

The ASAM dimensions of assessment and continuum of care graphics demonstrate the complexity of matching patients' needs, preferences, strengths, and supports to the appropriate treatment level.

Have a working understanding of the complexity, controversy and research base around abstinence and harm reduction philosophies. While sometimes abstinence and harm reduction are often poised as opposites, with proponents on both sides, it is important for clinicians to avoid 'claiming' a philosophy at the expense of individualized, patient centered treatment. The most decisive factor in what treatment goal is set, is of course the patient's own choice. However, there is considerable research to help clinicians guide patients in their goal setting. Generally speaking patients who have low severity addictive disorders are more likely to become moderate non-problem drinkers, while those who high severity tend to be unable to use moderately, making abstinence is a better goal. Clinicians who continually develop their understanding and knowledge in this complex and continually developing area will be more effective in assisting patients to set appropriate treatment goals and provide them effective intervention and support.

Know how and when to use and when to refer to Medication Assisted Treatment (MAT). MAT is a specific term that refers to the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Most of the time, MAT is used in opioid addiction treatments with medications such as Methadone or Suboxone (buprenorphine). However, more generally, MAT refers to any medication that is used during the treatment of an addiction or its symptoms, such as Naltrexone or Antabuse. Still, it is

important to note that medications used to treat addictive disorders or their symptoms should not be considered as treatment by themselves. They should always be used in conjunction with behavioral health therapy. Behavioral health clinicians need to be vigilant to guard against addiction being narrowly defined as a physical condition. Many times, medical settings prioritize pharmacology treatments as the primary or even the only necessary treatment. Behavioral health clinicians who work in integrated organizations that provide MAT typically should specifically work to develop a higher level of knowledge and understanding of this particular multi-disciplinary treatment method to ensure that behavioral health services are integrated as a primary component of MAT.

Trauma and Trauma Related Disorders

The ways of thinking about and defining emotional trauma have changed radically over the years. Historically, trauma was associated almost solely with those who had direct experiences with war. In the 1960's, the definition was broadened to include those who had experienced physical and sexual abuse. However, in the last decade, advances in neurobiology and psychology have further broadened the definition, recognizing that trauma can result from any number of experiences, included deeply humiliating or disappointing incidents such as break ups with significant others, the deaths of loved ones, the loss of a job, car accidents, and the like. While trauma in childhood seems to demonstrate the most significant negative impacts on ones health and mental health, trauma that occurs during adulthood can also lead to the same symptoms and effects.

Most traumatic events have some common characteristics and regardless of their source, often contain these elements:

- The event or events that occurred involved actual, threatened and/or perceived harm, such as death or serious injury, to the self or others, and/or were experienced as a threat to the stability of one's world
- The event or events caused intense feelings of fear, helplessness, or horror
- The event or events were unexpected
- The person was unprepared

This illustrates that, fundamentally, traumatic experiences are not just the result of an event in and of itself. Rather, traumatic experiences are the result of a combination of the event and the person's reaction, interpretation, or appraisal of the event. This means that not everyone who experiences trauma, or even similar types of trauma, will develop Posttraumatic Stress Disorder (PTSD) or related symptomology. There are many factors (and still so much that is unknown) that contribute to whether someone does or does not develop trauma related disorders. Some factors that seem to "protect" people from developing trauma disorders are called "resilience factors". Conversely, "risk factors" seem to increase one's likelihood of developing PTSD and other trauma disorders.

EXAMPLES OF RESILIENCE FACTORS:

- Seeking out support from others before, during, after the traumatic event
- Higher levels of pre-trauma happiness
- Feeling good about one's actions in the midst of the trauma (for example not feeling guilty or ashamed)

EXAMPLES OF RISK FACTORS:

- Exposure to other previous traumatic events (see below)
- A history of mental health difficulties or a family history of mental health problems
- Having a significant amount of added stressors after the traumatic event
- Having little or no support before, during, or after the event

REACTIONS TO AND SYMPTOMS OF TRAUMA

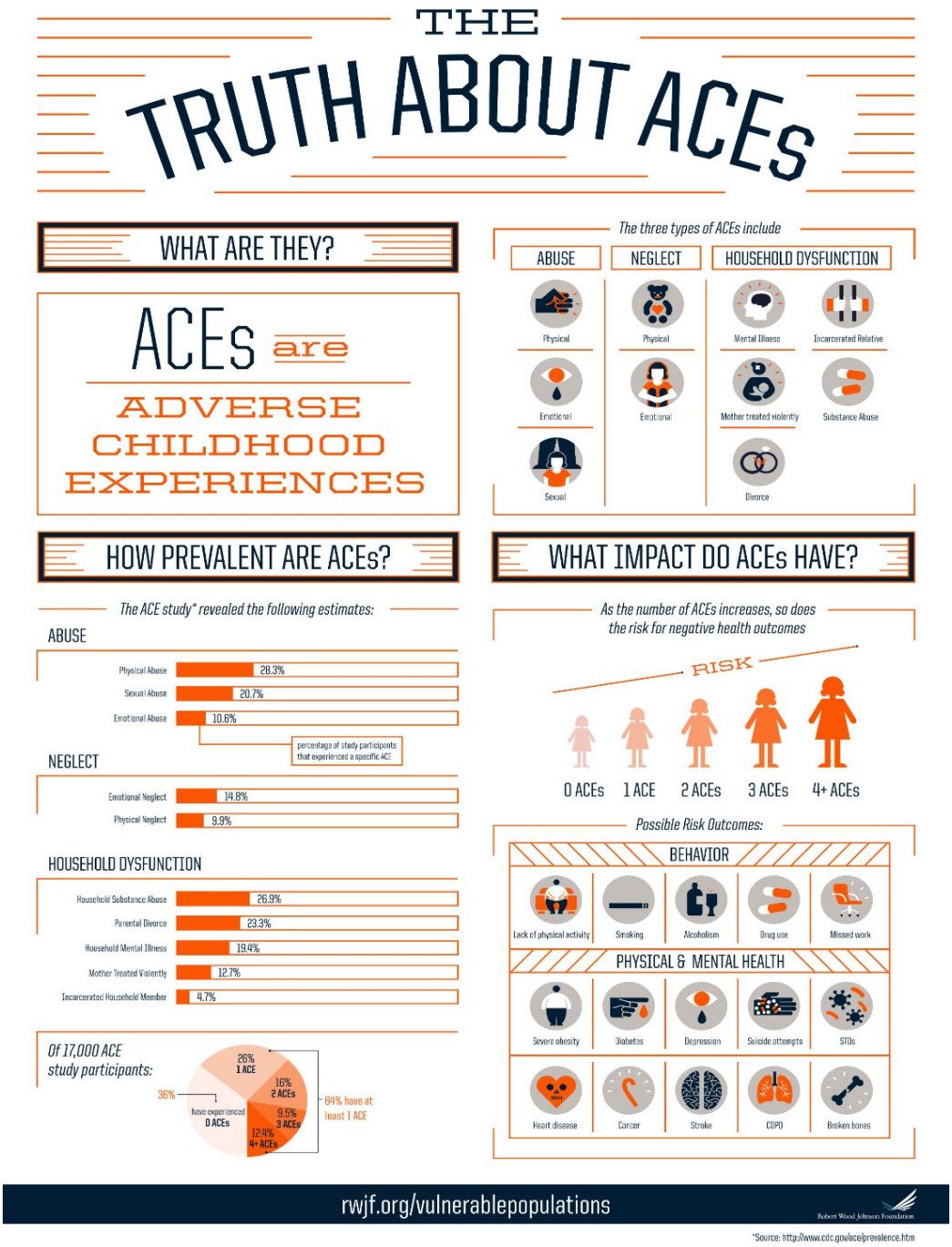
The reactions to and symptoms of trauma are broad, varied, and differ in severity from person to person. They might include intrusive memories and images (such as unwanted and persistent memories, flashbacks, or nightmares), avoidance of stimuli associate with the trauma (such as avoiding places or situations that invoke memories of the trauma), exaggerated startle reflexes, negative changes in thinking, mood, and emotions (such as being on guard all the time or anxious), hopelessness, memory problems, and/or intense feelings of guilt or shame. During the period of time immediately after the trauma, known as the acute phase, symptoms also often include a sense of numbness, detachment, depersonalization, and even dissociative amnesia (such as not being able to recall all or part of the trauma). Overtime, those who have experienced trauma can also develop other distinct clinical and/or concurrent conditions, such as depression, general anxiety, panic attacks, and substance abuse. Especially when individuals are alone in their struggles, without support, help, care, or treatment, anxiety and depression can develop as a secondary response to the difficult symptoms being experienced.

Mental Health America and other organizations have characterized trauma and, similarly, "toxic stress", as the most pressing public health problem of our time, taking the place of the infectious disease epidemics in the toll on human suffering, sickness, disability and death. For more information on "toxic stress" see the Resources for Further Exploration section.

CHILDHOOD TRAUMA

Research suggests that childhood trauma increases one's risk for developing both psychological disorders and physical health conditions throughout the life course. As outlined above, it increase's ones risk for developing PTSD, depression, anxiety, and substance abuse. However, it also increases one's risk for developing obesity, hypertension, COPD and diabetes. This is thought to be, in part, because childhood trauma occurs during the most sensitive and critical stages of psychological and physical development. Children who experience trauma often develop inadequate coping strategies to relieve their toxic stress and symptoms, such as over eating, drug and alcohol abuse, and other behaviors that lead to adverse health outcomes as adults. Moreover, trauma is also thought to have more direct impacts on the functioning of the immune system, endocrine system, and the brain. All of this contributes to the development of multiple and complex chronic diseases as the children grow older.

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess correlations between childhood trauma and other mistreatment on later-life health and well-being outcomes.



The study findings suggest that traumatic experiences during childhood are ultimately major risk factors for illness, disability, death, and overall poor quality of life as adults. The study also speaks to a "dose effect" where the more trauma one experiences, the larger amount of adverse health

outcomes they will also experience later in life. More information on ACEs can also be found in the Resources for Further Exploration section.

Screening and Assessment of Traumatic Events

Due to the large-scale dissemination of the ACEs Study, a lot has been written about the importance of screening for trauma in the medical setting. Some organizations choose to screen patients using the original ACEs research questions. These questions are highly personal and call upon the organization to have a thoroughly developed system for respectfully administering the screening and responding to the patient's answers in a compassionate manner. Organizations that have decided to use the original ACEs questions to screen the pediatric population have an even higher level of responsibility to ethically, legally, and empathically administer the screening and respond to positive screenings.

Most of the time, however, organizations use certain symptom-based screenings for depression, anxiety, and substance abuse to identify those who have experienced trauma in their past. In integrated settings, there should be a sufficiently developed treatment pathway for patients who screen positively, requiring them to be seen by a behavioral health clinician. The clinician can then engage in a more global assessment that looks further into the history of trauma and explores the avenues for treatment. For children, symptom-based behavioral screening tools, such as the Pediatric Symptom Checklist, will indicate a need for behavioral health services and a broader assessment of current or past trauma in the child's life.

Outside of screening, many times patients who have histories of trauma come into contact with behavioral health providers by seeking therapeutic services for a seemingly unrelated problem in their life. Most of the time, patients are unaware that their past trauma may be causing them to have a disproportionately strong reaction to their current life difficulty. For example, a patient who is seeking behavioral health services because they are having a hard time at work, being criticized by their manager, and, perhaps, feels that the manager is "out to get them", may present with acute stress symptoms (nightmares, panic attacks, rumination, anxious mood, etc.). This reaction might seem out of proportion to the actual events occurring. Often times, with careful assessment, providers learn that a patient like this has had a history of trauma with authority figures. This mistreatment by authority figures when they were younger caused them to feel powerless and betrayed. The new experience with their boss has triggered the same reactions. They are re-living the familiar feelings of a lack of empathy from those who have power or authority over them.

Screening and Assessment of PTSD and other trauma related conditions:

At minimum, behavioral health clinicians need to be familiar with the DSM-V criteria for acute stress and post-acute stress disorders. Because trauma can manifest in a wide variety of symptoms, there are many different assessment tools for PTSD and related conditions that aim to identify whether the particular symptomology is related to trauma. Some of the screenings and assessments are self-

administered, such as the PTSDS (Post Traumatic Stress Diagnostic Scale), while some are clinician - administered thorough structured interviews, such as the PTSD Symptom Scale Interview.

As with assessing and diagnosing other behavioral health conditions, self-administered assessment tools should never be used alone. Rather, they should always be used in conjunction with a clinical interview to ensure accurate diagnosis. This is because accurate assessment is based on self-disclosure and meaningful self-disclosure is based on the therapeutic alliance between the therapist and the patient (Screening and Assessment).

TREATMENT FOR PTSD AND RELATED TRAUMA CONDITIONS:

There are a number of therapeutic interventions that have proven to be effective for treating PTSD and other trauma related conditions, many of which are covered in this manual. Eye Movement Desensitization and Reprocessing (EMDR), Somatic Experiencing, Biofeedback, Seeking Safety, DBT, and CBT (especially with exposure therapy) are some of the well-researched treatments. With this, there are medications that have been shown to be helpful as well, both the SSRI family medications and anti-anxiety medications, though these are often only used on a short-term basis.

Crisis Intervention

Crisis intervention can be defined as the emergency psychological care provided to an individual who is in a crisis situation with the goal of restoring their emotional equilibrium as quickly as possible. Crisis intervention, by definition, is a temporary and immediate intervention, solely for the purpose of bringing an individual back to their normal level of functioning.

Crisis situations can range from encountering someone who is acutely suicidal or homicidal (or otherwise poses an immediate grave danger to themselves or others) to a patient who is disclosing some sort of child abuse (especially when the danger of immediate harm is high). A crisis situation could involve domestic violence (particularly when the perpetrator is in the building and the patient wants immediate assistance with leaving) or a situation where a patient is experiencing acute trauma symptoms, such as flooding, or a mental health crisis, such as disassociation.

How someone evaluates a crisis situation is the product of a complex combination of his or her external and internal circumstances. It involves their current environment, their state of mind, their individual history, skills, confidence, experience, training, beliefs, affective tolerance, and personality, and their appraisal of their environment given all of these factors. For example, a primary care provider may report a "crisis situation" after a patient reports "wanting to die", regardless of the actual clinical acuity. Likewise, a receptionist may call the behavioral health clinician after witnessing a patient talking to them selves in the waiting room, even if there are no apparent signs of danger.

Whatever the circumstance may be, because behavioral health providers are usually among the most skilled communicators in an organization or clinic, they are often called upon to intervene in crisis situations, apart from their normal patient care duties. While different organizations have different policies and protocols about a provider's involvement in these matters, behavioral health clinicians usually assume the role of the resident "expert" in de-escalation, mandated reporting, assessments of suicidality, and the like. For this reason, it is important for behavioral health clinicians to be well versed in the skills and techniques of crisis intervention.

Fundamental Skills and Techniques for Crisis Intervention

Self-managing your emotions, counter transference, and other reactions. The first task for a behavioral health clinician who is being calling into a crisis situation is to manage their own feelings. Outcomes of intervention are dependent on the clinician's ability to successfully identify and manage their own feelings of fear, anger, anxiety or sometimes shame from childhood. It is important for the clinician to be well aware of their emotional triggers, or the situations and circumstances that bring up strong feelings in themselves. For example, a male patient who is yelling could trigger strong feelings of anger or fear, or a child first disclosing sexual abuse could trigger grief, anger, or shame. When clinicians are aware of their own personal histories and how

they impact their reactions in different situations they can be more effective at managing their breathing, body language, and feelings during a crisis.

Rapidly assess the crisis situation for immediate safety concerns. Regardless of the type of crisis, a rapid assessment should be completed to evaluate everyone's immediate safety. In cases of mandated reporting, when the perpetrator has access to the victims, the assessment is both one of the danger of the perpetrator as well as the protective factors of the victim. For example, the access the perpetrator has to the victim, as well as how able the parent or guardian (or child, depending on age) is to provide protection. As with all assessments, accuracy is dependent on the information that is elicited, meaning, the information that is gathered from the individual, their family, and any other staff involved - not judgments based on reactions to the situation.

Validate and affirm how the person is feeling. Validating and affirming the feelings of the person involved demonstrates empathy and provides a relational sense of stability that can help restore someone to their normal level of functioning and aid in the development of a strong therapeutic alliance, even in the midst of a crisis. Without proper validation and affirmation, many crises worsen, as the parties involved develop a greater sense of urgency to have their concerns heard. With this, validation and affirmation can take on many forms. For example, validating the concern of a primary care provider who is urgently paging a clinician to come assess a suicidal patient might involve saying something like, "This can seem pretty scary sometimes. It's actually great that the patient felt they could tell you". This will not only model the skills that you would hope the primary care provider would be using with their patients, but it will calm the provider down and prompt them to share more meaningful information about the situation. For example, the primary care provider might respond by saying "yeah, it is scary because she had just told me her brother killed himself and then she said she wants to die too". Still, it is important to note that affirming and validating are not the same as agreeing or fulfilling requests and demands. For example, if a parent is demanding that the clinic drug test their teenager, the provider can validate affirm their concern in an empathetic way, but still follow the clinic's protocol concerning this issue. In the end, validating and affirming are simply about purposefully and skillfully acknowledging how people feel and making sure they feel "seen" and "heard".

Communicate with team members, including the patient's family. Crisis intervention is a team sport. Whether the intervention is happening in an exam room or a waiting room, effective team communication is necessary in order to achieve successful outcomes. As soon as a clinician realizes that a crisis is at hand, they should take a moment to assess what sort of intervention is needed and communicate it to the team. This may involve stepping outside to let a receptionist know that they need to call the mobile crisis team or huddling with the primary care giver and nurse to make a quick decision about how to intervene on the first disclosure of sexual abuse by a patient. Clinicians should remember that the patient and their family members are part of the team, as well. It is important to make every effort to communicate with them as clearly and transparently as possible. This helps to increase trust and a sense of safety. For example, in the case of a first disclosure of

sexual abuse, clinicians can, in addition to attending to the parent's feelings, walk them through the next steps in reporting and answering any questions.

De-Escalation

De-escalation refers to the skill set used to decrease a person's anger or agitation, especially when it is causing dangerous, abusive, or frightening behavior that could pose as a threat to them or someone else. De-escalation skills are developed over time, with very specific training and practice. It is important for organizations to have specific training curriculums for all staff about their specific policies, procedures, and protocols on incidents that require de-escalation. If organizations do not have standardized skills training for employees or do not have a response plan in place for when an employee has been mistreated by a visitor, the organization is at risk of modeling dysfunction, like that of a dysfunctional family, where abuse of its members is considered "normal" or is ignored completely. It is not uncommon for Behavioral Health Directors and/or clinicians to be the driving force behind developing these important policies and practices in an effort to drive an organization towards a healthier workplace culture, and for behavioral health clinicians to take on the majority of de-escalation incidents in an organization.

This document is not intended to be a replacement for training, however it does aim to outline the basic components of de-escalation and the skills needed to perform it effectively.

In general, there are three stages of intervention:

Prevention: The number of escalations at a given organization is in large part due to the culture of the organization, not to the patient population. Serious escalations are almost always the result of patients feeling repeatedly ignored or disrespected. Therefore, there are a number of evidenced-based strategies that can be employed by all members of the medical team and staff to lower the overall number of escalations in a given setting.

- Excellent customer service with all patients and at every level of contact. This involves eye contact, greeting the patient, and smiling within the first 5 seconds of a patient entering the facility and at every new point of entry (back office, exam room, etc.).
- "Repair" point of service infractions. This refers to acknowledging any trouble the patient may have experienced during their visit, such as having trouble finding parking and apologizing genuinely. If these small infractions are not repaired, they begin to compound. The next infraction, such as a longer than normal wait, will continue to cause the patients to escalate. Any staff member can repair an infraction at any point of service.
- Act with kindness, thoughtfulness, generosity, and warmth. No matter how small, any act that conveys empathy is an inoculation against escalation. This can be as simple as complimenting a patient, making small talk, offering their children crayons, or holding the door open for them.
- Even though the quality of interpersonal interactions is the most important factor in preventing escalations, the clinic environment, including the waiting room, exam rooms, and general facility should be kept clean and comfortable. This means making sure that

there are no ripped chairs, chipped paint, old magazines, and that the temperature is appropriate. When the environment seems unkempt or uncared for, escalations increase.

Early Escalation Intervention: As soon as a patient or other visitor demonstrates any level of unhappiness, anger, irritability, or unrest, staff members can take action to prevent the situation from escalating any further. Some examples of a person experiencing unrest include them stating that they are unhappy, angry or irritated, them complaining of poor service or attributing mistakes (accurate or not) to the organization, them using a strained or raised tone of voice, them interrupting those who are speaking to them, them repeating themselves, and pacing, sighing loudly, rolling their eyes, or averting their gaze when staff is speaking to them.

- As soon as early signs of escalation are noticed, staff should huddle as team to decide on a plan and communicate who will approach.
- The person who is most skilled in de-escalation, usually the behavioral health clinician, should approach the patient and speak to them on their level. For example, if the patient is sitting, the clinician should find a chair close to them, sit down, and voice an empathetic inquiry, such as "Is there anything I can do for you?" In terms of positioning, "under-dogging" or getting slightly lower than the patient, is also typically very effective.
- Use reflective listening, empathetic body language, and validate and affirm the person's strengths. For example, you may reflect back "you've been here for two hours, I would feel the same way, it is so frustrating" and then validate and affirm by saying " I appreciate your honesty and straightforwardness in telling me about your experience and I can see how much you care and worry about your son". It can also be surprisingly effective to affirm when someone is actively working to manage his or her anger. For example, you might say "I just want to thank you so much for keeping your voice low. I appreciate you not yelling with the kids in the waiting room".
- After you have gathered information from the patient and sufficiently validated their frustration, huddle with the team to decide on any further action needed to resolve the difficulty the patient is experiencing. This might involve moving the patient out of the waiting room to provide more comfort, offering water, or any other small offering that shows care. It is important to keep in mind that during de-escalation, it doesn't matter who is "right" and "wrong" or whether the patient "deserves" to be treated well or not. The only goal in de-escalation is de-escalation.

De-escalation Intervention: When a patient or other visitor is visibly escalated and displaying angry or aggressive behavior, such as arguing loudly, kicking or punching a wall, or swearing on a phone in the waiting room, there are some distinct strategies that can be employed to bring the person back to their base-emotional-level.

- Communicate what is going on to team members. This is paramount for safety. When a

person becomes escalated, a supervisor or other staff member should inform all employees in the area that there is a disturbance in order to keep other patients and staff away. For example, if there is a disturbance at the front desk, medical assistants should not send patients who have just finished their visit back out to the front. Care should be taken to avoid flooding the scene with untrained staff or others who could potentially continue to escalate the individual. Research shows this communication with other employees and team members is the single largest indicator of the outcome of the attempt at de-escalation.

- Find the person who is most skilled in de-escalation and call them to the location. The difference between having an employee who is skilled in de-escalation techniques and one who is not makes a significant difference in the outcome of the situation. It does not matter whom the individual states they are angry at or why, the person who should respond to the situation should be the one who has the most skill in de-escalation techniques. Again, this is commonly the behavioral health provider, but when they are not available, there is usually another person at the organization who is naturally skilled in de-escalation.

- Control the environment and patient safety as much as possible. If you have asked the escalated individual to move to another location and they are unwilling to do so, it is important to ask the other patients in the area to leave. In this situation, whenever possible, direct the other patients where to go. For example, ask them to move to a back office or separate floor. It's uncommon for incidents get to this level and it may seem scary to ask patients to move, but it is much more dangerous and frightening for patients to be close to a patient who is yelling and not have a staff member address their safety. Patients are, without fail, relieved and grateful to have been moved out of harm's way.

After the situation is resolved, it is important for supervisors and any other staff involved to properly document what has happened and carefully consider their actions going forward. If the individual who was acting out was a patient, the incident should also be documented in their chart. The behavioral health clinician or other qualified staff member should also address any patients who may have been witness to the event and ask if they would like to discuss their feelings about what happened. Depending on the severity of the situation, an open discussion in the waiting room might also be appropriate. For example, a clinician might say "Wow that must have been frightening to some of you. If there anyone who would like to speak more about this with a counselor, please let me or one of the other staff members know". Many times it is also important for an employee with excellent communication skills to call all of the patients who were witness to the indecent a day or two later and ask how they are doing.

The staff should then begin the process of de-briefing. The majority of the de-briefing should be about learning in a non-judgmental atmosphere. It isn't important to find fault or assign blame, it is only important to learn from the incident. Normally, staff is able to identify things could have been

done differently to prevent the incident from escalating or even happening at all. For example, they may identify that a staff member had a poor interaction with the patient on the phone before they arrived and argued with them about whether or not they had made an appointment. Then, perhaps when they arrived, the receptionist said, "sign in" or "take a seat" instead of providing an empathic, warm, greeting. Possibly, once the patient was yelling, a well-intentioned supervisor tried to intervene by repeatedly explaining the "sign in" policy to the patient, which just continued to increase their agitation. De-briefing all of the interactions and responses during the incident and discussing what could have been done differently can create a rich learning lab for employees. With this, it is important to elicit and attend to the employees' feelings. Encourage them to identify how they felt and what their experience of the incident was.

Lastly, make a decision about how to address the patient's inappropriate behavior going forward. Some organizations may choose to do this with a formal meeting, in order to come to a consensus about how to approach the patient's behavior. Other times, this may happen with a more informal "check in". But, at the very least, there should always be a discussion with the patient about their actions. If the situation was severe enough, it might also warrant discharge from the organization, although this is typically a last resort, reserved for when patients have threated staff or repeatedly abused staff, even after warning and intervention. Whatever decision is reached should be documented in the patient's chart. Normally a person (often a behavioral health clinician) is chosen to communicate the decision to the patient and skillfully let them know that they have crossed a boundary. They empathically let them know what will happen if these limits are crossed again (hopefully the organization has set policies about this), yet at the same time, can apologize for any mistreatment the patient feels they may have been the recipient of. If the patient is currently receiving behavioral health treatment at the organization, when the next session or opportunity presents itself, the behavioral health clinician should also discuss what happened with the patient. This is a clinical opportunity to examine the impact of the patient's outburst or disruptive behavior and any triggers that may have caused the event to occur. If the patient is not currently receiving behavioral health services, it might be a good opportunity to offer or encourage a visit with the behavioral health clinician as a way to process the incident. This not only conveys that the organization cares about the patient but it also shows that that they care about working with them.

More General Tips for De-Escalation

1. Always remember the number one goal when someone is very escalated (yelling, threatening, swearing, kicking chairs, etc.) is to avoid anyone being injured. The second goal is to minimize the situation's impact on others who may be frightened (patients, other staff). So…

2. This means "explaining", "defending", "being right" or "drawing boundaries" are NOT goals in these situations. This can ALL be done later. Forget all of these things. The ONLY goal is to have the escalated person leave the building with as little impact as possible. This means…

3. Do not explain why they shouldn't be mad, why what they are saying isn't accurate, or why it isn't the organization's fault that they can't get the patient what they want. Remember that those who are escalated have brains that are flooded with adrenalin and this means their cognition is impaired. It is not the time for reason or logic.

4. Agree, agree, agree, validate, validate, validate. See below…

5. Don't listen too closely to what they are saying. This probably sounds odd since when patients are unhappy with us or have "normal" anger, we usually do listen closely to what they are saying so that we can reflect back what we have heard and help solve a problem. However when someone is very escalated, the content of what he or she is saying is not the primary issue. Moreover, when we listen to closely we can be tempted to "explain" something to them so they won't be angry. This is a typically reaction, but it will make things worse.

6. Utilize reflective listening to summarize and reflect what you have heard, especially feelings. Remember that trying to "fix" what they are mad about will only anger them more if their feelings are not acknowledged first.

7. The immediate task is to get the patient AWAY from everyone else. This is in an effort to lower the situation's impact on other patients and staff, who can be very frightened by angry people. It is also easier to de-escalate someone when there is not an audience watching. Think immediately about the environment. First question to yourself and your team should be, "How can I get this person away from everyone else?"

8. Introduce yourself to the patient. Let them know that you will be the one to help them and that you want them to tell you all of the things that they are unhappy about. This is a specific technique that is used to have patients utilize a different part of their brain, which helps reduce anger and become more stable. You want them to have to THINK with their pre frontal cortex. So, as an example, you might say "Hi! I am Martha Overton. I am going to help you today. I need you to tell me all of the things that happened, from the beginning".

9. If the patient is very angry, but has not threatened verbally or non-verbally, ask them to come into an office to talk privately. Frame this offer as a benefit to the patient by saying something like, "I will be able to help you better if we are alone".

10. If the patient feels unpredictable or uncomfortable with being in an office, ask them to step outside the clinic to talk with you. Again, frame this as a benefit to the patient by saying something like, "We will have more privacy outside", or appeal to their caring side by saying something like "I think it might be a good idea in the case that the kids here get scared".

11. If the patient actually has threatened harm, communicate with your team to call the police while you stay at a distance to talk with them.

12. If the patient will not move, remove everyone else from around them. For example if the patient will not leave the waiting room when you ask them to follow you, then have all other patients in the waiting room led into the back office, break room, or other area instead. Make sure a staff member sits with the other patients to help them with feelings.

13. Avoid being the one to interact with an escalated patient if you tend to get angry, defensive, or very frightened when you are around angry people.

14. Avoid interacting with an escalated patient if you have had a very negative interaction with them before. You are less likely to be able to manage your own emotions (we are all human).

15. Never interact with an escalated patient who specifically asks not to deal with you.

16. It is a myth that if patients vent enough, they will "wear" out and feel better. If a patient is raging, yelling, arguing, and despite getting them alone, empathizing, reflectively listening, validating, their anger continues to escalate, it is important to indicate that the conversation has to end. To do this, you might say something like, "I am so sorry, I wish I could fix this, you've had a terrible experience here. I don't know that we are going to be able to do anything at this time and unfortunately I am going to have to go.

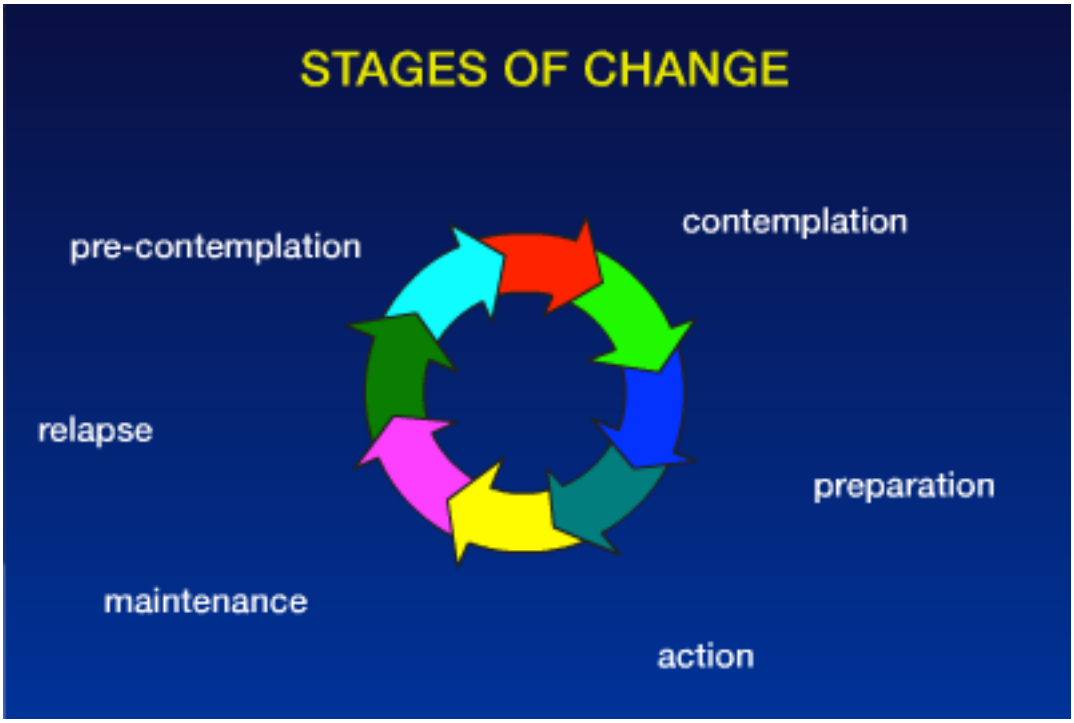
17. As related to the above, if a patient is demanding something that we would not normally give to them, it is imperative that we do not give it to them now in hopes that this will resolve their anger.

18. One definition of a "successful resolution" in de-escalation can be a patient leaving. This means that their feelings do not necessarily have to be resolved. If a patient leaves, with minimal impact on others, this is an acceptable ending.

19. Never follow a patient who leaves the office or facility in anger. For some employees or clinicians, it is hard to let someone leave angry and there is a temptation to follow, especially if we feel they may be a danger to themselves or others. However, if a patient leaves angry, they are self-managing their anger BY leaving, and it is important we do not pursue. If they have said something that indicates that they are a threat to themselves or others, we can call emergency services after the patient leaves.

Motivational Interviewing

Motivational Interviewing (MI) refers to the therapeutic approach developed by psychologists William Miller and Stephen Rollnick in 1983. They defined Motivational Interviewing as "a collaborative, person-centered form of guiding to elicit and strengthen motivation for change". It is based on the trans-theoretical conceptual model of the stages of change and affirms that change is not a straight line, but instead a circular progression.



Motivational Interviewing was originally created for use in treatment of those with addictive disorders, but is now used in a wide variety of settings. Since its main goal is to elicit behavior change it has proven to be successful for weight management, medication adherence, exercise, smoking cessation, mental health conditions, and chronic diseases. Motivational Interviewing has also been heavily researched, making it an evidenced-based practice for many years. A large Meta-analysis from 2005 (MARMITE) has also demonstrated strong evidence for its effectiveness in treatment, retention, and adherence. More information on the MARMITE study can be found in the Resources for Further Exploration section.

In specifically considering the application of Motivational Interviewing as a therapeutic intervention, it is important to note that it is highly collaborative and person centered. It is characterized by the clinician's skilled empathy conveyance, lack of judgment, and related acceptance of the patient's decisions. The therapist elicits, respects, and prioritizes the patient's beliefs, perceptions, preferences, and reinforces the patient's autonomy and choice.

FUNDAMENTAL SKILLS AND TECHNIQUES OF MOTIVATIONAL INTERVIEWING:

Ask open-ended questions. Open-ended questions elicit what is important to the patient, what their beliefs are, what they think would be helpful to them, and what they have tried before in regards to changing their behavior. In contrast with close-ended questions, which tend to force a patient into a particular answer, open-ended questions call the patient to explore and reflect on their cognitions and behavior. In considering Motivational Interviewing specifically, open-ended questions serve three main purposes. They increase the amount of accurate and meaningful information shared in sessions, increase a patient's engagement in therapy, and increase a patient's activation to change their behavior.

Affirm the patient's strengths, values, aspirations, and positive qualities. Clinicians should actively look and listen for the patient's strengths, values, aspirations, and positive qualities and reflect them back to the patient in an affirming manner. For example, if a patient states that they are afraid because they are "always angry and yelling at their children" and they worry that this may hurt their relationship with them, the therapist might tell the patient that this actually indicates that they really value their relationship with their children, which is a great quality to have, instead of just focusing on fixing the anger and yelling.

Reflectively listen. Instead of relying solely on asking questions, in Motivational Interviewing the therapist typically responds to patients with reflective statements that encourage or guide the patient to continue talking. For example, a therapist might reflect, "it was so frustrating for you to relapse again". This encourages the patient to continue talking about the relapse. Reflective listening should use exact words. Research indicates that patients feel more listened to when their therapist uses a few of their exact words, along with other simple non-judgmental statements or more complex reflections about the underlying meaning or feelings that a patient expressed. By doing this, the therapist is in a sense "checking" to make sure they are following the patient, hearing them, and understanding them correctly. Reflective listening allows the patient to turn their focus internally on themselves and to reflect on their own strengths and resources, as opposed to listening to the therapist's expertise or reactions.

Elicit "change talk". This refers to the therapist eliciting self-motivational statements from the patient, instead of just giving motivational statements to the patient. For example, the clinician may ask, "What are your hopes for your pregnancy?" as opposed to "Now that your pregnant, it is important to quit smoking". Eliciting "change talk" frequently happens in response to a patient's statement. For example, if a patient says "I am not interested in quitting. I only smoke 6 cigarettes a day anyways", the therapist might respond by saying "Tell me more about the decision to only smoke 6". This elicits change talk by implying the patient's motivation is to keep their nicotine use low. Moreover, as Rollnick and Miller said, patients talk themselves into and out of change!

Resolve ambivalence. Ambivalence is normal - all people have mixed feelings about changing their behavior. Working to resolve ambivalence helps the patient move forward into actively changing their behavior. To do this, a clinician may help the patient identify the pros and cons of

their behavior change and reflect both sides of ambivalence back to them in order to help them obtain clarity on their own internal conflict about change.

Skillfully convey empathy. Practitioners should always make a genuine effort to understand the patient's perspective and convey that understanding to the patient. As Carl Rogers said in 1962 "When the patient's world is clear to the counselor... [the counselor] can also voice meanings in the patient's experience of which the patient is scarcely aware..." He referred to this "highly sensitive" empathy on the part of the therapist as instrumental to getting a patient closer to him or herself. It allows them to learn, change, and develop. A plethora of research demonstrates that behavior change only happens in the context of patient feeling empathy from the helper and that insufficient empathy can cause patients to engage in more problematic behavior patterns.

Develop discrepancy. This is the act of listening for or employing strategies that facilitate the patient's identification of discrepancies between a particular behavior or situation, and their goals and/or values For example, reflecting back to the patient that they really value the relationship with their children (affirming) and that they disclosed that they spend little time with them in part due to their alcohol use (reflective listening) and then helping them to examine the discrepancies between their values and current behavior.

Roll with resistance. Avoid argumentation, in any form and at all costs, but try to elicit "resistance talk". Argumentation involves disagreeing with a patients appraisal or responding to a statement with conflicting information in order to "prove" them wrong. However, "rolling with resistance" refers to the therapist's ability to recognize resistance and instead, use techniques such as empathy conveyance, affirmation, and reflective listening to elicit change. Still, a clinician may try more direct ways of eliciting "resistance talk" or "sustaining talk" (such as talking about the benefits of continuing their current behavior, reasons why it isn't possible or desirable to change, etc.) by explicitly asking patients to identify benefits of their continued substance use, or other behavior and/or how their problematic behavior is helpful to them.

CRITICISMS AND CAUTIONS OF MOTIVATIONAL INTERVIEWING

The criticisms and cautions of Motivational Interviewing are minimal. However, it is important to note that Motivational Interviewing has been heavily manualized and acronym-ized, by different organizations for different purposes. These training tools sometimes over simplify motivational interviewing and under estimate the amount of practice and skill it takes to become an effective MI practitioner. In addition, sometimes Motivational Interviewing is talked about or taught in a way that is not consistent with the spirit of the technique, focusing more on "tricks" (handing them a page with goals to check off which ones they will do, for example) to get people to change than true empathic collaboration with patients.

Cognitive Behavioral Therapy

"…. Nothing is either good or bad, but thinking makes it so" - Shakespeare's Hamlet

Cognitive Behavior Therapy (CBT) is a type of psychotherapeutic treatment that rests on the principle that although we may not be able to change events, people, the past, the future, or even ourselves sometimes, we can change our appraisal or thinking about these things, and thus, impact our feelings and subsequent behavior. CBT first began to develop in the 1950s, with the work and writing of Albert Ellis. His early version of CBT was called Rational Emotive Therapy (RET) and was borne out of Ellis' frustration with traditional psychoanalytic techniques, which he saw as largely indirect and ineffective. In the last decade, CBT has become increasingly popular and research has shown that it is equally, if not more, effective than medication in treating everything from depression to chronic pain. In fact, it has been used to treat a wide range of disorders including phobias, addictions, depression, and anxiety as well as general low self-esteem, stress, resentments, complicated grief or other conditions involving faulty cognitive patterns.

It should be noted that while CBT is incredibly well researched and demonstrates very good effectiveness, this might be due to the ease of studying CBT, as it is usually focused on specific behavioral outcomes.

Fundamental Skills and Techniques of Cognitive Behavior Therapy

Collaboration, genuineness, and the therapeutic alliance. As in previous sections of this manual, the therapeutic alliance is the foundational principle in which other techniques can be used. This must be successfully established and maintained in order for other interventions succeed. Read more on this subject in The Therapeutic Alliance.

Elicit information from the patient about their beliefs and what they think will be helpful to them. In CBT one of the first steps is assessing whether the patient actually thinks their thinking patterns are problematic. For example, many patients who have General Anxiety Disorder (GAD), or sub-threshold diagnosis, worry so much that it impairs their social, emotional, functioning and their overall health but do not believe that the worrying itself is causing the problems. They might believe that their worrying is actually a protective factor or that it helps them "prepare" for something else that is coming. Because of this, they think that they "need" to worry. While CBT would likely be helpful for this patent, it would useless unless the patient had a sense that their worrying, or their thinking patterns, was problematic. Many times, clinicians will need to use motivational interviewing or a similar technique to help patients come to a better understanding of their cognitions and elicit motivation to change them, before employing CBT.

Assess cognitive distortions. This is sometimes known as the "functional analysis" and helps the patient learn how their thoughts, feelings, and situations contribute to maladaptive behaviors. It is important for the clinician to elicit insights from patients about their own thoughts and thought

patterns. This is highly collaborative and involves the therapist guiding the patient to examine their thinking and identify their most common thinking errors

Elicit "cognitive correctives". This involves the therapist asking the patient what might have been a better or more helpful thought to replace their faulty thought. As with all interventions, it is best for the patient to come up with their "cognitive correctives" on their own. However if the therapist finds that the patient is struggling to do this, they may provide some CBT text or handout that gives some examples.

Set goals for new thoughts and behaviors. The therapist should work to elicit information from patient about what they would like to practice outside of the therapy. It is important to remember that the therapist should be careful not to give advise or suggestions about this, as patients who set their own goals are much more likely to succeed at them. However, the therapist can "whittle down" goals to make them appropriately achievable, as patients will often set goals that are too high. Breaking them into steps can be a good way to improve the likelihood of successful outcomes and give the patient something that they feel highly confident they can achieve.

Criticisms and Cautions of Cognitive Behavior Therapy

Cognitive behavior therapy involves "meta-thinking" or "thinking about thinking". The great majority of patients, including children and even those with psychosis, have this ability to do this, although it usually takes a bit of practice. There are some patients however who do not have the capacity to reflect on patterns in their thinking. For these patients, CBT would not be appropriate.

A rigid or strict focus on discerning problematic thinking, without collaboration, sufficient therapeutic alliance or accurate empathy, can lead therapists to engage in a pattern of combatting a patient's thoughts/feelings with logical arguments, which is not effective therapy. Sometimes focusing exclusively on "cognitive correctives" without sufficient focus on the patient's goals can frustrate patients, as knowledge does not always translate directly into behavior change. Many patients "know" what they are thinking is inaccurate, however are still unable to change their behavior.

Dialectical Behavioral Therapy

Dialectical Behavioral Therapy (DBT) is a modified form of Cognitive Behavioral Therapy (CBT) that was developed by Dr. Marsha Linehan at the University of Washington in the late 1980's for treating those with Borderline Personality Disorder (BPD) and chronically suicidal or other self-harm behaviors. Although there is limited research about it's effectiveness for treating other conditions, DBT has also been used to treat mood disorders, substance abuse disorders, and even those with traumatic brain injuries.

DBT was founded on the principles of increasing mindfulness, interpersonal effectiveness and emotional regulation and tolerance, through a combination of individual and group therapy sessions. Because patients are expected to attend weekly individual sessions and weekly group therapy sessions, DBT is considered to be somewhat time intensive, taking about a year of commitment from the patient in order to show substantial progress.

FUNDAMENTAL SKILLS AND TECHNIQUES FOR DIALECTICAL BEHAVIORAL THERAPY:

***Develop and maintain a successful therapeutic alliance*.** While a strong therapeutic alliance is the foundation any effective therapeutic interventions, it is specifically important in DBT. Patients with BPD and/or chronically suicidal behaviors are thought to have histories of poor attachment to their primary care givers, which results in maladaptive relational patterns that disrupt therapy's effectiveness. Because of this, the therapeutic alliance in DBT needs to be consistently attended to. The patients must see their therapist as an "ally" who provides a climate of unconditional acceptance. This can be particularly complex as the therapist must concurrently establish and maintain clear boundaries in order to prevent the patient from repeating self-defeating interpersonal patterns in their therapeutic relationship. Therapists should consider inviting discussions about this early on in the therapeutic relationship. They should discuss what the patient might do if the therapist is not available when the patient feels an urgent need to see/talk to the therapist, how phone calls with be handled, and other situations where the patient's perceived need is more than what the organization's or therapist's capacity allows. Maintaining the therapeutic relationship while identifying limits and boundaries takes specific skills, but typically, therapists grow in their abilities to do this over time and with experience. New therapists, and even experienced ones, often utilize colleagues and supervisors for consultation and support when establishing and maintaining boundaries during treatment with patients who have personality disorder characteristics.

Teach and model mindfulness. Teaching mindfulness is considered to be the foundational skill of DBT. Mindfulness is defined as "the practice of cultivating awareness and paying attention to the present moment without judgment or fear". It is based on the idea that strong emotions only exist fleetingly in the present. By cultivating the ability to stay in the present and focus on these emotions, the patient is able to build affective tolerance and develop the ability to tolerate uncomfortable emotions without self-harm (or harm to others). Perhaps more than any other skill, the therapist

should be also be personally well versed in mindfulness. This better prepares the clinician to teach the skill effectively and elicit motivation in their patients to learn the skill as a way of facilitating growth and development in the future.

Teach and model interpersonal effectiveness. Therapists should work to elicit motivation from their patients to increase their interpersonal skills and encourage them to model the newly learned skills in sessions. The content of interpersonal skill training is focused on building effective communication techniques that increase one's level of assertiveness and neutralizing interpersonal conflict. Enhancing a patient's level of assertiveness helps them learn to ask for what they need or want without damaging their relationships.

Teach distress tolerance. This refers to eliciting motivation from the patient to increase their distress tolerance. Distress tolerance training helps patients to accept, tolerate, and deal with stressful situations without reacting in maladaptive ways, such as harming relationships or themselves. Distress tolerance training often times involves mindfulness, breathing, centering, and other physically oriented techniques.

Teach and model emotional regulation. Emotional regulation training is related to, but also distinct from, distress tolerance training. Emotional regulation training is rooted in cognitive techniques, such as reflection, analysis, and future planning. It helps the patient to deal with negative emotions, increases their awareness of their present state of mind, and thereby gives them the skills to better tolerate unpleasant or scary emotions while increasing positive emotions. With this, the therapist works to elicit motivation from the patient to increase their emotional regulation and model these skills in sessions. By modeling the skills in session, the patient becomes more comfortable with using them and develops the ability to take them into relationships outside of therapy.

Seeking Safety

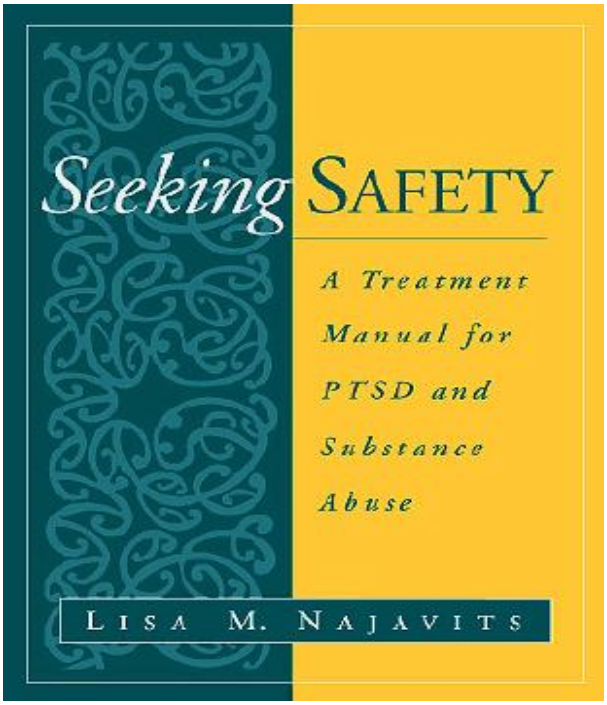
Seeking Safety is an evidenced-based counseling model used to help patients who have Post-Traumatic Stress Disorder (PTSD) and/or a substance abuse condition. It was developed in 1992 by Lisa M. Najavits, PhD at Harvard Medical School in response to research indicating that nearly 60% of those who had an addictive disorder also had PTSD.

Although Seeking Safety was originally developed to treat patients who concurrently experienced PTSD and a substance abuse disorder, today, it is considered to be a highly flexible therapeutic model. Patients do not necessarily have to meet formal criteria for PTSD or substance abuse to partake in the therapy and it is used with both individuals and groups. Moreover, it has proven to be successfully implemented across many different patient populations, including adolescents, homeless individuals, those involved in the criminal justice system, those affected by domestic violence, those with severe mentally illness, veterans and military personnel, as well as people of many different ethnicities. More generally, Seeking Safety is used as a model to teach coping skills and is considered to be very "safe", as it can even be used by clinicians who lack formal training.

Seeking Safety is present-focused and does not ask the patient to specifically share about their past trauma. It focuses on coping skills and psycho-education to empower patients by giving them practical tools to use in their daily lives. Seeking Safety uses five key principles:

1. Safety is the overarching goal (helping patients attain safety in their relationships, thinking, behavior, and emotions)
2. Integrated treatment (working on both PTSD and substance abuse issues at the same time)
3. A focus on ideals to counteracting the loss of ideals in both PTSD and substance abuse
4. Work in four content areas: cognitive, behavioral, interpersonal, and case management
5. Attention to the clinician's processes (helping clinicians work on counter-transference, self-care, and other issues)

Seeking Safety offers 25 topics that can be addressed: Introduction/Case Management, Safety, PTSD: Taking Back Your Power, When Substances Control You, Honesty, Asking for Help, Setting Boundaries in Relationships, Getting Others to Support Your Recovery, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Integrating the Split Self, Recovery Thinking, Taking Good Care of Yourself, Commitment, Respecting Your Time, Coping with Triggers, Self-Nurturing, Red and Green Flags, Detaching from Emotional Pain (Grounding). Life Choices, and Termination.



These can be addressed in any order and include as few or many as time allows and are outlined extensively in the Seeking Safety manual (purchased at http://www.treatment-innovations.org/about-us.html). The manual also includes materials, handouts, and other tools for the therapist.

FUNDAMENTAL SKILLS AND TECHNIQUES OF SEEKING SAFETY

The therapeutic alliance. As in previous sections of this manual, the therapeutic alliance is the foundation for a clinician using the Seeking Safety model (Establishing an Effective Therapeutic Alliance).

Provide psycho-educational information. Providing psycho-educational information during therapy is necessary for the patient to begin considering their thoughts, behaviors, and environment. However, there is an important difference between providing information and giving advice. Giving advice should always be diligently avoided. Instead, use the "Ask, Ask, Tell, Ask" (AATA) technique - Ask what the patient already knows about the subject, ask for permission to give them any missing or corrective information, tell them the information using third person pronouns, and ask the patient what their thoughts are on that information. As a general rule of thumb, patients should always talk more than the therapist, both in psycho-educational groups and individual sessions.

Self-reflection and insight. The ability to identify counter-transference and more generally, to self-reflect, without judgment, on one's own history and discern how it impacts one's therapeutic work, is imperative for any therapist. It is also a key a principle of the Seeking Safety model. More broadly, self-care and wellness are largely dependent on a therapist's ability to self-assess. For more information on self-reflection and insight see the Clinician Support section.

Criticisms and Cautions of Seeking Safety

Seeking Safety is considered to have a few noteworthy limitations. It may not be helpful for patients who have a strong inclination to focus on and talk about the specifics of their traumatic history in therapy. There is also some research to show that patients who have difficulty with choosing one of the 25 topics may not achieve the same level of symptoms resolution as those who are able to choose. However, as with all therapeutic interventions, symptom remission is correlated with the number of sessions a patient has.

Problem Solving Therapy

Problem Solving Therapy (PST) is a brief focused therapeutic treatment used to intervene on those who have engaged in self-harm and presented in the emergency room. It was initially developed in New Zealand by Thomas D'Zurilla and Marvin Godfried in 1971 in response their to observations of patients who had depressive symptoms and were at higher risk of suicide. They found that these patients had patterns of negative cognitions about the problems in their lives and their ability to solve them. The patients saw their problems as a threats to their wellbeing, blamed themselves for what they were experiencing, and lacked the self-confidence to attempt to solve them effectively. Patients with these thinking patterns tended to see their problems as unsolvable and either avoided them completely or put the responsibility on others to solve the problems for them.

Problem Solving Therapy is a collaborative approach to assist patients with effectively solving the life problems they are experiencing. It aims to address the patient's negative cognitive patterns, much like CBT, and build their problem solving skills. The behavioral health clinician may focus the intervention on one particular problem, but the problem solving skills learned through PST can be applied to other problems the patient may have currently or in the future. Specific interventions include psycho-education, interactive problem-solving exercises, and motivational homework assignments.

There are 7 steps in PST as shown in the graphic below.

Beyond its use for treating depressive disorders and suicidal ideation, PST has been shown to be effective for a wide range of behavioral health issues, including anxiety, relationship difficulties, certain personality disorders, and emotional distress related to medical difficulties. For more information on how to become a certified PST practitioner, go to http://www.impact-

uw.org/training/problem_solving.html. With this, for more information about how PST is used in the IMPACT model, take a look at a PST manual that was developed by Mark Hegel, PhD and Patricia Areán, PhD for the IMPACT study (http://www.impact-uw.org/files/PST-PC_Manual.pdf)

Behavioral Activation

Behavioral Activation (BA) is considered to be a component of Cognitive Behavioral Therapy (CBT) but can also be used as a stand-alone intervention. The theory holds that insufficient environmental reinforcement or too much environmental punishment contributes to depression and other behavioral health conditions. The goal of Behavioral Activation, therefore, is to increase one's environmental reinforcement. While most cognitive therapies focus on changing thinking patterns as the way to change behaviors and affective states, BA focuses on changing behaviors as the way to change thinking and affective states. BA has been shown to be effective with those experiencing both depressive and anxiety states and symptoms.

The BA model proposes that life events, such as trauma or loss, biological predispositions to depression, or the daily hassles of life, lead to an individual's experience of low levels of positive reinforcement. When patients feel sad and no longer find pleasure in things they used to, they tend to decrease their activity levels, avoiding social and occupational activity, as well as other pleasure producing actions. They "shut down" and may choose to cope by oversleeping, overeating, using nicotine, alcohol or drugs, which reduce the severity of the difficult feelings in the short-term but actually increase depressive symptoms and compound their problems in the long-term.

Therefore, BA seeks to intervene in this cycle through behavior changes that work from the "outside in". Therapists help patients to set behavior goals and schedule activities in order to facilitate positive reinforcement. BA specifically addresses avoidance and inertia through structured sessions that include assignments and outside of session tasks. An example of this type of assignment might be a worksheet where patients list 3 activities they used to enjoy and 3 responsibilities they need to take care of. The patient sets a small, manageable, goal of engaging in one of each of the activities before the next therapy session and then scales or rates their depression, pleasant feelings, and sense of achievement before and after doing each of the activities. BA typically takes place over several sessions and progressively ranks activities according to their level of difficulty. Therapists assist patients in moving up the ladder as they experience success with the easier, lower ranked, behaviors and eventually build the confidence to achieve success with the higher ranked, more difficult, activities.

Criticisms and Cautions of Behavioral Activation

One caution with using BA, as with all therapy techniques, is that when insufficient attention is paid to the therapeutic alliance, the therapy will likely be ineffective. BA is most appropriate for patients who have a belief system that supports the intervention. With this, therapists should be careful to not be overly directive with BA. Although therapist should guide patients towards setting goals that aren't too high (like a walk every day for 15 minutes for someone who spends the majority of their days in the bedroom) or too low, therapist should also try to elicit goals from patients and avoid telling them what actions the "must" take to "get better". As stated above, therapists can do this by

guiding patients gradually towards more "difficult" goals, as setting goals that are too high sets patients up for failure and will likely reinforce a familiar cycle of failure.

Clinician Support

Clinician Self Care and Well-Being

Therapists have a special responsibility to tend to their own well-being because the "tool" that they use in their profession is them selves. How they are doing personally has a direct impact on their professional skills and subsequently the quality of care that patients receive. However, being perfectly well physically, spiritually, and emotionally is not only impossible, it is undesirable. Personal growth and learning are only experienced during times of difficulty. It is, therefore, the responsibility of the therapist to develop the ability to recognize the early signs of difficulty, self-assess how they are doing personally and professionally, and surround themselves with supportive people in their personal and professional lives who can help them work through their struggle. This allows the therapist to continually enhance their own health and wellness while simultaneously developing the varied repertoire of coping and thriving strategies that is necessary for professional life as a therapist.

COMMON CLINICIAN DIFFICULTIES

Burn Out: Clinician burn out, sometimes called or related to "compassion fatigue", is the "imbalance between the psychological resources of an individual and the demands being made on those resources". It is common among all of the "helping" professions and usually builds incrementally over time. Some signs that a clinician might be experiencing burnout are:

- The feeling of dragging oneself into work most days
- Repeating the same interpretations or other "scripts" over and over
- A reliance on giving advice rather than helping patient's grow
- Beginning sessions late and/or ending them early
- Spacing out frequently during sessions
- A decline in empathy and increase in judgment
- The tendency to push personal theories, techniques, or agendas rigidly
- A decline in the quality of listening
- A lack of excitement for learning new things related to the field.
- Self-disclosures without judging their usefulness to patients

Vicarious Traumatization: Vicarious Traumatization, sometimes called "Secondary Traumatic Stress" or "Secondary Victimization" is "the emotional residue that a counselor experiences after hearing people speak about their traumatic stories". It is the process of vicariously becoming "witnesses to

the pain, fear, and terror that trauma survivors have endured". Therapists working in most settings hear a high percentage of trauma disclosures and integrated settings are no exception. Some signs that a clinician might be experiencing Vicarious Traumatization are:

- Irritability
- Exaggerated startle response
- Over-eating or under-eating
- Difficulty falling asleep and/or staying asleep
- Losing sleep thinking about patients
- Diminished joy toward things they once enjoyed
- Feeling trapped by their work
- Intrusive images of patient trauma disclosures
- Feelings of hopelessness associated with work and patients
- Rumination about a patient's traumatic events
- Dreaming about patients, especially their trauma experiences

PREVENTATIVE AND EARLY INTERVENTION SELF CARE STRATEGIES

It is should be noted that, historically, self-care was not seen as being important to the medical field. Until recently, it was not common for professionals and researchers to write about it, study it, or discuss it openly. For this reason, behavioral health professionals are usually the first ones to advocate for and model the importance of self-care in a given organization. Below are a few strategies behavioral health clinicians can adopt in regards to enhancing self-care.

Setting Boundaries: Early in their careers, therapists often become aware of the importance of setting boundaries and how it relates to their own wellbeing. Boundaries around office space, session times with patients, limiting "add-ons" or "crunching in" patients when there is no appointment time, and restricting work at night and on weekends (including EHR work) are some examples. There are no "right" limits or boundaries to set. Each therapist must personally decide what limits they need to have in place in order to protect their own energy and well-being.

Utilizing Professional Support: Prioritizing and utilizing clinical supervision both formally and informally allows therapists to have a forum for openly discussing the difficult issues that come up in their professional life. Ideally, these forums are safe, open, spaces that encourage the therapist to self-disclose without fear of judgment. Continuing education courses and books that directly address clinician wellbeing can also be very helpful. The Greater Good Science Center researches and

writes about self-compassion and compassion fatigue for helping professionals and often offers continuing education on this topic. For more information, see their website, http://greatergood.berkeley.edu.

Utilizing Personal Support: Although therapy is required in only a small number of graduate programs, research indicates a high percentage of behavioral health professionals have engaged in therapy themselves. There are many reasons this can be helpful. It increases empathy for what it is like to be a patient, it gives a personal, on-the-ground, look at what works and what doesn't, and it helps in lowering stress and treating other conditions a therapist might suffer from, such as depression, anxiety, and substance abuse. In addition, many therapists have grown from a caretaking role in their families, into a caretaking profession, and sometimes a caretaking role in their organization. Alice Miller, author of The Drama of the Gifted Child, and others believe that therapists who come from this childhood role are bound to need to confront their inability to "fix" others and care for everyone at some point in their career. Therapy can provide the valuable insight and support needed to overcome this. Employee insurance plans usually cover therapy services, while many organizations also have Employee Assistance Programs in place that allow for personnel to access therapy services.

Utilizing Physical, Emotional, and Spiritual Well-being Practices: While therapists often refer to these things as a matter of course when they are working with patients, they often forget that they are important for themselves as well. Daily exercise, plenty of sleep, healthy eating, time with friends, time spent in hobbies and other interests or activities one is passionate about are foundational to wellbeing. Engaging in spiritual practices, participating in spiritual communities, and maintaining healthy relationships that are marked by love, affection and open communication are pillars of self-care for most helping professionals. All of these things are easier said than done and it is natural for most helping professionals to struggle with any number of these life components, however, they are nonetheless important to incorporate into one's self-care routine.

Balancing Personal and Professional Life: There are many factors that influence how one chooses to balance their time spent working and not working. Some professionals may be most influenced by the specific messages, modeling, and beliefs that they received from their family of origin. Others may hold onto the beliefs and values of their culture, while still others may be most influenced by the norms of the particular organization for which they work. Beyond this, an individual's preferences for how much time is spent working vs. not working changes throughout the life course. A person's age, health status, and whether they have young children or elders to care for at home will influence how devoted they are to their work. It is important for each individual to examine their own preferences for how they wish to spend their time and it is equally important for organizations to model a culture of personal-professional life balance.

Clinical Supervision

Clinical Supervision is a practice that was developed by early psychotherapists to assist practitioners in learning from their experiences, progressing professionally, and to monitor the quality of services being administered to patients. Today, different forms of supervision are used by a wide variety of disciplines.

Clinical supervision usually consists of a private meeting between a senior clinician and a junior clinician, but can take many different forms. It can occur in groups where a senior or experienced clinician facilitates clinical learning, it can occur one on one with experienced clinicians who may formally or informally consult with each other for continued learning, and in the absence of a clinical supervisor, clinicians may have "supervision" by consulting with a senior clinician who is not their direct supervisor.

Because clinical supervision is broad, it can be helpful to distinguish between the different types of supervision in order to provide clarity for both the supervisee and the supervisor.

Administrative Supervision: Administrative supervision is primarily focused on the administrative competencies and tasks of the supervisee. It includes monitoring productivity, scheduling, EHR training and issues, paperwork, report writing, rules, policies, protocols, legal and ethical issues, and related information-specific topics. Any disciplinary actions and annual or semi-annual evaluations also fall into this category but can overlap with the following categories, as well. Administrative supervision is sometimes referred to as "supportive" supervision, in that the task of the supervisor is to provide the necessary organizational and operational supports for the supervisee so that they can provide quality care to their patients.

Clinical Supervision: The term clinical supervision is often used as a blanket term to refer to any supervision that occurs between a therapist and his or her supervisor who is also a therapist. It is usually didactic in form and focused on continued learning in the clinical realm. It addresses case presentations and reviews, diagnostic impressions and general diagnosis competencies, enhancing learning of evidence- based research supported interventions, reviewing interventions and treatment plans, evaluating the clinical progress of patients, and increasing the clinician's overall insight and knowledge about particular conditions and treatments. Often times, clinical supervision will also include administrative topics as they intersect with clinical considerations.

Reflective Supervision: Reflective supervision is distinct from the other types of supervision in that it is always clinically focused but also often includes administrative topics. At the heart of reflective supervision is attention to relationships, including the relationship between supervisor and supervisee, the relationship between the supervisee and their patients and families, and how these relationships affect each other. In reflective supervision, the supervisor and supervisee strive to model the same sort of relationship that would be desired between a therapist and a patient. This is sometimes referred to as the "parallel process", or as Jeree Pawl would say, "Do unto others as you would have

others do unto others." In reflective supervision there is also a greater emphasis on attending to the emotional content of the therapist's work. The supervisor aims to increase the supervisee's insight and learning about how their emotions impact their work and ultimately, the patient's process. In reflective supervision the supervisor spends much more times listening than they do talking or teaching. This allows the supervisee to find his or her own beliefs, perceptions, and solutions to problems. Again, this serves to model what the supervisee should be able to provide to their patients. In reflective supervision the initial focus is on forming a trusting relationship between supervisor and supervisee. The focus then shifts to using the safety of the relationship to allow the supervisee to explore the parallel process, self-reflect, learn to identify emotions, and use them purposefully in therapy with patients.

TIPS TO MAXIMIZE THE FRUITFULNESS OF SUPERVISION:

- Set a regular time to meet. It may be necessary for the clinician to advocate for this. Clinical and reflective supervision can be particularly challenging in integrated settings, in that there is not a corollary in the medical culture. Sometimes certain organizations or clinics have difficulty with understanding the importance, value, and professional necessity of supervision and this might be demonstrated when little or no formal time is carved out of schedules for clinical supervision meetings.
- Whenever possible, meet before patient care time begins, before a lunch break, or at another time that provides sufficient "space" for focused reflection.
- The supervisee should come prepared with clinical questions, case presentations, reflections, or other topics they would like to discuss. The supervisor may have some agenda items of their own, but the supervisee should be largely responsible for directing the content of the meetings and focusing them on where they would like input, support, and growth.
- The supervisee should elicit feedback from their supervisor directly. Even experienced supervisors can have difficulty with giving feedback, particularly if they feel it is negative. Encouraging feedback directly can motivate supervisors to share any important observations they may have about the supervisee.
- As related to the above, when feedback is received, the supervisee should avoid the urge to explain, defend, deny, or blame. These are normal defense mechanisms for most people as they begin evaluating the negative feedback they receive, but this type of response can inhibit further feedback, denying the supervisee of the opportunity to grow and develop fully. When supervisees feel the need to defend themselves, they can say "Thank you. I will think about what you said and we can talk about it next time."
- Cultivate an awareness of the supervisee's feelings as different topics are discussed. This practice is a parallel process for self-awareness in sessions with patients and even if the

supervisor does not explicitly engage in reflective supervision, practicing this awareness will enhance the therapist's skills.

- Supervisees should be willing to utilize the relationship with their supervisor as a tool for learning. Supervision can teach one a lot about their patterns of relating to authority, relating to women or men, seeking approval, rebellion, avoidance, and transference. When a supervisee is willing to articulate these insights and observations, a supervisor can be a partner in maximizing learning. The more self-insight a therapist has, the more they can trust their own perceptions and insights during their work with patients.

- Supervisees should remain as open and curious as possible. Many professionals have been through years of schooling (and perhaps family systems) that rewarded the understanding and knowing of things. Cultivating curiosity and "not knowing" sometimes takes practice.

- As much as possible, the supervisee should avoid critical or harsh judgment of themselves and others. This is because judgment is the opposite of empathy and empathy is the foundation for growth. However, when the supervisee does find that they are judging a patient or their own abilities, they can use supervision time to increase their insight, explore the judgment, and resolve it. To this end, we can acknowledge professional growth as the diligent practice of noticing, examining, and addressing areas of judgment in an effort to have fewer and fewer judgments as time goes on.

Conclusion

Summary

Through efforts to integrate behavioral health and primary care, providers and organizations have the opportunity to ensure that all patients with behavioral health needs are identified, offered quality services, and that these services are coordinated in a meaningful way with other aspects of their healthcare. On a broader level, integrating behavioral health can also serve as a vehicle to embed the principles of whole-person care and humanize the healthcare experience for patients, families, and employees.

We hope that this manual has served as a useful resource for supporting and enhancing the work of providers in integrated behavioral health settings, whether they are new or seasoned professionals. Moreover, we hope that the overview of the foundational operational, leadership, cultural, and clinical aspects of a whole-person care system will help providers as they go forward in with the complex work that they do with patients and families, as well as in lead the cultural transformation of healthcare.

Finally, in consideration of the constant evolution of the field and the broad array of organizations practicing or developing integrated systems, it is important to reiterate that there is no single, dominant, or correct definition of integrated behavioral health. Indeed, striving to find the definitive "models" that all should adopt, may be at odds with some of the fundamental principles of behavioral health: Autonomy, empowerment and honoring unique strengths and limitations. We encourage organizations to collectively identify and articulate a vision for their highest good, build on the organizational and community strengths in enhancing their systems, and explore and embrace the strategies and techniques that work best for their patients and employees.

Resources for Further Exploration

- American Society for Addictive Medicine: www.ASAM.org
- The Recovery Research Institute (Massachusetts General Hospital and Harvard Medical School): www.recoveryanswers.org
- A Meta-Analysis of Research on Motivational Interviewing Treatment Effectiveness (MARMITE) (Annual Review of Clinical Psychology): http://www.motivationalinterview.net/library/MARMITE_files/v3_document.htm
- Toxic Stress, Behavioral Health, and the Next Major Era in Public Health (Mental Health America): http://www.mentalhealthamerica.net/sites/default/files/Toxic Stress Final.pdf
- The Adverse Childhood Experiences (ACE) Study (Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic): http://www.cdc.gov/violenceprevention/acestudy/
- Resources for Integrated Behavioral Healthcare (Mary Rainwater and Elizabeth Morrison):http://www.blueshieldcafoundation.org/sites/default/files/u9/Resources_for_Integrated_BH_Info.pdf
- Resources for Mental Health Prevalence Data (Mary Rainwater and Elizabeth Morrison): http://www.blueshieldcafoundation.org/sites/default/files/u9/Prevalence_Data_Resource_Page%20.pdf
- Article on patient acceptance level (Arndt Büssing, Peter F Matthiessen, and Götz Mundle - Health Qual Life Outcomes) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2262062/
- Table of for measuring patient level of acceptance (Arndt Büssing, Peter F Matthiessen, and Götz Mundle - Health Qual Life Outcomes) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2262062/table/T2/
- Confidentiality, HIPPA, and 42-CFR (SAMHSA): http://www.integration.samhsa.gov/operations-administration/the_confidentiality_of_alcohol_and_drug_abuse.pdf
- FAQs for confidentiality, laws, and regulations (SAMHSA) http://beta.samhsa.gov/about-us/who-we-are/laws
- Tools and Resources for the therapeutic alliance (Scott Miller): ScottdMiller.com
- PST training certification: http://www.impact-uw.org/training/problem_solving.html.
- PST Manual (Mark Hegel, PhD and Patricia Areán, PhD for the IMPACT study): http://www.impact-uw.org/files/PST-PC_Manual.pdf

- Research and writings about self-compassion and compassion fatigue for helping professionals (The Greater Good Science Center): http://greatergood.berkeley.edu.

Suggested Reading List

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse; Lisa Najavits

This is the manual for Seeking Safety, and includes a comprehensive overview of the history and research, as well as a thorough explanation of how to conduct the treatment. The bulk of the manual is made up of the Seeking Safety treatment topics and includes all the requisite patient education materials.

Treating Addiction, a Guide for Professionals; William R. Miller, Alyssa A. Forcehimes and Allen Zweben

This is an excellent guide from authors who include the originator of Motivational Interviewing. One of the most useful, concise and engaging books on evidenced based treatment for those with addictive disorders.

The Drama of the Gifted Child, Alice Miller

This is Alice Miller's classic text (published in 1981 and causing much controversy) examining the consequences of repression at the personal and social level and the causes of the physical and psychological harm done to children. The book also looks at prevention and treatment of the consequences of childhood trauma.

Motivational Interviewing: Helping People Change, 3rd Edition; William R. Miller and Stephen Rollnick

The original Motivational interviewing text, in it's 3rd edition, written by the grandfather's of MI. Both theory and practice, and updated to reference and apply the most current research, this is a must read for any clinician who considers behavior change a part of their clinical practice.

Motivational Interviewing in Health Care; William R. Miller and Stephen Rollnick

This is a practical, simplified MI text for those in the health professionals. It is applicable to anyone working in healthcare, from Medical Assistants to Physicians to Health Educators. While it is relevant for behavioral health clinicians, the primary MI text (above) is much more comprehensive and appropriate for therapists. The primary reason for reading this book is for behavioral health clinicians to usefully refer medical professionals to it, as well as inform how behavioral health clinicians informally train and coach their colleagues in healthcare.

Becoming Naturally Therapeutic: A Return To The True Essence of Helping; Jacquelyn Small

This book, which was originally written for addictions counselors over 20 years ago, has become a classic text. The principles and guidance in this book apply broadly to counseling and other therapeutic situations, as well as interpersonal relationships. Based on the extensive research about empathy conveyance and its impact on healing, it is a short and inspiring read.

Feeling Good the New Mood Therapy; David Burns

David Burns is one of the most famous living cognitive behavioral therapists. Feeling Good was originally written in 1980, however has been updated several times, the most recent version was published in 2008. IT has sold over 4 million copies, and is the most frequently recommended book by mental health professionals for depressed patients in the United States. The genius of this book is that it is an incredible course in CBT for therapists (much better than any graduate course or CEU), and it is also effective bibliotherapy for patients who have the appropriate reading and intellectual level to benefit. In addition to depression, it is also a treatment guide to anger problems and anxiety.

The Heroic Client: A Revolutionary Way to Improve Effectiveness Through Client Directed, Outcome-Informed Therapy; Barry L Duncan, Scott D. Miller, Jacqueline A. Sparks

Duncan and Miller are co-founders of the Institute for the Study of Therapeutic Change. This book was controversial at the time, as it presented the research that the traditional focus on diagnosis, pharmacology, and other "silver bullet" interventions were empirically "bankrupt" practices. They argue that the client's voice, perceptions, beliefs and preferences are the crucial factors in the therapy's success. This is the most profound text on what "partnering" with a client truly means.

Delivered from Distraction, Getting the Most out of Life with Attention Deficit Disorder; Edward M. Hallowell, M.D. and John J. Ratey M.D.

ADHD/ADD is the highest prevalence behavioral health condition in children in primary care, so having a firm grasp on this is important. This book is a follow up to their book Driven to Distraction. These doctors both have ADD themselves, so the book is first person, friendly and fun read. It is packed full of information, research and practical strategies for ADD patients (adult and child) and their parents/partners. Their stance is/was revolutionary in that they frame ADD as a strength, as opposed to a pathology, and discuss finding the right teacher, friends, job and partner as more important than the tired argument of "medication/no medication". The book does, however, include a thorough review of current research on all treatments, including pharmacology. This, like Feeling Good, is a great book for therapists, and also for patients who have the appropriate reading levels.

Treating Addiction A Guide for Professionals; William R. Miller, Alyssa A. Forcehimes; Allen Zweben

Most behavioral health clinicians get little, if any, education in graduate school on addictive disorders, making this book a must read for any therapist working in any setting. This is written by researchers and clinicians (including William Miller, co-founder of Motivational Interviewing). This is a thorough review of evidence-based treatments for addictions, providing examples, resources and tools for clinicians. The principles in this book are evidenced based, holistic, and patient/client centered.

The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients; Irvin Yalom

Most know Irvin Yalom as the father of group therapy (there are a few grandfathers); he is also a fiction writer, and has written extensively on the therapeutic process, focusing on the patient as a "fellow traveler". This book is essentially a "tips" book, with personal stories and valuable insights for any mental health professional.

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Appendix

(For Medical Providers)

What Does a Therapist Actually Do?

(Please Note: This document was created at the request of a group of doctors, who wanted a better understanding of what therapist "do" in the room - what "treatment" is. The list below is not in any way exhaustive, but more of an attempt to describe some of the fundamental and foundational interventions therapists engage in with patients)

They skillfully listen. Therapists don't give advice, judgment, or referee between family members. They instead engage in highly focused, mindful listening, utilizing verbal and non-verbal techniques to convey a level of complete attention to the patient. Therapists facilitate the disclosure of things that patients have kept secret for years, out of fear or shame, causing them significant emotional and physical suffering. Disclosing meaningful things in and of itself can be healing for a patient and therapists have the ability to listen to patients talk about their deep issues and feelings without judgment about their beliefs, decisions, or actions.

They help patients practice relationship skills. Many people enter into therapy because they are not satisfied with the quality of their relationships. Over time, they may have developed issues with attachment, resentment, or anger and found that these issues have manifested into faulty relationship patterns that are detrimental to their well-being. Not surprisingly, often times patients will re-create these same relationship patterns in their relationship with their therapist. For example, if a patient lacks assertiveness and rarely tells their family or friends how they feel but has a pattern of later becoming overwhelmed by resentment and eventually blowing up, this can be worked on in therapy. The therapist may try to explore how this relationship pattern plays out in their own relationship with the patient. For example, they might say "I wonder if you ever have any feelings of irritation with me or any disagreement with anything I have ever said?" or "I wonder if it is difficult to tell me how you feel about me being an hour late?". In this way, the very patterns that have caused patients difficulties in their relationships in the past can be pulled into the therapy room, examined, and eventually changed.

They learn to identify and express feelings. Many of those who enter into therapy do so because they have trouble naming or acknowledging their feelings. This may stem from being raised by parents who were not able to name or acknowledge their feelings or it could have been something that developed over time. Either way, many people have no idea how to interpret how they really feel. They may have their voice raised and yell "I am not angry!" or even look very down or sad and say "I have no reason to be sad!". Even when they know how they feel, they may judge themselves for having these feelings. This resistance or wall against truly identifying and accepting their own

feelings causes significant diagnostic problems such as depression and poor functioning in relationships. Therapists give patients psycho-educational information about feelings and then help them to identify and express them in sessions.

They help patients to identify "thinking errors". Thinking errors are faulty cognitive patterns that cause depression, anxiety, anger, and other issues that affect one's mental health. Most patients have not been trained in "meta-cognition", or thinking about thinking. Therefore, therapists help them to notice, identify, and name the specific cognitive patterns that are causing them problems. Moreover, therapists help patients with "cognitive correctives", or the practice of replacing thinking errors with more helpful thought patterns. This is the crux of cognitive therapy.

They elicit motivation from patients. Therapists motivate patients to engage in helpful and healthy behaviors. Most patients, and all people in general, are ambivalent about changing their behavior. For example, they may want to exercise every day because they know it is important, but they just feel horrible taking an hour away from the little time they have with their kids at the end of a long work day to go for a run. Or, they may want to quit smoking, but they just don't feel like they can do it right now - last time they did, they gained 40 pounds and yelled at their kids for 2 weeks. Therapists are trained in evidence-based techniques that elicit the resolution of this ambivalence (such as Motivational Interviewing). Many times, this involves motivating an individual to examine their current coping skills (such as drinking, yelling, over sleeping, over eating, or isolating) and helping them to expand their coping skills to more healthy and helpful ones.

They create meaning. Often times, patients have developed belief systems about who they are or why things have happened to them, such as "I am just too giving and people take advantage of that", "I think I am being punished by God ", or "My mom just didn't care enough about us to quit using drugs". Beliefs that support dysfunctional behaviors can be very harmful to patients, as they create self-judgment and other self-deprecating feelings. Therapists help patients to examine their own beliefs systems and make conscious decisions about what beliefs they want to keep and which ones they want to give up in order to create their own meaning for their life. This positively impacts their functioning and their level of activation around their own health in general.

They increase insight. Frequently patients do not see themselves as they are. They may not know that they frequently vent or use sarcasm. They may be unaware that they keep themselves from crying when they are sad. They may not know that their posture and tone of voice intimidates others. And likewise, they may not know their strengths and that they are actually articulate and insightful and a loving parent. Therapists give patients feedback by holding up an imaginary mirror that reflects back to the patient what others really see. For example, in session, a therapist might give a patient feedback (after asking permission) that they often vent about others in their life and frequently blame. This is descriptive feedback, not evaluative or judgmental. Giving feedback without judgment is a highly complex skill. Many patients have never received feedback but rather have only received criticism, which has lead them to a state of entrenching defensiveness about

their behavior. However, within a safe, empathetic, environment, the patient can use feedback to explore how their thoughts and actions have affected their lives. Patients, like all of us, are better at making decisions when they can see their patterns of thinking and behaving more clearly.

They assess patients. Therapists are trained to assess the "bio-psycho-social" or the "biological, psychological, and social" context of a patient historically and currently. It is important to note that assessment is not a discrete activity that occurs during the first visit. It is a continual process that unfolds over time. Therapists assess the strengths, beliefs, coping mechanisms, safety (in terms of suicidality and homicidality), security (in terms of housing and food), and presenting or historical symptoms of behavioral health difficulties (including substance abuse) of a patient and much more. Assessment, by nature, depends on self-disclosure, so its quality and accuracy depends entirely on the ability of the therapist to elicit information from the patient. This means that the therapist must create a strong therapeutic alliance within just a few seconds or minutes. Guided, open-ended, questions are the gold standard of assessment. For this reason, a skilled clinical interview should always replace written assessment tools whenever possible. While one of the goals of assessment is to identify a proper diagnosis, it is rarely the main goal. The goal of an assessment is to continually get a sense of a patient as a whole person and to direct interventions in the way that will be most helpful to them.

They diagnose. All therapists are trained in DSM-V diagnosis. In the field of behavioral health, diagnosis has historically been suspect. Many have seen it as being driven largely by insurers and/or health plans, and as being used as a marginalizing "label" for patients, and as being somewhat unnecessary since pharmacological treatment is often based on symptoms and not a diagnosis. However, it is important to recognize that a diagnosis can be an important part of a patient's care when it informs treatment. It can be helpful for a team communicating with Electronic Medical Records, as it indicates a cluster of specific symptoms to all treatment team members. It can inform other treatment decisions, such as when a diagnosis of alcohol dependence indicates that some other medications to treat chronic pain would be unsafe. Diagnosis can also be an important way to provide educational material to patients about the signs, symptoms and treatment of their condition. In this sense, it can facilitate self- management and empowerment. Lastly, for some patients, having a name for what has been troubling them is freeing. It may provide validation to them that their suffering is "real", that it is recognizable to others, and that there is hope for a treatment or solution to their suffering. Behavioral health providers should share and talk about diagnosis only as much as it is meaningful to the patient.

(For Medical Providers)

Tips for Medical Providers Working on a Team With Behavioral Health Providers

Who to refer? ALMOST ANYONE! Research tells us that 70% of patients in a primary care setting want or need behavioral health intervention. In addition to severe mental illness, high scores on screening tools, and patients who request behavioral health services, here are some other examples to start with:

- Depression, including dysthymia (therapy is first line treatment)
- Anxiety, all types (therapy is first line treatment)
- Nicotine Dependence
- Obesity (BH can r/o binge eating disorder or eating disorder NOS; can assess childhood abuse that is connected to weight/body image, provide motivational interviewing to increase behavior change success)
- Patients with chronic diseases that are not well managed (BH clinicians are usually experts in behavior change techniques such as motivational interviewing)
- Substance abuse, including ETOH (research shows 20% of patients misuse alcohol).
- Children, to dx ADHD (BH clinicians can administer and score Vanderbilt's and do clinical interview)
- Parents of ADHD kids for parent directed therapy re: behavioral interventions for ADHD support
- Parents with high needs children
- First time parents to assess stressors
- Chronic Pain (CBT is evidenced based adjunct treatment)
- Patients who have low acceptance of their chronic pain or other chronic disease
- Patients who are angry at their PCP or care team
- Patients who have lost someone close to them
- Patients that have yelled or otherwise treated staff/providers poorly, and need to be warned about the consequences of their behavior
- Anything involving feelings, beliefs or behavior!

TIPS FOR A SUCCESSFUL TEAM

- Your therapist is a trained professional, and therapy is a highly skilled treatment modality; avoid referring to therapy or psychological assessment as something you just "don't have time to do". This can feel devaluing to your BH clinician, even though of course it isn't meant to be. This is like a BH provider saying they could diagnose and treat diabetes if they had time
- BH Clinicians are providers -- it is helpful to be conscious of informal and formal indications of this. For example, if the providers are pooling money for Christmas gifts for support staff, ask the BHC to donate money, as opposed to including them in the gifts for the staff.
- Similarly, it is important that BH providers are mandatory attendees at provider meetings, to increase the cohesion of the integrated health care team, and to encourage informal and formal communications between medical and behavioral health professionals.
- It is helpful to have direct conversations with the BH clinician on your team about how best to communicate about patients- in person and in the EHR. What do you want clearly in the notes for chronic pain patients? Do you want an alert when patient is ETOH dependent? The more the BHC knows about how to help you help patients, the better.
- BHCs cannot advise about what psychotropic to prescribe or not prescribe, it is out of their scope. They can only give assessment information that can help with decision making including what patient has tried before, response to trials, what medication family members may have had success with, what medications patient believes will help them and which ones they believe will harm them.

TIPS FOR REFERRING

- Ideally the whole team is empowered to refer without asking you first. The receptionist, the medical records person, and especially your MA and nurses. Not only does it indicate they are a valuable member of the care team, it also speaks to the fact that patients often disclose more about their difficulties to staff members. To this end…
- It can be useful to create something similar to "standing orders" for staff referrals. For example, all new patients who have chronic pain as chief complaint, all pregnancies under 17, all ADHD children and adults, all PHQ-9s over 10, all GAD7 over 10, positive CAGE-AID, all children with stomach aches, and other conditions where there is an evidence base of the positive impact of BH intervention.

- Sometimes it can be helpful to avoid the word "counselor" or "therapist" in an initial referral conversation with a patient. These can be high stigma words, and can be more effective to use the word "colleague" or "stress specialist" or something similar.
- It can be useful to think of wording referrals to BH clinicians as "treatment". Although therapy is a first line treatment for many conditions, patients often don't know this, and have little confidence in how "talking to a stranger" could help them. Conveying your confidence to patients that BH is a treatment for their difficulties, not just a 'friendly ear' can increase the likelihood the patient will go, and increase their expectation that they will obtain help from the visit.
- No show rates for BHCs, even in a primary care setting are very high for first appointments. Even if the BHC doesn't have time for a session with the patient on the same day you see them, just introducing the patient to the BHC will increase the likelihood that the patient will show for the appointment.