

# The *What* and *Why* of Culturally Responsive Integrated Behavioral Health Care

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1. Name one benefit of integrating behavioral health into primary care settings

2. Name 2-3 screening tools utilized in integrated care settings

3. Name two culturally responsive therapeutic modalities/ approaches utilized in integrated care settings

# Where Our Journey Will Take Us Today

Definition & Models of Integrated Behavioral Health (IBH)

How IBH works on the ground

The IBH Team & Role of IBH Clinician

The client perspective & culturally responsive considerations



# Integrated Behavioral Health Defined

The care that results from a practice **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.

This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization. (Peek, 2013)

## Key Principles of Integrated Care:

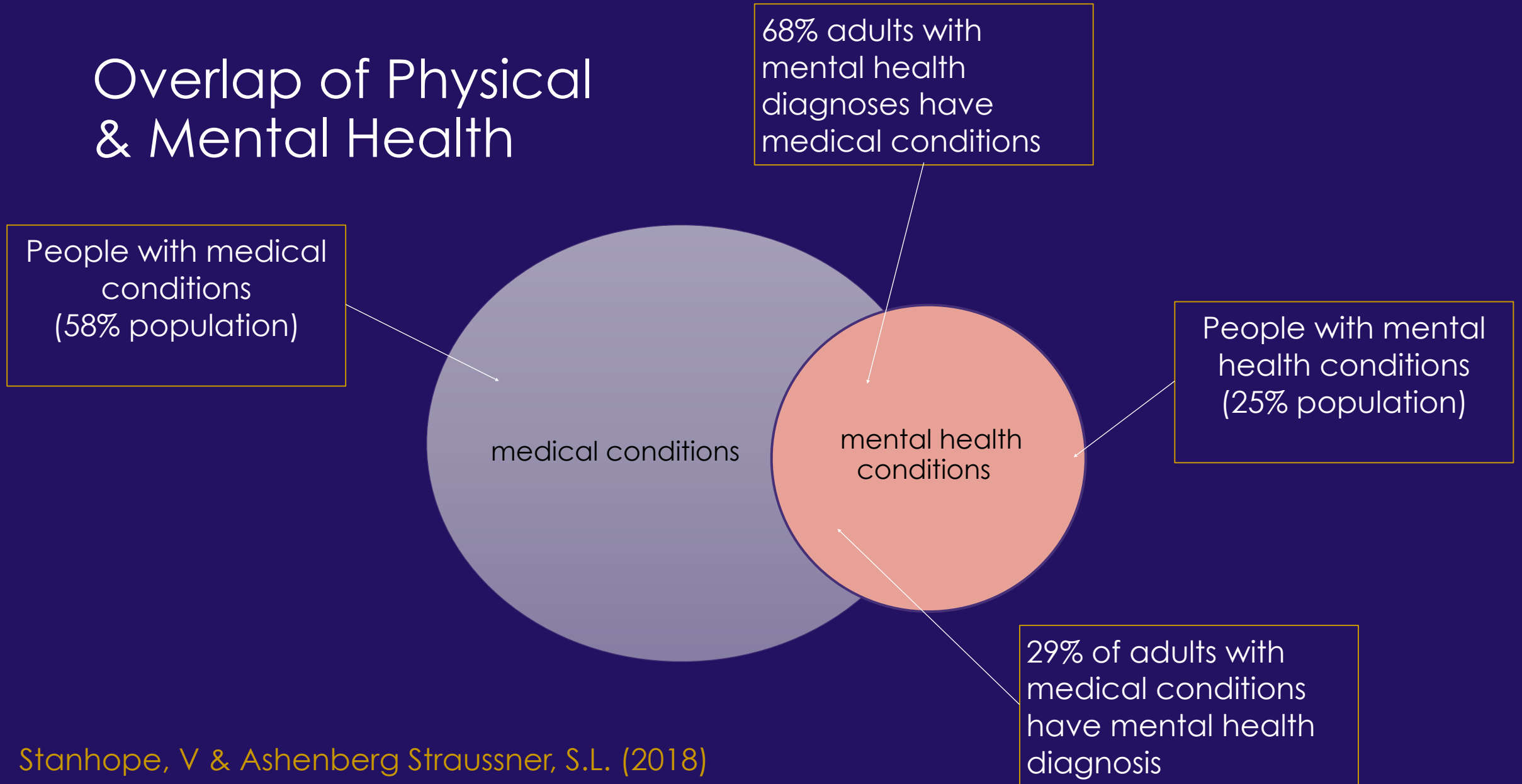
- Patient-Centered care team
- Population-based care
- Measurement-based treatment
- Evidence informed care



- More than **65%** of antidepressants are prescribed by primary care physicians and yet depression screening does not occur in most practices
- Only **41%** of patients with mental health issues receive treatment
- Between **30% and 50%** of patients referred by a PCP to outpatient mental healthcare never make it to their first appointment
- Compared to routine primary care, enhanced primary care behavioral health services deliver **superior health outcomes** for the following conditions: chronic pain, diabetes, obesity, alcohol abuse, tobacco use, depression, generalized anxiety disorder, social anxiety disorder, and panic disorder.



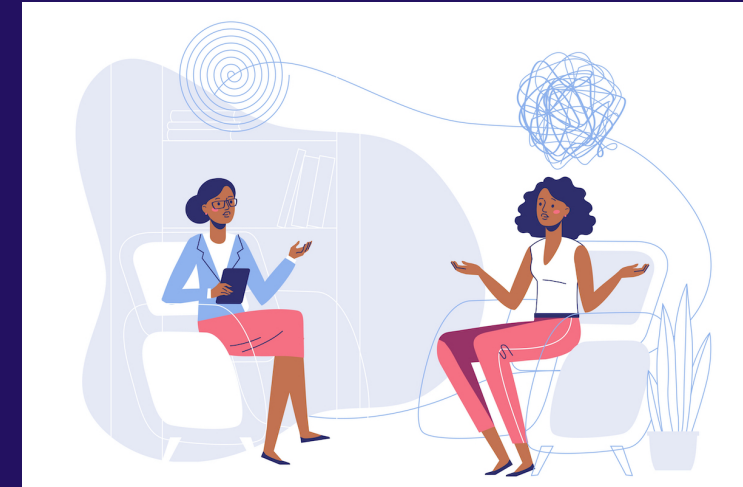
# Overlap of Physical & Mental Health



# Why Integrate?

## Barriers to Care:

- Transportation
- Stigma
- Language
- Time
- Unknown/Unfamiliar System
- Access



# Why Integrate? *Health Equity & IBH*

## Health Equity:

*all members of community have fair and just opportunity to be as healthy as possible*

## Health Disparities:

*preventable difficulties in access to care, quality of care & coverage for care*

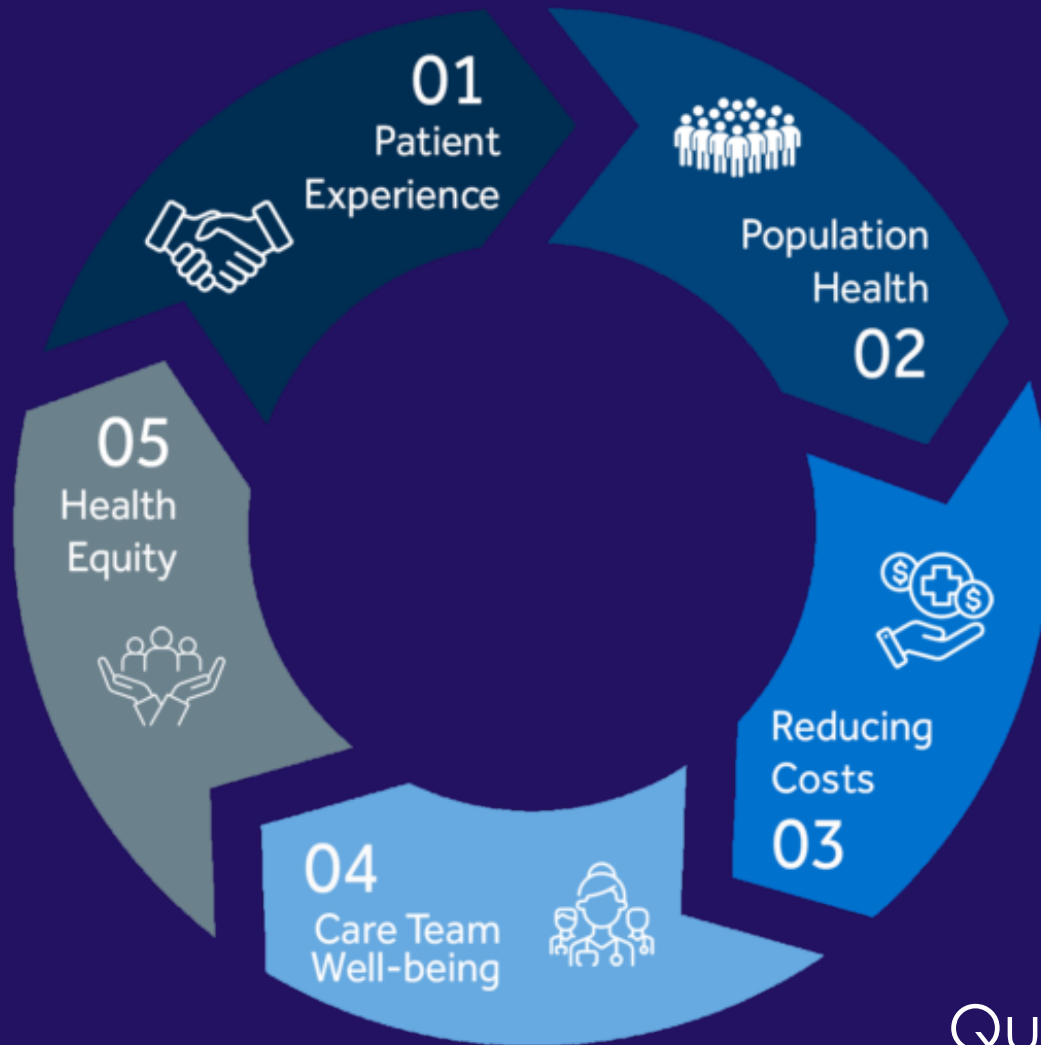
## How IBH Addresses:

*patient-centered care engages, informs, empowers patients & caregivers to participate in care while offering it in a way that is highly accessible and relevant*





# Why Integrate?



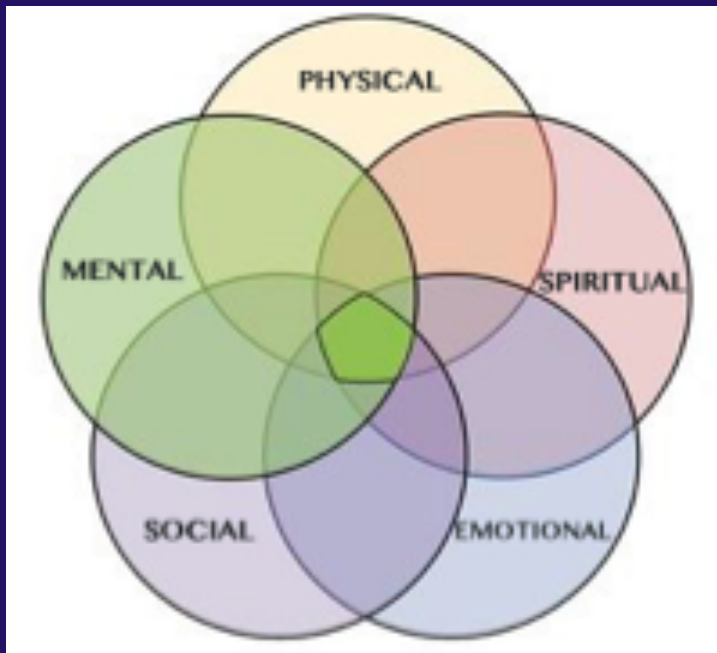
Quintuple Aim

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# IBH Models of Care

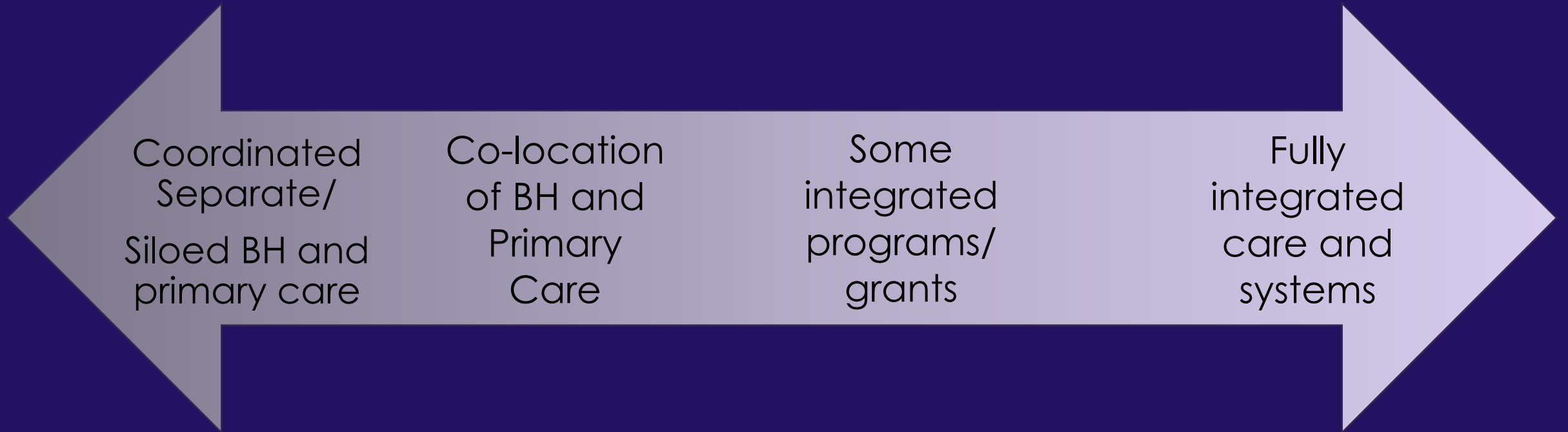
**Vertical Integration:** specific condition/population

**Horizontal Integration:** all conditions/populations



- **Primary Care Behavioral Health model** “*consultation*”
- **Co-Location Model** “*together but separate*”
- **Collaborative Care Model** – IMPACT model “*specific focus*”
- **Reverse Integration** “*we’ll go to you*”
- **Hybrid/Blended Models** “*do what works for your population*”

# The Continuum of Integration

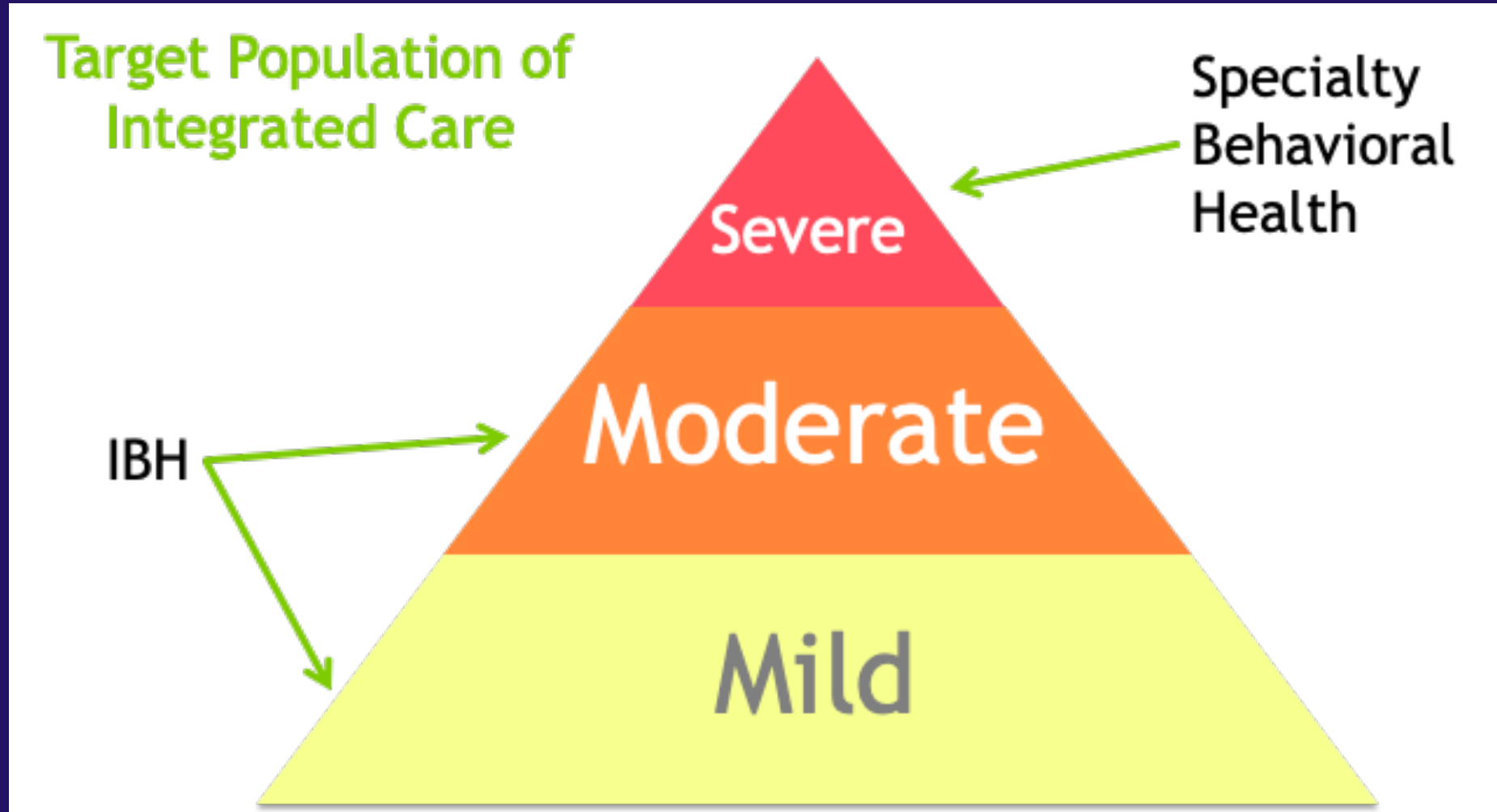


- *Integration level can move/change as programs, grants, initiatives change*
- *One agency/site may have various levels of integration*
- *Integration level/models should follow needs of population*

# IBH is One Part of the Puzzle of Care



# IBH & The System of BH Care



# IBH and “Stepped Care”

- Stepping “up” to a higher level of care when needed
- Stepping “down” to lower level of care when needed
- *Fluid Process*: Individuals move in/out of care as needed at any given time based on continuous assessment and patient feedback





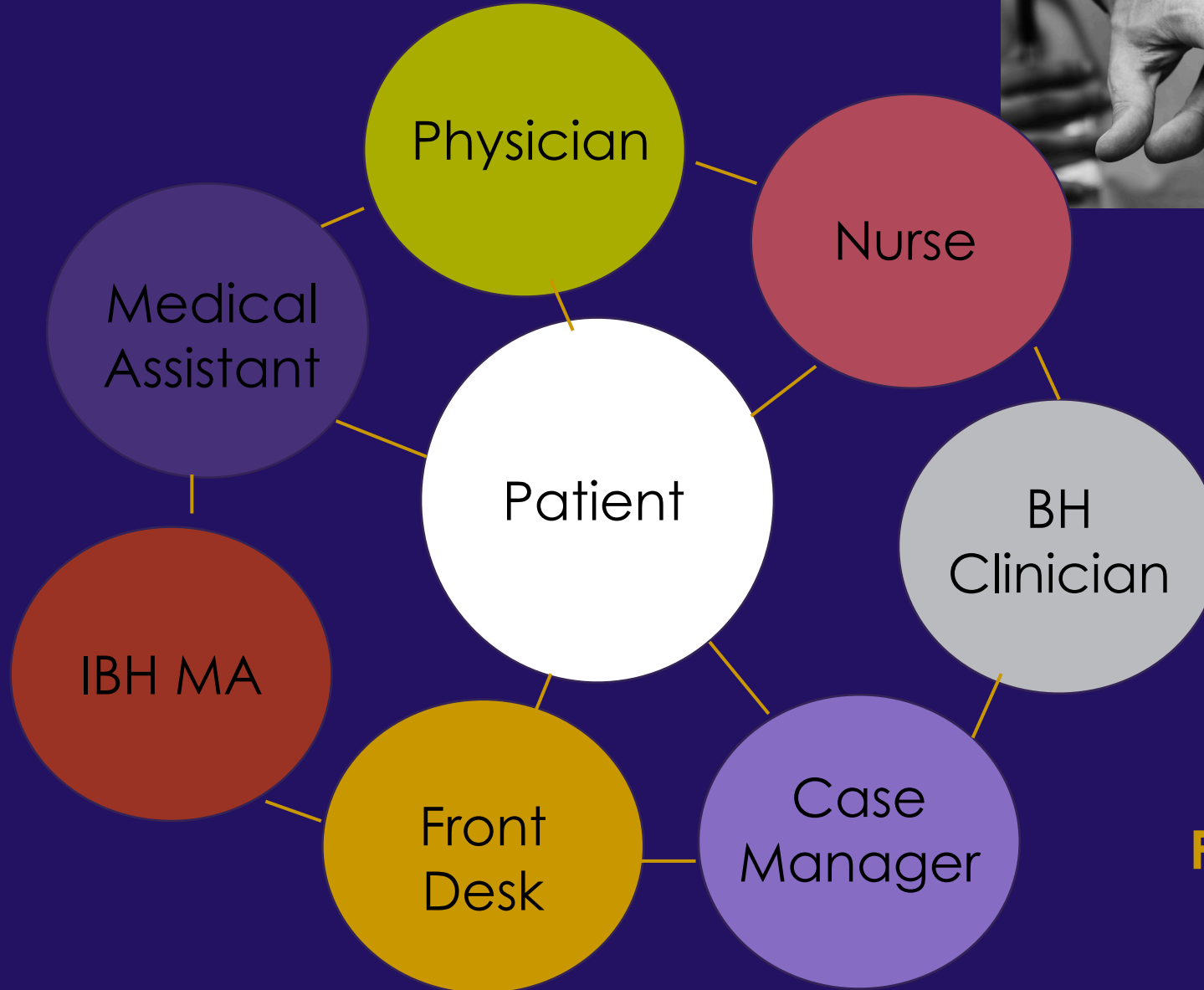
# How IBH Works on the Ground...

## General Structure...

- IBH Target = mild-moderate
- No “opening” cases – population-based care
- Higher severity: support linkage to specialty BH programs/services
- Episodic Care
- Crisis Support
- Adjunct group interventions
- Intergenerational and lifetime course/medical home concept



# Who is on the TEAM?



**Patient-Centered  
Care**

# How IBH Works on the Ground...

## Core Components of IBH

- **Universal Screening:** depression, substance use (other screening: trauma, partner violence, community violence)
- **Warm Hand-off:** bridge from medical to BH; extension of relationships and team-based care
- **Assessment:** bio-psycho-social-spiritual / whole person assessments with community contexts
- **Evidenced-Informed Treatments**
- **Shared Medical Records**
- **Population-based Care**
- **Social Determinants of Health**

# Universal screening

DETECTION  
PREVENTION  
INTERVENTION



## Why Behavioral Health Screening?

- Identify patients who need BH support
- Triage need
- Tracking symptoms and progress
- Practice standard; understood by all providers
- Psychoeducational tool for patients
- Gauging severity of symptoms; diagnostic info

*\*Note: standardized screening tools may not always work – be flexible!*

# Universal Screening

## Annual Screening:

*Federal guidelines mandate annual screening for **depression** and **substance use***

- **Depression:**

- Adults: Patient Health Questionnaire (PHQ-9)
- Adolescents: Patient Health Questionnaire -Adolescent (PHQ-A)

- **Substance Use:**

- UNCOPE +
- AUDIT (Alcohol Use Disorders Identification Test)
- DAST (Drug Abuse Screening Test)
- CRAFFT 2.0 +N (for adolescents)

# Additional Useful Screening & Assessment Tools

## Trauma Screening:

- PC-PTSD-5
- ACEs
- \*Maya Toolkit Screener (adapted)

## Relationship Safety:

HITS

## Anxiety Screening:

- GAD-7

## Additional Questions:

Newcomer Access

Panic

Psychosis



# BH Screening Flow

Medical Assistant  
Administers  
Annual BH  
Screening

```
graph LR; A[Medical Assistant Administers Annual BH Screening] --> B[Medical Provider reviews screen & discusses with patient]; B --> C[Medical Provider introduces IBH services and may warm hand off to IBH or schedule appointment];
```

Medical Provider  
reviews screen &  
discusses with  
patient

Medical Provider  
introduces IBH  
services and may  
warm hand off to  
IBH or schedule  
appointment

# Warm Hand Off/Warm Introduction

- Extension of **relationship** between medical provider and patient (*transfer of trust*)
- Team-based care & **communication**
- Framing IBH Role, **de-stigmatizing** behavioral health care
- **Autonomy** & Choice



# BioPsychoSocial-Spiritual-Cultural Assessments

- **Biological Factors:** medical history, diagnoses, chronic conditions, medications, family history
- **Psychological Factors:** behavioral health symptoms, symptom history, diagnoses, medications, treatment history, significant events that have impacted behavioral health (trauma, loss, etc)
- **Social Factors:** living situation, relationships, history of family relationships, social activity level, employment history, history of abusive relationships, strengths
- **Spiritual Factors:** spiritual beliefs, practices, affiliation with any organized spiritual or religious groups, impact of spirituality on health/wellness and medical decision-making
- **Cultural Factors:** cultural background, beliefs, practices, participation in cultural activities and traditions, cultural norms surrounding health, mental health, social roles, worldview, and cultural practices and resources

***\*\*\*Person In Environment  
Perspective***

# The IBH Clinician Toolbox

## Evidenced-Informed Treatment Modalities Commonly Utilized by IBH Clinicians

- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing (MI)
- Problem-Solving Therapy (PST)
- Solution-Focused Brief Therapy (SFBT)
- Dialectical Behavioral Therapy (DBT)
- Mindfulness-Based Stress Reduction (MBSR)
- Narrative Therapy
- Trauma-Focused Therapies
- Cultural Adaptations for various modalities



# Culturally Responsive Context in Care

## Social Context:

Social determinants  
of health  
Access to resources  
Post-pandemic  
landscape  
Immigration policies  
Community  
resiliency factors



## Cultural Context:

Concepts of  
“healing”  
Cultural resiliency  
factors  
Stigma  
Immigration status  
UIY populations

# What lense(es) are we using?

- *Indigenous healing philosophies are based on a “wellness” model, while the medical model can be based on “illness” model. [from “Decolonizing Trauma Work” - Renee Linklater]*
- How do we talk about “trauma” (intergenerational, multigenerational, a diagnosis or a context?) And awareness of misdiagnoses related to trauma events
- *Focus on strengths & resilience*
- *“Full person” assessments and interventions (cultural, spiritual, somatic)*
- *Cultural adaptations to EBP’s (evidenced-informed treatments)*
- What does your “clinical summary” say?
- *Multiple perspectives on “healing” and how we heal - allowing space for co-existing approaches*



# Questions for consideration...

- What does your [partner, family, child] think about this?
- How is [depression, anxiety, trauma] viewed by your family and/or community?
- If you were back with your family (in home country) how would you manage these feelings?
- What does it mean to be [use client language re: sad, anxious, upset] in your family/community? and/or What does it mean to you?
- What are you most proud of? What do you do well?
- What do you think is happening? Why do you think this is happening?

# The Patient Perspective: Alex

*Alex identifies as a 16 year old cisgender Guatemalan male who recently arrived to the U.S. from his home country. He crossed the border on his own and reunited with his biological father, who he has not seen for five years and is now living with him and his wife and children. Alex had to leave his home country due to community violence and threats to his safety. Alex is establishing care at a primary care clinic today as he needs immunizations to complete his school registration.*

- *As he is roomed for his medical visit, the clinic's medical assistant provides him with a behavioral health screen for depression, substance use and trauma.*
- *Alex scores high on depression and trauma screeners; the medical assistant alerts the primary care provider that screeners were positive*

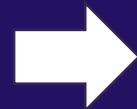
# The Patient Perspective: Alex

## **Medical Assistant:**

"We provide this screen for all of our patients"

"This screen asks about different aspects of your health"

"Only fill out what feels ok for you to share"



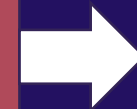
## **Medical Provider:**

[Provides informed consent]

"I'd like to talk to you about your responses"

"I work with someone who specializes in..."

"Would you be interested in..."



## **Medical Provider introduces IBH:**

"I work closely with [IBH provider] who is part of our team"

"Alex and I have been discussing..."

"We're hoping you can help with..."

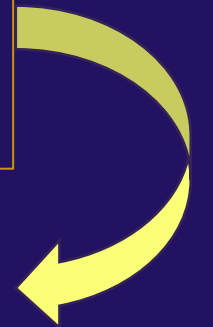
# The Patient Perspective: Alex

## After the warm hand off...

➤ IBH clinician meets with Alex and introduces IBH services + informed consent



➤ If Alex consents to IBH visit, clinician begins general assessment and/or any crisis intervention needed and exploration of options for further treatment/linkage



➤ IBH clinician loops back with primary care provider (through electronic health record or face-to-face) to update them on the IBH visit with Alex for coordination of care



# Care Context Considerations for Alex

## Cultural factors to consider:

- Family identification /culture
- Language
- Family role & reunification
- Cultural expectations and acculturation factors
- Self/family perception of BH treatment

## Social Factors to consider:

- Immigration context
- Exposure to trauma (pre/during/post immigration)
- Access to resources
- Family stress related to SDH and/or access to legal supports

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# Thank you!!



Questions Regarding the Equity and Justice Focused Integrative Behavioral Health Training Project can be directed to:

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