Behavioral Health Provider Perspectives on the Integration of Behavioral Health into Primary Care

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Research Objective: Integrated Behavioral Health (IBH) is a holistic care delivery model that encourages medical and behavioral health clinicians to work together as a team to provide whole person care, usually in a primary care setting. Despite success in some community health centers and Federally Qualified Health Centers (FQHCs), IBH has not been widely implemented in other primary care settings which have different business and clinical models. This study aims to identify implementation challenges, strategies, and leadership skills needed to successfully employ IBH more broadly.

Study Design: We conducted qualitative depth interviews with behavioral health providers working in different care settings in New Jersey, identified using purposeful snowball sampling. Immersion-crystallization review to assess thematic saturation was done during data collection, with the interview guide modified as needed. Editing style analysis to identify themes occurred in a group setting.

Population Studied: Interviewees (n=10, 100% response rate) included generalist Behavioral Health Consultants, specialized Behavioral Health Consultants, and Directors of Behavioral Health. They represented 7 organizations and worked in different care settings, including adult primary care, pediatrics, and women’s health. All were licensed clinical social workers, with an average of 6 years at their current organization.

Principal Findings: The key themes included: (1) IBH is an evolving discipline that is nascent, complex, and ambiguous, which some Behavioral Health Consultants strategically use as an asset to explain their role and purpose, (2) A major barrier to IBH implementation is physicians’ socialization and philosophy that leads to the separation of mental and physical care; dissolving this barrier requires a societal paradigm shift, (3) IBH is not readily accepted by most physicians and requires leadership endorsement in addition to mindset changing about the utility of the Behavioral Health Consultant one individual physician at a time, (4) The care setting impacts how readily IBH is accepted, with FQHCs being more receptive, (5) Use of the Behavioral Health Consultant may differ based on the perceived utility of a behavioral intervention for a given medical indication, and (6) Care is needed to distinguish Behavioral Health Consultants from the social worker label and role.

Conclusions: This study is novel because it focuses on the perspective of the behavioral health provider, who is often problem-solving during IBH implementations. Even with leadership endorsement, we found that all interviewees had challenges implementing IBH into their practices and had to develop strategies to “sell” the concept to the physicians. Our findings help in understanding existing impressions of IBH and identifying barriers and facilitators in the adoption of the model, particularly in non-FQHC settings.

Implications for Policy or Practice: For IBH to be widely disseminated, future physicians need to be socialized to the IBH philosophy early in their training. IBH training should also be offered as continuing education for practicing physicians and as a part of new employee on-boarding in primary care practices. Finally, leaders in the field of IBH need to make the Behavioral Health Consultant role less ambiguous.