REFLECTION

Integrating Behavioral Health and Primary Care: Turning a Duet Into a Trio

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ABSTRACT

Family physicians are at the front lines of mental health concerns and distress, yet often feel stymied in their attempts to fully support patients' biopsychosocial needs within the barriers of a fragmented health care system. This article describes a practice transformation designed to facilitate more empowered care experiences. We reflect on our interdisciplinary work as a family physician and a behavioral health consultant working closely together in a Primary Care Behavioral Health model within a university setting. We describe our collaborative approach to a composite character from clinical practice: a college student with symptoms of psychomotor depression who screened negative for mood and anxiety concerns. Akin to a musical ensemble, wherein the inclusion of each voice turns a solo into a symphony, we describe key details of interdisciplinary collaboration which promotes holistic care for patients and fulfilling biopsychosocial practice for us as colleagues.

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You don't get harmony when everyone sings the same note.

Commonly attributed to author and musician Doug Floyd, this quotation captures the spirit of collaboration that we feel when practicing integrated behavioral health in primary care. Together, in the 2010s, we (A.C.J. and K.R.L.) had the privilege of leading a group of approximately 20 medical and behavioral health professionals through a practice transformation of integrating behavioral health in primary care using the Primary Care Behavioral Health (PCBH) model.[1] Through this work, we became close collaborators. We examined our office protocols and workflows, developing performance dashboards and feedback surveys to iterate changes. We developed staff, co-leading trainings to promote positive working relationships between medical and mental health professionals. Most importantly, we shared patient care.

This essay uses a firsthand narrative, but the story is of a composite character developed from our years of shared clinical practice to describe the nuances and success factors involved in behavioral health integration in primary care.

Dr Jones

I walked out of the exam room and approached Dr Lilienthal's office just across the nurse's station. Her door was closed, but a sign said "In Session, But Knock If You Need." I gently tapped 3 times and she answered, with an assured and calm posture, inviting and welcoming.

"We have a patient—non-urgent, but a moment of opportunity. Do you have a few minutes to do a warm handoff?" I asked.

"I'll wrap this up and come find you." Dr Lilienthal answered, which I had come to appreciate as her consistently affirmative reply.

As I walked back to my patient, I reflected on her care to date. She was an 18-year old college student here for her third visit in just under 2 weeks. Her main complaints were fatigue and headaches. Her initial medical workup was negative for likely physical causes, yet she did not seem relieved by this, nor was she responsive to initial treatment suggestions for pain relief and sleep hygiene. Her patient health questionnaire (PHQ) and generalized anxiety disorder (GAD) screening were negative for mood and anxiety concerns, yet what she described in the exam room were all examples of psychomotor depression: trouble falling asleep, then sleeping for 10

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hours per day but never feeling rested; not feeling hungry, skipping meals, but getting ravenously hungry and eating too much. She joined several clubs when she came to school, but quit them all because her headaches were too problematic and she lost interest. With questioning, I discovered another reason for quitting the clubs abruptly was that she felt a burden after making a few minor mistakes with her club responsibilities. She just thought it was better to not be involved so she could focus on her classes—but try as she might, she couldn't seem to concentrate.

I asked her more about her headaches, the symptom that was particularly troubling to her that day. She described the pain as not really a pain—just a fullness—just in the way.

"A headache really doesn't describe it, because it's not really an ache, although it's on my forehead," she described. She went on. "It's like I'm walking around in a rain cloud all the time," she said. "Like, every day is a rainy day for me." The words came out of her mouth in an off-handed, almost casual, way. It struck me. She wasn't considering that her physical symptoms could be related to mental health, or if she was, she was not ready to directly acknowledge this.

As this moment hung in the air, I understood that I had options not available to most family physicians. In many family practice settings, the next steps would involve counseling or medication, both of which may take time to implement due to the need for referrals, access to appointments, and insurance process hurdles. It is also possible the patient would decline referral options, not experiencing her concerns as mental-health related. The unfortunate reality of the current health system imposes a choice between mental and physical health, while many patients may not ascribe to this strict dichotomy. The time it would take to overcome these systemic barriers, in addition to any hesitancy the patient faced, would rob valuable time from her progress, distancing her from necessary care. Moving from appointment to appointment without symptomatic improvement is classic fragmentation, one of the key drivers of increased cost and decreased quality in many facets of the health care system, and especially now within mental health.

In integrated behavioral health and primary care practices, clinicians are not just co-located, but operate through shared care, warm handoffs, and frequent consultation with mental health professionals. For today's patient—presenting with somatic symptoms, negative workup, yet persistent distress—a behavioral health consultant is available immediately. The opportunity to collaborate with integrated behavioral health clinicians often reminds me of a musical ensemble, wherein the contributions from others elevate my voice and make the whole ensemble better.

"Sometimes we can feel that something is wrong, but we can't figure it out, and while this is happening, we aren't truly thriving, are we?" I said to the patient. "I'm wondering if you'd be willing to think through this in a different way." She tentatively agreed. "I have a colleague who works with me in primary care who I think can be helpful. She is a doctor—within behavioral health—who helps in situations when we can't figure out a cause of someone's symptoms, but we want to help them function better." I explained.

"So you're saying this is all in my head?" she asked.

"No," I said, "I'm saying that when we can't quite figure out what is going on, it can be helpful to have another expert help with the diagnosis, and in the meantime help us feel and function better."

"Ok, do I have to make another appointment? I really don't have time to come back so many times," she commented. I explained to her that the doctor was in her office and could come to meet her right away.

Dr Lilienthal joined us 5 minutes later, and what began as a duet between the patient and me became a trio, with each of us bringing our knowledge into the room: Dr Lilienthal in behavioral health, me in holistic family medicine, and the patient as the expert in being herself.

Dr Lilienthal

When Dr Jones described her patient to me, I immediately appreciated a paradox all too common in primary care—a patient with much to gain from addressing their behavioral health needs, but hesitant to, unsure of how, or unable to seek this care directly. Knowing this reality, we worked to facilitate access to behavioral health through warm handoffs—immediate patient engagement initiated by a primary care physician through introduction of a behaviorist during a pre-established primary care visit. Primary care physicians at our clinic referred to me as a team member, or a trusted colleague, and were encouraged to knock on my door anytime they had a question. Even when my door was closed for a visit, it was metaphorically "always open" for a primary care physician to consult and potentially engage.

When I walked in, Dr Jones immediately set the stage for collaboration. Addressing our patient, she said "I hope you and Dr Lilienthal can brainstorm ideas for how to best manage your headaches," aligning immediately on the mutual goal she and the patient established with our patient. This allowed me to focus my support right away, on the area perceived as most helpful to our patient, which was key to her engagement.

"Dr Jones tells me your frequent headaches are keeping you from the social activities you planned for yourself during your first few weeks here. That is very hard for anyone, but especially as a freshman. Is this something you would like to talk more about today?" For the first time since I entered the room, her eyes looked at me directly, and she nodded earnestly.

Dr Jones stepped out, and from there, we talked about her transition to college, and the hindrance she was feeling due to her physical concerns. When asked directly about her mood, she admitted to being unable to experience pleasure where she once did—classic anhedonia—but resisted the label of depression, remarking, "I don't think that is quite it—I just wish I could sleep better and have more energy and that these headaches would go away." So, we started there.

Across visits, my role blended practical skills for sleep, headache management, and fatigue with education about depression, validation, problem-solving, and creating space to speak about deeper family pressures. If I pushed too far in a perspective that emphasized only mental health, she would bring me back to her functional and somatic limitations, and I would seize the opportunity to partner with Dr Jones around treatment options for pain and sleep. Nonetheless, she would return, and seemed most eager to talk about her pressures from home. Recognizing the relationship between her physical symptoms and her family pressures, I offered the patient a referral for traditional counseling, encouraging her to delve a bit deeper. She initially turned this offer down—"I don't need a therapist." But we kept meeting, and after a few additional visits and growing trust, she asked for help finding more regular counseling support. When she finally got established, I reflected on its importance for our patient population—the less we fragment, the more we help patients move fluidly within and across care systems. Our patient reinforced the unique harmonies that ascend from the trio between a patient, their family doctor, and a behavioral health consultant.

Dr Jones

Over the years, our patient returned to see "both of her doctors" as she referred to us, me focusing on her physical health needs, and Dr Lilienthal offering behavioral intervention. Sometimes she would make an appointment with one of us, who would settle the issue. Other times, she'd come in to see one of us, who would do a warm handoff to the other. In her final year, she came in for a transition appointment, and thanked us both for helping her get through college.

And then, with my hand on the doorknob, she said, "When I find a new doctor, I'm going to ask about an SSRI. I think it's time I call it what it is, Dr Jones: depression."

Dr Lilienthal

The ways in which integrated care is structured create an environment in which a patient can refer to a family physician and behavioral health consultant as "both of her doctors":

- The way the primary care and mental health clinicians address each other in the clinical setting, referring to each of us by professional title/role, cues the patient to envision their physical and mental health needs as equally respected.
- Keeping office doors open signals to each other that collaboration is the norm, and that none of us are "going it alone."
- Facilitating warm handoffs models for the patient how complex the mind-body connection can be, normalizes their experience, and ultimately results in their empowerment as an equal member of the care team.

When we work to implement behavioral health into primary care, we apply humanistic principles far upstream in the health care system. In so doing, we truly meet patients where they are, walking together with them, at their pace, toward mental health care more finely tuned to their needs.

Dr Jones and Dr Lilienthal

It is difficult to know what would have happened with this patient had we not engaged her in an experience of integrated behavioral health in primary care. Would she have decompensated and needed to take a leave of absence? Would she have developed an eating disorder? Would she have failed out? Would she have attempted suicide? Or would she have done just fine, as many college students do?

Over the course of her time with us, she learned to speak in the language of emotion and embrace the importance and complexity of mental health. At the same time, we learned that the most challenging situations are opportunities for collaboration, where the care is shared between colleagues who come from different disciplines, but connect deeply in the spirit of whole person care.

Access to mental health care within university settings and the community alike remains a conundrum, but a solution seems possible when we create the environment for collaboration between a patient, a primary care physician, and a behavioral health consultant. Not every primary care physician has the opportunity to orchestrate these connections. But for those who do, we encourage creating chords where you might be using simple melodies, assembling ensembles instead of solos, and empowering each expert on the clinical team—primary care physician, behavioral health consultant, and the patient—to find and use their voices harmoniously together.

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