Integrating Behavioral Health Services in a Student-Run Medical Clinic

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Abstract

Integrating behavioral health services into a student-run medical clinic serves multiple purposes. One primary goal of such an initiative is to address the mental health needs of uninsured individuals who are more at risk for mental illness and less likely to seek help than individuals with insurance. An additional objective is to create a venue to train future healthcare providers in integrated healthcare models. This article describes the process of developing and implementing a behavioral health service within a well-established student-run medical clinic. Within the article, issues related to workflow, types of behavioral health services offered, patient recruitment, and clinical supervision are described. The purpose of this article is to explore key lessons learned and to inform other individuals and institutions interested in similarly integrating behavioral health services into current student-run health clinic models.

Introduction

There are an estimated 43.6 million adults in the United States living with mental illness (18.1% of all US adults),[1] yet access to mental health services and stigma about receiving treatment continue to be barriers to care. Poor access to treatment is problematic because adults living with chronic mental illness have poorer health outcomes and, on average, die 25 years earlier than those in the general population.[2] Much of this morbidity and mortality is related to modifiable health risk factors, such as use of cigarettes, lack of exercise, substance use, and unsafe sexual practices.[2,3] Such issues can be addressed through integrated behavioral health interventions that promote healthy behaviors in patients, enhance patient protective factors, and target mental health concerns.[4] Integrating behavioral health into primary care has been shown to reduce access barriers and improve both mental health and quality of life outcomes.[5,6] Moreover, there has been increased awareness of the role that this integration can play in meeting the "Triple Aim" of enhancing the patient experience of care, improving population health, and reducing costs.[5-8] More recent attention to a fourth aim, improving the work lives of healthcare providers,[9] can also be addressed through integrating behavioral health into primary care. Specifically, primary care physicians report that approximately two-thirds of their patients with mental health needs are not able to access specialized care,[10] thereby requiring more time and resources from the physician. In this way, the presence of integrated behavioral services also has the potential to improve the well-being of the healthcare workforce. Taken together, it is imperative that practitioners continue to develop strategies for integrating behavioral health services into primary care settings to meet the needs of patients, providers, and the broader healthcare system.

In order to integrate behavioral health into primary care, it is important to train behavioral and medical health providers on how to collaborate appropriately in such models of care. However, limited formal training programs and practical experience opportunities are barriers to developing

this critical workforce.[11] Student-run medical clinics are an ideal venue for facilitating inter-professional training as they typically involve students from multiple disciplines working cooperatively to provide patients with a range of health-related services. While many student-run medical clinics integrate learners from disciplines such as medicine, pharmacy, dentistry, and social work, behavioral health services are typically not included within this framework. This paper outlines the process of establishing a behavioral health service within an existing student-run medical clinic. Specifically, we integrated a behavioral health service within the Student Health Action Coalition (SHAC) clinic, a student-run, free clinic based in Carrboro, North Carolina. This clinic aims to provide free health services to local underserved individuals, partner with communities to develop sustainable programs, and create an interdisciplinary service-learning environment for students at the University of North Carolina (UNC) at Chapel Hill. In addition to describing the program development and behavioral health services provided through this initiative, we discuss issues surrounding clinical supervision, patient recruitment and screening, crisis management, and meeting the needs of non-English-speaking patients within the clinic.

Program Development

Founded in 1967, SHAC is the oldest student-run free medical clinic in the United States and provides services for both acute and chronic medical issues.[12] The student leadership at SHAC observed that there was significant physical and mental health comorbidity within the patient population, but minimal structure and expertise to address such concerns within the existing infrastructure. As a result, the SHAC behavioral health clinic was created in order to address the unmet need of mental health services within this population.

Integrating behavioral healthcare into a student-run medical clinic required collaboration with new stakeholders as well as garnering strong institutional support. The first step was to consult a clinical psychologist on faculty at the Department of Family Medicine at UNC, the department that provides the clinical supervision for medical students within SHAC. This individual facilitated a

meeting with faculty from the UNC Department of Psychology to develop a supervision structure and recruitment process for clinical psychology graduate students interested in gaining clinical experience within a primary care setting. For the first year of the program, two advanced clinical psychology graduate students assisted in program development and provided behavioral health services at SHAC through an established practicum experience within UNC's Family Medicine Center. As the program entered its second year, the SHAC behavioral health clinic has become an independent practicum experience through the UNC Department of Psychology. In order to successfully implement this initiative, it was essential to develop strong relationships with psychologists familiar with integrated care, as well as with the Department of Psychology, so as to identify students who could fulfill the role of behavioral health providers.

Supervision

Clinical supervision of the psychology graduate students was provided through weekly face-to-face meetings with the clinical psychologist in charge of overseeing the practicum. The supervising psychologist was also available via phone for consultation if issues arose during encounters, such as treating a patient expressing suicidal ideation. In addition to providing mental health services at SHAC, the program was designed to provide interdisciplinary training opportunities for both medical and clinical psychology students. Within this collaborative spirit, students also received guidance related to patient care from the attending physicians present in clinic.

Patient Recruitment

SHAC is a well-known free clinic in the community and no formal advertising is needed to sustain a high volume of patients in the medical clinic; however, it was initially challenging to recruit patients to receive behavioral health services for various reasons. It was anticipated that medical providers at SHAC would refer patients to the behavioral health clinic when it appeared that they could benefit from those services. However, very few referrals were actually made through this ave-

Table 1. Screening Tool for Identifying Potential Behavioral Health Patients in an Integrated Student-Run Primary Care Setting

1. Are you concerned about any of the following... (circle all that apply)
   - Anxiety/panic
   - Depression
   - Insomnia/trouble sleeping
   - Substance use (drugs or alcohol)
   - Marital, parenting, or family problems
   - Remembering to take medications
   - None
   - Other _____

2. Would you be willing to discuss the concerns above with a provider?

   Yes   No

3. Over the past two weeks, how often have you been bothered by any of the following problems?

   (0) Not at all   (1) Several days   (2) More than half of the days   (3) Nearly every day

   Little interest or pleasure in doing things?

   Feeling down or hopeless?

4. Are you currently being seen by a mental health provider?

   Yes   No

nue, likely because medical providers received limited training regarding which patients were appropriate candidates for behavioral health services. In order to more systematically identify patients, a 4-item screening tool was developed for all patients to complete during the clinic check-in process, regardless of the patient's chief complaint (Table 1). The screening tool inquires about different psychological symptoms that a patient may experience and includes the two-item Patient Health Questionnaire[13] that assesses depressive symptoms. The screening tool also assesses for a patient's interest in discussing their noted concerns with a clinic provider as well as whether or not a patient is currently receiving mental health treatment elsewhere. Any patient who had a "positive screen," defined as reporting a psychological symptom or concern and expressing a willingness to address the issue with a provider, was offered a brief consultation with a behavioral health provider during their appointment and scheduled for an initial intake appointment if interested. As the clinic has become more established in the community, referrals were also received from providers at outside medical clinics who had learned about SHAC's services. Moreover, members of the community who were not established patients at SHAC also presented to the clinic to access the behavioral health services offered. Over time, the SHAC behavioral health clinic has built a favorable reputation within the community and recruits patients via word of mouth, as well as through the clinic-wide screening process.

Services Provided

In order to accommodate the needs of a high-volume primary care clinic with only one or two clinical psychology providers operating on a given night, a consultation and brief intervention model of care plan was implemented. Therapy was typically problem-focused, consistent with the brief psychotherapy model.[14] Other therapeutic techniques that were utilized include motivational interviewing, health behavior change counseling skills, as well as broad cognitive-behavioral therapy skills, which have demonstrated efficacy in integrated primary care settings.[15] Patients typically began treatment with a one-hour intake session to determine if their behavioral health concerns were within the clinic's scope of treatment, which primarily includes addressing mild to moderate depression, anxiety, substance use, or interpersonal issues. If, based on the intake appointment, it was determined that a patient was outside this scope of practice, the patient was linked to community resources offering a more appropriate level of care. Up to ten follow-up sessions, which

Table 2. Demographic Characteristics of the Medical and Behavioral Health Encounters at SHAC (N= 780)

Characteristic	N	% of Responses
Gender		
Female	391	50.1
Male	389	49.9
Race		
White (Caucasian)	297	60.0
Black or African-American	125	25.3
Asian	61	12.3
American Indian or Alaskan Native	10	2.0
Native Hawaiian or other Pacific Island	2	0.4
Did not respond	299	
Ethnicity		
Not Hispanic/Latino	444	56.9
Hispanic/Latino	336	43.4
Education		
Less than high school	135	20.5
High school diploma/ GED	181	27.5
Some college	152	23.1
Completed college	128	19.4
Beyond college	63	9.6
Did not respond	121	
Employment		
Unemployed	245	36.7
Part-time	156	23.4
Full-time	166	24.9
Student	77	11.5
Retired	24	3.6
Did not respond	112	

Note: This data describes demographics across individual clinical appointments, not individual patients. Individual patients may be represented more than once. Data range: October 2015 - September 2016.

ranged from 30 to 60 minutes, were offered depending on patient need and provider availability.

Demographic data on the patients attending SHAC are provided in Table 2. Given that specific demographic data for patients using the behavioral health service were unavailable, this demographic data represents patients who were seen at SHAC for any services (e.g., medical, behavioral health, HIV testing, etc.). Examining the broader clinic demographic data suggest that many patients identify as racial or ethnic minorities, have up to a high school education, and are unemployed. It is notable that between 14 - 38% of encounters did not have the key patient demographic information completed, suggesting a need for a more robust data collection system within the clinic.

Although demographic data for the behavioral health service was not collected, other measures were collected within this service over the first 13 months of operation. SHAC patients completed a total of 273 behavioral health screeners and 158 patients (57.8%) did not endorse any items. Of the remaining 115 screeners, 54 patients met criteria for a "positive screen." During this time, the behavioral health service provided care for 38 patients, which suggests that approximately 70% of patients who identified a behavioral health concern and were interested in treatment were able to see a provider. The number of treatment sessions ranged between 1 and 10, with 24 patients completing only one session at the clinic. For patients who attended more than one session (n = 14), the average number of sessions attended was 4.71 (SD = 2.61). There were a number of reasons that emerged for patients only completing one treatment session. The most common reasons included not being eligible for clinic services due to greater severity of psychopathology, patients missing scheduled appointments, and one session was sufficient to address patients' concerns. Among these reasons, patients missing their scheduled appointment was the most common reason for only completing one treatment session, with 42.8% of patients missing their scheduled follow-up appointment after visiting the clinic once for behavioral health needs.

Meeting the Needs of Non-English-Speaking Patients

Spanish speakers constitute 38% of SHAC's patient population. Developing ways of providing psychotherapy services to this population was a priority, as none of the clinic's primary clinicians were or are fluent in Spanish. Given the sensitive nature of clinical work, and the general importance of trust and rapport with clients, it was necessary to identify means of interpretation that would maintain the integrity of therapy, while still being feasible in a free, student-run clinic.

In order to meet this need, the clinic employed two different strategies: using a student interpreter and conducting co-therapy with a fluent, Spanish-speaking first-year student in the clinical psychology doctoral program. The interpreter was a post-baccalaureate student who was fluent in

Spanish and had worked as an interpreter in a medical research setting. Importantly, because the interpreter did not have formal training in the domain of clinical psychology, he interpreted all exchanges word-for-word so as not to unintentionally intervene in the therapeutic process. Moreover, the decision to have only one interpreter on the behavioral health team was meant to facilitate continuity of patient care, as opposed to using rotating interpreters provided by the SHAC medical clinic. In other cases, co-therapy was conducted with a fluent, Spanish-speaking first-year clinical psychology graduate student. This provided a clinical training opportunity for the junior graduate student to practice basic clinical skills. Within the co-therapy model, the Spanish-speaking graduate student was encouraged to take more of an active role during therapy. Additionally, a stepwise supervision model was also used for co-therapy, whereby the advanced graduate student provided supervision to the junior student, and the advanced graduate student in turn received supervision from the licensed clinical psychologist. Overall, this model served as a unique training experience for both graduate students while also meeting the needs of non-English-speaking patients at SHAC.

Interdisciplinary Training

While the primary aim of the behavioral health initiative was to offer mental health services to the community, an important secondary aim was to provide an interdisciplinary training opportunity for the students involved. Working as part of a medical team allowed clinical psychology students to develop consultation skills and competencies that are essential in team-based medical settings. In turn, medical students gained a better understanding of the presentation of a range of psychopathology. And, students provided treatment to patients from a variety of socioeconomic, racial, and cultural backgrounds, an opportunity that does not exist in many other training environments. Thus, serving in this role helped to increase graduate students' exposure to a wide patient population as well as better understand the essential role of psychologists in integrated primary care settings.

Considerations and Lessons Learned

Developing a behavioral health service within a free, student-run medical clinic posed certain challenges, which we hope to highlight for others interested in developing a similar initiative. One of the initial major challenges was patient recruitment. Implementing the universal patient screening process during the initial paperwork procedures greatly increased the number of identified patients in need of services, which allowed us to utilize the available student workforce. It has continued to be important for us to engage the other staff at the clinic and remind them of the behavioral health services offered. For example, some volunteers responsible for patient check-in were unaware of the behavioral health service months after services began, which created confusion and difficulties for patients trying to check in to receive these services. Because SHAC has over 60 volunteers each night, many of whom volunteer only occasionally, it has been necessary to regularly communicate with each volunteer unit.

The elevated no-show rate within the clinic was another issue that arose. Although there is much evidence to suggest that high rates of treatment dropout are common in community mental health centers,[16] it may have been that some of the clinic's practices contributed to the low follow-up rates. Specifically, patient appointments were scheduled a week beforehand, typically in-person at the end of a session, and patients did not receive any reminder notifications prior to their visit. To address these shortcomings, a text message based appointment reminder system was implemented, which allowed patients to confirm or cancel appointments from their phones the day of clinic. With more advanced notice of patient cancellation, patients were scheduled from a waitlist in order to fill available provider time, thus maximizing staff resources and increasing patient reach. Once patient volume increased, a behavioral health clinic coordinator was added to the team, whose primary responsibilities were calling potential patients and scheduling appointments. This also resulted in more time for the provider to focus on patient care and provide direct clinical services. Finally, while the presence of Spanish-speaking graduate students represents a strength of this

clinic's model, there may be times when the graduate student volunteers do not speak Spanish. In these times, we plan to we plan to conduct therapy with a non-psychologist interpreter, which is also an evidence-based method for improving communication and client-provider relationships.[17]

Next Steps

One important goal of the SHAC behavioral health service that was difficult to meet was fostering an interdisciplinary environment between the medical students and clinical psychology students so that both could learn about the interface of mental health needs in a primary care setting. We envisioned clinical psychology student providers joining the intake teams for new medical patient evaluations, where the provider teams usually consist of medical, pharmacy, and social work students. However, it was logistically difficult for the clinical psychology students to join medical teams due to the shortage of clinicians available to provide direct psychotherapy. That said, such a collaboration represents an important training goal for the SHAC clinic as a whole and could be achieved by having a dedicated role fulfilled by a clinical psychology student. We hope to implement this integration in the coming year.

Finally, with the infrastructure in place, the behavioral health service is well-positioned and ready to begin to evaluate the efficacy of its services. Our aim is to track changes in patients' symptoms, examine patient satisfaction with the clinical services received, and possibly link patients' participation in therapy to their medical outcomes. Acquiring this data will help us to better understand the impact of the behavioral health service as well as lend further support for the role of integrating behavioral health in primary care settings.

Conclusion

Overall, the goal of this paper has been to offer a guide for integrating behavioral health services into an existing primary care medical setting in the context of a student-run free clinic. Given the well-documented need for behavioral health services, as well as the many constraints placed on

clinics across the country, including student-run clinics (e.g., lack of funding, new trainees), we believe that describing these experiences, the barriers faced, and the lessons learned will be of service to other organizations considering pursuit of a similar endeavor. This has been a very rewarding undertaking and our patients continually share the many ways that this service has been helpful; we look forward to corroborating their experience with data in the near future.

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