Integrated care psychologists and their role in patient transition from medical to psychiatric specialty care settings: a conceptual model

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Psychologists’ participation within integrated primary and specialty medical care settings continues to expand and the benefits to patients, caregivers, and multidisciplinary healthcare teams are well described in the literature. However, specialty psychiatric care referrals are still necessary, particularly for patients with severe and persistent mental illness or other individuals whose psychiatric illness requires treatment of an intensity and duration that is often not practical in integrated care settings, and/or those not improving based on interventions available in the context of their medical care. A complex and interacting set of systemic, provider, and patient barriers can make the transition from integrated care to specialty psychiatric care arduous, resulting in decreased patient motivation for care, frustration by referring providers, and delayed or failed attempts to transition the patients to a level of care better suited to their needs. Integrated care psychologists have an opportunity to facilitate this transition when necessary as part of their work with patients, although guidance is lacking regarding an evidenced-based conceptual approach for their role in doing so. To this end, the purpose of this article is to describe the ACCESS model, a conceptual framework and set of evidenced-based strategies that evolved through years of “trial and error” within several integrated care clinics to facilitate successful transitions into psychiatric care when needed. The aim of each component in the ACCESS model, research evidence for suggested interventions within each component, and examples of clinical implementation are presented. Implications and limitations of the model’s applicability across integrated care settings and within different patient populations are discussed. Formal evaluation is needed to assess the relationship between psychologists’ use of ACCESS strategies and engagement and retention in specialized psychiatric care, psychiatric symptom severity, patient satisfaction with care, and health outcomes.

Keywords: integrated care; care continuity; health psychology; collaborative care; referral

1. Introduction

Psychologists continue to experience a rapidly expanding and increasingly integrated role within primary and specialty medical settings (i.e. oncology, HIV, and pain) in the USA and internationally (Bray, 2004; Fann, Ell, & Sharpe, 2012; Farber et al., 2012; Gatchel, McGeary, McGeary, & Lippe, 2014; Setiyawati, Blashki, Wraith, Colucci, & Minas, 2014). Although there is considerable variation with regard to psychologists’ responsibilities, level of integration, and relationship to the healthcare team (Heath, Wise Romero, & Reynolds, 2013), active participation by
psychologists in healthcare settings has advantages for patients and providers (Butler et al., 2008). For instance, patients report preferring an integrated care model, which is often more convenient and can reduce patient and family burden as well as the stigma attached to mental health care when it is carved out from physical healthcare settings (Pomerantz, Cole, Watts, & Weeks, 2008). For members of the healthcare team, having ease of access to psychological providers to facilitate, among other things, (1) decreased burden on the medical provider who often spends significant time managing the emotional well-being of their patients; (2) improved follow-through on common patient concerns such as depression and anxiety; (3) shared understanding of the relationships between emotional wellness, sociocultural factors, and health outcomes; (4) increased non-mental health provider knowledge about evidence-based psychotherapies and their application; and (5) buffering team members from burnout and compassion fatigue (Alschuler, Hoodin, & Byrd, 2008; Amiel & Pincus, 2011; Bluestein & Cubic, 2009), and consequentially to these factors, (6) can engender provider buy-in. For effective integration, practice modifications conducive to the medical environment frequently involve psychological assessment that is targeted, problem-focused, and suited to interventions that may be more narrow in scope and briefer in duration, frequency, and session number than in traditional psychotherapy settings. Similarly, documentation is succinct and concentrated on findings and recommendations most useful to a diverse care provider team (Haley et al., 1998). For medical providers, the tailoring of psychological services to the medical culture can increase familiarity with and acceptance of the process. And for patients, this model provides increased access to psychological services, especially for underserved populations, and an opportunity to receive brief interventions for emotional and physical distress (Stepleman, Hann, Santos, & House, 2006). Despite numerous advantages to the integrated care model, there continues to be an ongoing need for specialty psychiatric care from psychiatrists, psychologists, and other licenced mental health providers, especially for patients with serious and persistent mental illness, multiple comorbidities, and/or diagnoses such as post-traumatic stress disorder (PTSD) or borderline personality disorder, where multifaceted evidenced-based treatment protocols and lengthier treatment duration are often needed but cumbersome and impractical in the context of a medical clinic (Comer & Barlow, 2014). Although the diverse practices of psychology within traditional outpatient psychiatric settings have been meticulously described and the adaptation of these practices to medical settings increasingly well-defined (Pomerantz et al., 2008), there is little discussion on how psychologists in integrated care settings can best facilitate a patient’s transition to specialty psychiatric care when needed.

Assisting patients with transition from one type of care clinic to another, especially within a single healthcare entity, may appear to be a relatively straightforward process; however, there is a body of evidence to support that in actuality it is often inefficient and ineffective (Bodenheimer, 2008). A variety of interacting systemic, provider, and patient factors can contribute to the complexity of this problem. For example, if a specialty psychiatric care clinic has a reputation for long wait times for a new patient appointment, this might decrease a referring provider’s inclination to act expeditiously on the patient’s behalf during a busy clinic (Hartley, Korsen, Bird, & Agger, 1998; Koch & Iliffe, 2010). Even if an appointment is secured, long wait times to first appointment for specialty mental health care have been shown to reduce patient motivation, especially for those already ambivalent about treatment, and decrease the likelihood of attendance (Gallucci, Swartz, & Hackerman, 2005), which can serve as a barrier to future care depending on a clinic’s policies around missed appointments. In fact, approximately 40% of patients referred from other care clinics for psychiatric care refuse or do not attend their initial intake appointments (Oldham, Kellett, Miles, & Sheeran, 2012; Sparks, Daniels, & Johnson, 2003). These numbers are even higher for patients who experience chronic healthcare disparities, such as individuals who are racially and ethnically diverse and/or from low socio-economic backgrounds (Defife,
Conklin, Smith, & Poole, 2010). However, mental health care continuity is crucial, having been linked to patient quality of life indicators such as physical and mental health, symptom severity, and satisfaction with care (Adair et al., 2005).

2. Development and implementation of the ACCESS model

Psychologists within medical settings have an opportunity, if not an obligation, to ensure patient transition into specialty care settings when necessary, although guidance is lacking regarding an evidenced-based conceptual approach for their role in doing so. Within the context of an academic health centre located in the southeastern region of the USA, the lead author and a rotating team of psychology residents and postdoctoral fellows (including the second and third authors) have been developing, refining, and implementing a team-based model of psychological consultation, triage, and intervention services integrated into several medical clinics, including Infectious Disease (HIV) and oncology clinics as well as a multiple sclerosis centre. Due to the demographic makeup of the region and specifically the population served by our health centre, the vast majority of clinic patients, particularly within the Infectious Disease clinic, have significant health disparities as individuals who are majority African American, live at or below the poverty line, and frequently are affected by intersecting health, mental health, and substance abuse problems. In an examination of our triage process within the Infectious Disease clinic, we found that only 43% of individuals referred to specialty psychiatric care attended their first appointment, with racial minorities more likely to miss these intake appointments than their white counterparts despite being referred at rates consistent with the clinic’s racial and ethnic diversity (Bottonari & Stepleman, 2010).

Making the decision to seek specialty psychiatric care can be anxiety-provoking for patients, especially for those naïve to mental health care or with negative past experiences in mental health services or internalized mental health stigma (Corrigan, 2004; Jorm, 2012). After considering the personal, provider, and systemic barriers for our patients, drawing from the literature, and our years of “trial and error”, we created the ACCESS model (see Figure 1). The ACCESS framework, philosophically and practically, applies a biopsychosocial cultural approach to understanding patients and their unique strengths and barriers to care. In using the biopsychosocial cultural approach, we consider each individual relative to (1) physical factors such as current physical functioning and limitations, health comorbidities, medications, and biological predispositions to mental illness and substance abuse; (2) psychological factors including current and past emotional health, coping strategies, personality, motivation, and intellectual capabilities; (3) social factors including family relationships, social stressors and supports, engagement in school, work, and other activities, and access to care; and (4) cultural factors including religion and spirituality, acculturation level, cultural values, beliefs, practices, and traditions, especially in relation to help utilization. Within this context, we implement an evidenced-based approach of best practices for identifying patients in need of psychiatric specialty care and intervention strategies that anticipate likely barriers to care transition and collaborative problem-solving to resolve them. For our purposes, an evidenced-based approach means that each model step has theory and data offering support for usage in this context.

Ideally, all steps of the model occur within a single 15–20-minute consult during the patient’s medical visit, although the focus and outcome of the steps vary dependent upon a patient’s readiness to engage in services; additional follow-up by phone with the patient (e.g. to facilitate scheduling of an appointment) or medical provider from the integrated clinic (e.g. to provide feedback on the status of treatment plan) also occurs. In-person follow-up with the patient is also common at subsequent medical appointments, particularly if he or she was not ready to engage in services at the last meeting or has not established psychiatric services as planned by that time, the process
Assess patient’s psychological needs

Aim: To identify patients’ current psychosocial needs through screening and brief assessment.

Consider patient’s level of motivation and other relevant factors

Aim: To determine, through brief assessment, the patient’s current level of motivation to enter treatment, severity of psychiatric symptoms, patient individual and/or cultural preferences, and other factors relevant to accessing treatment in order to most appropriately intervene and establish a plan for care.

Create sense of hopefulness

Aim: To generate hope that change is possible and that this change would have a positive impact in the patient’s life.

Establish short-term symptom management plans

Aim: To provide patients with evidence-based strategies and build self-efficacy for managing symptoms using naturally occurring strengths and supports.

Strategize around possible barriers to care

Aim: To pre-emptively address barriers to engaging in care to increase the likelihood of attendance.

Smooth transition into care

Aim: To capitalize on patient motivation to enter treatment, as well as demonstrate that providers are working as a team in the service of patient care.

Figure 1. Access model.

can be repeated. We describe herein the evidenced-based model components, examples of how they are actualized within our clinic setting, and next steps for implementation and evaluation.

2.1. Assess patients’ psychological needs

Aim: To identify patients’ current psychosocial needs through screening and brief assessment.

Patients often do not explicitly have their mental health needs at the forefront when seeking care from a physician for medical concerns; yet, research has identified that physicians in primary care and other medical settings spend a significant amount of time trying to care for the emotional well-being of their patients (Amiel & Pincus, 2011). Although these issues sometimes are revealed through the patient’s set of physical complaints, direct inquiry and the use of validated screening instruments during medical appointments provide the opportunity to accurately
identify, educate, and collaborate around treatment needs (Kush, 2001). Depression screening is among the most common evidence-based mental health practices adopted by primary and specialty medical care clinics and endorsed by organizations such as the Centers for Medicare and Medicaid Services (2011), American Psychological Association (2009), and the US Preventive Services Task Force (2009) (though the latter qualifies their recommendation, stating that evidence is strongest for adults and only when adequate supports are present for triage and follow-up). Psychometric evidence, practicality, efficiency, and clinical utility are primary considerations for screening instrument selection and implementation (Kush, 2001).

Our clinics utilize a two-part screening instrument: an author-derived checklist of typical behavioural health concerns (e.g. sleep improvement, smoking cessation, difficulty taking medication, depression, anxiety, and stress) followed by brief validated screening tools for depression (Patient Health Questionnaire-2; Kroenke, Spitzer, & Williams, 2003), substance abuse (the Two-Item Conjoint Screen; Brown, Leonard, Saunders, & Papasouliotis, 2001), and trauma (Primary Care PTSD Screen; Prins et al., 2004). The checklist, in particular, is intended to facilitate patient health literacy around the array of medical, psychological, and social issues in which a mental health provider might assist. Additionally, by allowing patients to self-identify areas for consultation, it provides an opportunity for patients to take “ownership” of their emotional well-being (see Stepleman et al., 2006, for further discussion). A positive screen (designated as such by meeting a clinical cut-off score on any of the three screening tools) or endorsement of any behavioural health areas of concern prompts a brief consultation for further assessment. Although patients frequently screen positive for one or more mental health concerns that are further confirmed through additional assessment, a wide chasm may still remain between a patient acknowledging the need for help and being ready to engage in help, making consideration of additional patient factors beyond need vital to this process.

2.2. Consider patients’ level of motivation and other relevant factors

Aim: To determine, through brief assessment, the patient’s current level of motivation to enter treatment, severity of psychiatric symptoms, patient individual and/or cultural preferences, and other factors relevant to accessing treatment in order to most appropriately intervene and establish a plan for care.

When an individual is determined to have psychological needs through the screening and consultation process, patient and providers work together to set goals and formulate a treatment plan. In this collaborative process, level of motivation, psychiatric symptom severity, history of treatment, current health, and barriers to care are considered in determining the appropriateness of referring to an outside provider for psychiatric care, returning for brief therapy in clinic, consulting with the patient’s medical provider about initiating psychotropic medications, or providing initial psychoeducation and reassessing at the next medical appointment. For example, whereas a patient presenting with new onset symptoms of depression may be started on an antidepressant medication with follow-up to reassess symptoms and the need for specialty care, an individual presenting with severe symptoms and a history of not responding to antidepressant medications may be referred to specialty psychiatric care imminently (Schulberg, Katon, Simon, & Rush, 1998).

With any intervention, collaborative goal setting prepares patients to take an active role in self-management of their symptoms and can increase treatment adherence (Yeung, Feldman, & Fava, 2010). It involves an intentional practice by the provider to engage the patient and elicit and make room for patient preferences, beliefs, and concerns (Chinman et al., 1999; Osborn, West, Kindsvatter, & Paez, 2008). Incorporating patient preferences further reduces the likelihood
of treatment refusal (Oldham et al., 2012). This is particularly noteworthy given the health disparities in access to mental health treatment and cultural differences in preferences for types of treatment (Cooper et al., 2003). Goal setting also can incorporate caregivers or significant others who are present during the consultation with patient permission. Social networks have been recognized as important factors in identifying and attributing presenting problems to psychological disorders and then encouraging individuals to seek mental health care (Saunders & Bowersox, 2007), and social norms applied by these networks are implicated in health behaviour change more broadly (Ajzen, 1991). For example, patients may choose to include partners as sources of reinforcement in attempts to quit smoking or may want the partner to accompany the patient at the initial intake appointment to provide emotional and/or instrumental support.

After an individual has identified a need for mental health treatment and reviewed the options with a provider, it is important to determine the patient’s motivation to enter treatment. Though resources may be available, patients often cite lack of motivation as a principal factor in not following through with a referral. For example, among individuals abusing substances, nearly 70% of patients who identify a need for treatment ultimately do not make an effort to receive it, and of those, 39% reported that they were not ready or motivated to stop using (Substance Abuse & Mental Health Services Administration [SAMHSA], 2012). Thus, intervention strategies used and referrals provided during consultation depend on the patient’s current level of motivation to change.

The transtheoretical model of behaviour change (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992) has been supported in the literature as a useful model for conceptualizing a patient’s readiness to change health behaviours, particularly with regard to entrance into addiction treatment (DiClemente, Schlundt, & Gemmell, 2004). It is perhaps most useful for understanding and intervening with patients in the early stages of change (Prochaska, 2008).

Our consultation team typically begins the assessment of readiness to change using a standard question set forth in the motivational interviewing (MI) literature (Rollnick & Miller, 1995): “On a scale of 1 to 10, how motivated are you to enter treatment?” If a patient responds with a higher level of motivation, he/she would be referred to treatment at that time and engaged in problem-solving around any potential barriers to care. When a patient responds with a lower level of motivation, he/she would be engaged in a discussion around the pros and cons of entering treatment, providing the patient the opportunity to reflect on and express his/her hesitancy around change, without judgement on the part of the clinician. The patient is also afforded opportunity to examine the consequences of current behaviours. If experiencing depression, a patient may acknowledge the detrimental impact of these symptoms on personal goals and/or values, thus allowing the patient’s own examples to draw motivation. This is important especially given the literature on self-determination theory suggesting the importance of internal motivation with regard to willingness to change (Deci & Ryan, 1985, 2000).

As part of this conversation, the clinician would address the patient’s concerns about treatment, which often include stigma around mental illness. Relevant psychoeducation also is appropriate here. Assessing the patient’s knowledge of mental health concerns and treatment options and providing education around symptoms and treatment can reduce some of its mystery and correct misinformation the patient previously may have learned.

For patients not ready to enter treatment, the clinician may provide contact information for the patient to seek future treatment, but would not schedule for specialty care during the consultation, both to respect the patient’s current readiness for change and to empower patients to actively make decisions about their treatment, as well as to decrease the burden on the system. Using a developmental approach, the clinician would plan to follow-up with the patient at subsequent clinic appointments, building patient familiarity with mental health providers and treatment through
brief interventions relevant to patient concerns (i.e. mindfulness exercises for stress, pleasurable activity planning for depression) and then reassessing for readiness to change.

2.3. **Create sense of hopefulness**

Aim: To generate hope that change is possible and that change can have a positive impact in the patient’s life.

Hopefulness and hopelessness are important constructs to assess during a clinical consultation. Research suggests that hope, patients’ beliefs about treatment success, and wait time are associated with the likelihood to attend the initial appointment and that hope is associated with outcome expectations (Swift, Whipple, & Sandberg, 2012). In fact, hope is considered to be a necessary component of mental health recovery (Schrank & Slade, 2007). Hopelessness, on the other hand, is a significant predictor of suicide attempts and, therefore, is considered a warning sign for future attempts (Klonsky, Kotov, Bakst, Rabinowitz, & Bromet, 2012; Rudd et al., 2006). Thus, assessing a patient’s current level of hope can guide decision-making around intervention and referral (e.g. whether a referral is appropriate or more immediate safety planning is necessary).

The consultation team may assess hope verbally or via a patient self-report measure, such as the Beck Hopelessness Scale (Beck & Steer, 1993). It then may be appropriate for the clinician to take a values-focused approach to generating a sense of hopefulness. Patients may find a list of common values, such as those used within the context of Acceptance and Commitment Therapy (Hayes & Lillis, 2012), helpful to determining values of most importance. Once a patient has identified his/her values, a brief discussion highlighting potential discrepancy between stated values and actual behaviours can help the patient better understand the source of his/her current level of distress and identify opportunities to better align his/her values and behaviours to improve mental health (Strosahl, Robinson, & Gustavsson, 2012).

A related mechanism for helping to generate hope is to guide the patient in considering how his/her life would be different if he/she received treatment and felt better, similar to using the “miracle question” from the solution-focused therapy literature (Gingerich & Eisengrat, 2000; de Shazer et al., 1986). This allows the patient to think beyond apparent barriers. Often, patients may feel so overwhelmed by all the reasons why treatment does not seem like an option in the short term that it clouds their vision of what life could otherwise be like. The ability and willingness to envision a different future, however, are essential to engender hope.

2.4. **Establish short-term symptom management plans**

Aim: To provide patients with evidence-based strategies for change and build self-efficacy for managing symptoms using naturally occurring strengths and supports.

When behavioural health concerns have been identified, reviewing patient strengths, current use of effective coping, and community supports as well as providing brief interventions for patients to practise outside of clinic can be helpful in identifying whether the patient has mild distress and is not in need of formal mental health treatment, has significant distress and is not ready to engage in care in either setting, or has significant distress and is agreeable to specialty care referral but has lag time until the first appointment.

Brief, strengths-based, solution-focused counselling interventions have been used in community mental health centres to provide patients with short-term solutions to effectively manage symptoms and have resulted in client improvements (Mireau & Inch, 2009). As
effectiveness of interventions translates from specialty to generalist settings (Schulberg et al., 1998), the same principles and strategies of engaging the patient early in the process, collaboratively identifying patient strengths and solutions based on those strengths, and keeping the patient focused on his/her identified goals can be utilized when establishing brief interventions as part of the consultation in a medical setting. Such solution- and strengths-based approaches acknowledge the patient’s need for help, assist him/her in thinking about the possibility of successful outcomes, help the patient to notice positive steps he or she already is taking, and reinforce provider beliefs about the resiliency of the patient (Davidson, 2014). Further, providing patients with effective, evidence-based short-term interventions helps to demonstrate the potential utility of engaging in mental health treatment, thereby increasing patient buy-in (Yeung et al., 2010).

In our consultation service, typical interventions include introduction to brief stress management and relaxation techniques, psychoeducation about sleep hygiene (Hauri, 1991), behavioral activation for depression with brief pleasant events scheduling (Gawrysiak, Nicholas, & Hopko, 2009), and safety planning if suicidal ideation had occurred recently (Stanley & Brown, 2012), among other short-term management strategies. Patients also are assisted with forming a contingency plan should their symptoms worsen before their appointment. For example, they identify resources for emergent needs (e.g. suicide prevention hotline, and walk-in clinics) and may schedule a phone check-in with the referring provider.

2.5. **Strategize around possible barriers to care**

Aim: To pre-emptively address barriers to engaging in care to increase the likelihood of attendance.

When an individual agrees to a referral for follow-up psychological care, the patient and the provider must consider the myriad obstacles that are likely to interfere with the patient’s ability to present to the intake appointment. This step supports the patient’s decision to seek help by acknowledging the barriers to accessing care and helping to generate possible solutions to overcome those hurdles using the patient’s available resources and strengths and providing additional resources when possible.

Among the most frequently cited reasons for “no-showing” to an initial intake appointment in community mental health are long wait times, inadequate transportation or child care, inability to take leave from work, lack of motivation despite ongoing distress, low perceived need or effectiveness, and stigma (Davis, Ressler, Schwartz, James Stephens, & Bradley, 2008; Mojtabai et al., 2011; Peeters & Bayer, 1999). Using this list as a representative sample suggests that barriers generally can be categorized into individual, social/cultural, and institutional domains (Davis et al., 2008; Stepleman, Wright, & Bottonari, 2009). Individual or attitudinal barriers may be more important and require more time or attention from referring providers than structural barriers (Mojtabai et al., 2011), particularly among racial and ethnic minorities (Stepleman et al., 2009).

Person-related barriers may require MI (see Section 2.2); providing psychoeducation about the particular disorder, the benefits of treatment, and what to expect in therapy; and conversations to break down the stigma about seeking psychological care. Addressing structural or treatment-related barriers may require a more problem-focused approach. In our practice, we seek to address such barriers by asking patients to anticipate and rehearse the process through which they might overcome various obstacles to accessing treatment in a way that allows the behaviour to seem more feasible. Such mental rehearsal and intention-setting are important in establishing the means to reach a goal, as it allows individuals to anticipate the situations (the “when, where,
and how”) in which they will implement the behaviours necessary to reach their goal (Aarts, 2007, p. 61). Common issues faced in our own practice include the following:

1. **How will the patient pay for services?** Individuals are encouraged and assisted in contacting their insurance provider to identify mental health benefits and covered in a network of behavioural health providers. Individuals with limited or no insurance benefits are offered community mental health options that use a sliding-fee scale. We also may assist patients with determining co-pays and the amount of payment expected at sliding-fee scale operations, as even these options may be unaffordable.

2. **How is the patient to get to the appointment?** In urban settings, individuals may be assisted with navigating a bus route or other public transportation or with finding a treatment centre that is within walking distance. If possible, providing bus tokens or cab fare to and from appointments can remove a transportation barrier. In more rural locations, individuals may be able to identify a person who can provide transportation or, in some settings, may be assisted with a gas voucher. If the patient does not live locally, a more conveniently located rural mental health centre may need to be identified, where available.

3. **Does the patient know where he or she is going?** Healthcare systems can be very large and complex. In fact, we have numerous patients who cite anticipatory anxiety about going somewhere new and unfamiliar to be a reason for not attending their appointment. To help navigate the system, patients should be provided with maps and/or directions to the location of the intake appointment. When a patient is especially anxious and the appointment is within our health system’s specialty psychiatric clinic located in a nearby building, we have walked patients to a location from which the building could be seen or even met patients at a familiar location and escorted them to the specialty care appointment.

4. **Does the patient know whom to contact if lost or he or she needs to change/cancel appointment?** Patients should be provided with contact information for the clinic day-of-appointment needs, as well as the specific phone number for scheduling (if different from the main clinic number). Also, patients may be given information on cancel/no-show policies and charges, when applicable, so that they are aware of any possible consequences for missed appointments.

It can be helpful to have ready-made brochures or packets of information to more easily and efficiently address the above structural barriers. Treatment navigators or care coordinators also may be able to facilitate access to appointments by trouble-shooting barriers and encouraging engagement in care. Patient navigators initially were implemented to reduce health disparities in cancer treatment by identifying and helping to remove barriers to care (Freeman, Muth, & Kerner, 1995) and now are evolving for use in other types of treatment (e.g. in primary care settings and for HIV and substance abuse/mental health treatment) as additional support for treatment engagement for patients who may have a history of inappropriate engagement (e.g. non-engagement in preventive/routine services or overutilization of emergency services), non-adherence, or have been otherwise underserved due to multiple treatment barriers. For example, individuals with serious mental illness are being linked with navigators who may coordinate appointments, provide information/education (Marcus, 2014), arrange transportation, address financial and other resources barriers, and provide support (Bieling, Madsen, & Zipursky, 2013) to increase the likelihood that an individual referred for treatment will present to the appointment. In our own practice, if the clinic is especially busy with several patients waiting for a psychology consult, the psychological provider may engage the patient in the first several steps of the
ACCESS model (i.e. assessment, brief intervention, and MI) before introducing him or her to a treatment navigator to finalize plans for psychiatric care and schedule an appointment; in so doing, flow of patients through the clinic is maintained, and the patient is able to identify several team members who are supports. In addition to handling these logistic barriers, we also seek to provide some basic psychoeducation about the therapeutic process and what to expect at the first appointment, which also may help to reduce treatment anxiety-related missed appointments or treatment refusal (Oldham et al., 2012).

2.6. **Smooth transition into care**

   Aim: To capitalize on patient motivation to enter treatment, as well as demonstrate that providers are working as a team in the service of patient care.

   Given that long wait times are among the most widely cited reasons for not initiating treatment, it becomes important to act quickly on patient motivation to engage in treatment. Though the referring provider ultimately may have relatively little control over appointment wait times, efforts should be made to assist the patient in accessing treatment as soon as possible. Creating collaborative relationships with specialty community mental health providers can increase patient access to those resources (Collins, 2009). In our practice, we use the following guidelines for arranging appointments:

1. The patient should be provided with the first available appointment.
2. That appointment should be scheduled during the consultation if at all possible.
3. If it is not possible to schedule during the consultation, the patient should be contacted within 48 hours by the provider about the status of the appointment.
4. The patient should provide several active phone numbers at which to contact them, as numbers may change or be listed incorrectly in the electronic health record. Further, patients should provide or decline permission to leave messages at any of the numbers provided.
5. If the patient is scheduled for an appointment internally (i.e. within the health system vs. being referred to a community mental health centre), we ask the treating provider to call the patient prior to the appointment, when at all possible, to confirm, build commitment, and allay concerns. Appointment reminder letters and phone calls have been shown to reduce treatment refusal (Oldham et al., 2012).
6. The psychology consultant should continue collaboration with the physician and follow-up about the referral and treatment. When the patient is treated within our health system, we consult the electronic health record and inform medical providers whether the patient is actively in psychiatric care. If the patient is externally referred, it is recommended that the patient sign a release of information so that communication can occur between providing sites as needed. When medical providers are kept abreast of patient treatment, they may be able to reinforce patient engagement in treatment at medical appointments, and their comfort in managing patients is increased by knowing they have the support of a specialized psychiatric provider (Vickers et al., 2013). Further, as treatment of psychiatric disorders may improve medical outcomes (e.g. effectively treating depression improves HIV medication adherence; Sin & DiMatteo, 2014), physicians would be important stakeholders in supporting patient engagement in treatment. Additionally, being able to introduce the patient to the behavioural health provider, if possible, and demonstrate the collaborative relationship between the teams enhances provider satisfaction and allows the patient to feel supported by a care team (Vickers et al., 2013).
3. Discussion

Though increasing emphasis is being placed on integrated care models to increase patient access to mental health services, a portion of patient mental health needs remains best served in specialty psychiatric settings. Unfortunately, numerous barriers exist that complicate transition of care to specialty mental health care. When integrated care teams are in place, these providers can help to facilitate initiation of psychiatric care by addressing individual barriers and enhancing patient motivation using the steps outlined in the ACCESS model: assessing the patient’s psychological needs, considering the patient’s motivation level and other factors, creating a sense of hopefulness, establishing a short-term symptom management plan, strategizing around possible barriers to care, and smoothing transition into care. This model has been particularly useful in educating psychology trainees to consider internal and external barriers to care and take a culturally competent and patient-centred approach to interventions and referrals in integrated care.

Although the interventions described herein evolved authentically from the challenges we repeatedly experienced with patient transitions to specialty psychiatric care, other integrated care settings may experience more, fewer, and/or different barriers based on the patient populations and supports embedded within the clinic, healthcare system, and community. Feasibility of psychological service providers to perform the many interventions offered in ACCESS may differ significantly based on psychologist role and responsibilities within these settings. Further, not all psychologists will view these interventions, especially the logistical assistance for patient care transitions, as fundamental to their role. However, especially when working with underserved, low socioeconomic status (SES) individuals in medical settings, culturally competent care would necessitate understanding patient treatment barriers as well as having the skills to help resolve them. Vera and Speight (2003), in discussing the expanding roles of counselling psychologists, note that “direct services other than therapy, such as advocacy, outreach, prevention programmes, and psychoeducational interventions would be a priority in multi-culturally competent, communitarian social-justice-based practice” (p. 263). Even within our clinics, the addition of patient and treatment navigators and peer specialists over the last several years has provided increased collaborative sharing of responsibility for care transitions. Though the ACCESS model can be used flexibly based on clinic needs and context and may include care providers who are not psychologists, the psychological assessment and intervention portions of the model should be implemented by providers with training and/or appropriate credentials to provide such services so as not to encourage other individuals to engage in activities outside the scope of their practice. Yet, social workers and psychiatric nurses, among others, may also have the skills to carry out all or most of this model with appropriate training. Still, we fully embrace the collaborative care model and believe that each team member offers critical skillsets and roles to the team and to their patients.

Finally, reimbursement for services provided within the ACCESS model must be addressed by clinics implementing similar integrated care services. Billing for psychological services of any kind within integrated medical care settings is a complex issue that is beyond the scope of this article (see Bruns, Kessler, & Van Dorsten, 2014, for a useful description of the reimbursement challenges, progress, and recommendations to date). Our programme uses cost-effective trainees who are also funded through educational grants, Ryan White funding, and similar sources. Other clinics frequently justify psychological services as offsets to the time involved in physician management of mental health issues, which, when reduced, can increase physician productivity and decrease costs, especially if delays in mental health treatment due to lack of handoff to psychologists result in symptom exacerbation and inpatient hospitalizations for acute mental or medical health issues. Also, either in tandem with or separate from the “offset” argument is the use in the USA of Medicare’s Health and Behaviour codes, which include
assessment and intervention service codes that focus on biopsychosocial factors related to physical health status—although reimbursement rates are significantly lower than using codes for traditional assessment and psychotherapy services, and not all insurers will reimburse under these codes (Bruns et al., 2014).

In our most recent undertaking—a free integrated primary care clinic for lesbian, gay, bisexual, and transgender individuals staffed by volunteer physicians, health professions students, and members of our psychology consultation service (www.equalityclinicaugusta.com), we find the ACCESS framework critical as clinic space and time limitations (two evening clinics per month) necessitate we provide only “consult and triage” psychological service. Virtually all psychiatric services are referred into the community. Extensive knowledge of community-based resources is called for in this context. Not unlike other clinics, inadequate referral resources are cited frequently as a limitation to effective provider referrals (Nutting et al., 2002).

Related to the discussion of feasibility and tailoring ACCESS to different integrated care environments is to make the shift from ACCESS being rooted in a variety of evidenced-based practices to investigating the ways in which ACCESS can serve as one. Though each component of the ACCESS model individually is drawn from research findings in the psychological literature, the process as a whole has not yet been studied empirically, providing an avenue for future research. As we have been evolving and implementing these practices in current clinics for some time, it would be optimal to test and compare these practices in our next integrated care clinic where patients and providers have not already been exposed and oriented to the model. We especially are interested in assessing shifts in patient motivation and stigma relative to this model and the extent to which such shifts are further predictive of engagement and retention in specialized psychiatric care, psychiatric symptom severity, patient satisfaction with care, and health outcomes. Studies ideally would help refine ACCESS and determine the components most effective within and between integrated care environments and for a variety of patient populations with the goal of closing the gap between identifying patients in need of specialized psychiatric care settings and facilitating their full engagement in them.

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