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Descriptive Report

Establishing Independent and Integrated Student-Run Behavioral Health Clinics to Address Mental Health Disparities in Gainesville, Florida

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Abstract

Florida continues to rank among the highest states for mental health diagnoses in the nation. Alachua County, which is home to the Gainesville community, continues to experience significant disparity in diagnoses versus access to behavioral health interventions. A significant contributor to this disparity may be the socioeconomic wellbeing of the region, where many individuals report low socioeconomic status and limited access to medical insurance. Gainesville is also home to an advanced network of primary care services and specialties to meet community needs. Among these networks is an established system of student-run medical clinics for uninsured/underinsured patients. New to this system is a psychology graduate student-run behavioral health clinic with an integrated primary care system working hand-in-hand with other medical services. The present article aims to (1) describe the development of an independent, student-run behavioral health clinic model by a graduate student team and (2) describe the implementation/integration of this new clinic model within a free clinic network to meet a need for accessible mental health services, as well as provide patients with an opportunity for integrated care. Current barriers, facilitators, and plans for the models moving forward are discussed.

Introduction

Nationally, Florida ranks 49th in per capita behavioral health support. Florida ranks last in access to behavioral health services, and age or racial-ethnic access disparities may further reduce likelihood of care.[1-2] In 2018, 61.7% of adults with mental illness did not receive treatment, well above the national average of 55.8%[3]. The current ratio of the Florida population to behavioral health providers is 750:1, the third largest disparity in the country.[4] Alachua County, located in North Central Florida (NCF), is designated as a Mental Health Professional Shortage Area; a federal indication of communities with high mental health need but substantively limited resources.[5] These disparities exist in the context of complicated sociodemographic stratification. In Alachua County, 23.2% of individuals live below the Federal Poverty Level (FPL), and 41.1% live below 200% of the FPL; 12.2% of all non-elderly individuals are uninsured, comparable to the 15.5% of uninsured individuals in the state of Florida.[6] Alachua County is also disproportionately burdened by suicide, which is also comparable to state suicide rates. In 2016, Florida experienced over twice as many suicides (3,122) as homicides (1,292), making suicide the second leading cause of death among Floridians aged 25-34 and third leading cause of death for those aged 10-24.[7]

Student-run health clinics provide an innovative way for health professionals to address clinical care gaps among under-resourced pop-ulations.[8] Largely absent from the literature is clini-

cal protocol for addressing behavioral health disparities.[9] Foster and colleagues described their student-run behavioral health clinic to address the behavioral health needs of immigrant and refugee populations to positive ends.[10] While this report highlights medical trainee efforts to address behavioral health disparities, it illuminates the absence of psychologists and behavioral health professionals in this clinical model. Existing student-run medical models do not address the possibilities of integrating psychology graduate students to provide collaborative community healthcare. To the authors' knowledge, no current published reports discuss establishing a free student-run behavioral health clinic and/or the ways an integrated, student-run care team can address mental health disparities.

The aims of this article are to describe both the development of a student-run behavioral health clinic model by a graduate student team and the implementation/integration of this new clinic model within a free clinic network along with associated barriers and solutions.

Clinical History

Equal Access Clinic Network

Gainesville – located within Alachua County – is the largest city in NCF, with a population of 133,997.[11] It is also home to one of Florida's most expansive medical systems. Accordingly, medical education and resources have facilitated a system of student-run clinics called the Equal Access Clinic Network.[12] Sponsored by University of Florida (UF) College of Medicine, the Equal Access Clinic Network is comprised of eight free, specialty medical clinics.

Original Free Behavioral Health Clinic

The first free student-run behavioral health clinic in Gainesville opened in 2015. Operating independently and without funding, the clinic served nine patients a week. Staffed by volunteer graduate students in clinical and counseling psychology from the UF and supervised by licensed clinical psychologists, this clinic served individuals referred from large local medical centers, such as the UF Health Shands Hospital. In light of continued barriers to treatment (e.g. transportation), and limited resources for the independent clinic, the team developed a clinical model to provide services more efficiently to the community. Subsequently, an independent and an integrated clinical model were created respectively within the Equal Access Clinical Network.

Current Clinical Models

Independent Behavioral Health Clinical Model: The Equal Access Behavioral Health Main Clinic

The Equal Access Behavioral Health System is divided into two components: a Main Clinic and an integrated presence in primary care. The Equal Access Behavioral Health Main Clinic is an independent clinic established by students from the UF Department of Clinical and Health Psychology. It currently operates weekly from a community health center in Gainesville, Florida and serves individuals who are uninsured/underinsured (i.e. insufficient insurance coverage for mental healthcare). The Equal Access Behavioral Health Main Clinic is staffed by volunteer licensed clinical psychologists with training in evidence-based practices (e.g. Cognitive Behavioral Therapy, Acceptance and Commitment Therapy). Currently, five clinical psychologists serve as supervisors. The clinic is staffed by six to eight graduate student volunteers in clinical and counseling psychology. Volunteers are recruited through word-of-mouth and departmental advertisements. Two graduate student volunteers and one undergraduate volunteer provide privacy-compliant clinic coordination, including scheduling patients and recruiting volunteers.

Outlined in Table 1, intake assessments are conducted weekly on a walk-in basis. Patients complete a brief intake assessment with a graduate student and the Patient Health Questionnaire-9 and the Generalized Anxiety Disorder-7, brief, empirically validated questionnaires[13-14] that establish a baseline of symptomatology for the patient prior to therapy. The case is then presented to the on-site supervisor and matched with a graduate volunteer whose skillset is appropriate to their concerns. Patients whose symptoms are not appropriate (i.e. severe mental illness, psychosis) for our model of psychotherapy are referred to community providers who specialize in acute crisis care or long-term psychiatric intervention available at no cost.

Table 1. Equal Access Behavioral Health Main Clinic (EABHC) model

Objective	Content
Referral	Clinic receives community referrals and/or word of mouth
Intake Assessment	Patient presents for 45-minute intake assessment and administration of Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7
Psychotherapy	Patient is matched to graduate student therapist Patient begins five sessions of psychotherapy over the course of five weeks
Community Referral and Maintenance	Therapy ends Supportive materials for maintenance provided Referral to acute crisis center and/or behavioral health center if appropriate

Table 1 provides a detailed explanation of the components of the proposed EABHC independent model from referral to treatment termination and behavior change maintenance. Patients present for an initial intake assessment and completion of the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7 to identify clinically significant symptoms of distress. Patients are then matched to a therapist and complete five sessions of abbreviated cognitive behavioral therapy. Therapy is then terminated, with appropriate community referrals placed to support continued behavior change maintenance.

Table 2. Adapted Brief Cognitive Behavioral Therapy practice model

Session	Session Content
Session 1	Patient orientation to Cognitive Behavioral Therapy Establish rapport Assess patient concerns Set initial treatment plans/goals
Session 2	Identify and begin intervention techniques
Session 3	Reassess goals/treatment plan Continue intervention techniques
Session 4	Continue intervention techniques Discussing ending treatment and prepare for maintaining changes, follow-up care
Session 5	End treatment Help patient to maintain changes

Table 2 provides a detailed description of abbreviated, evidence-based Cognitive Behavioral Therapy. Throughout the course of therapy, patients develop rapport with their therapist, identify relationships between thoughts, feelings, and behaviors, practice skills, and work on behavior change maintenance following therapy termination.

Weekly psychotherapy sessions last approximately 45 minutes and are embedded in Cognitive Behavioral Therapy, a highly efficacious form of therapeutic intervention whose positive outcomes are well-documented.[15] Due to the high volume of community members seeking behavioral health services, the clinic has implemented an adapted version of the Brief Cognitive Behavioral Therapy model delineated by Cully and Teten,[16] this adaptation is illustrated in Table 2.

In this model, patients receive five sessions of psychotherapy once weekly; though abbreviated, research has documented the maintenance of Cognitive Behavioral Therapy efficacy in patient behavioral health outcomes in as few as four to five targeted sessions.[17] At the culmination of therapy in five weeks, the graduate student therapist works with the patient to help maintain behavioral changes established in therapy. If follow-up care or psychiatric intervention becomes a crucial next step, the therapist may refer the patient to a local acute crisis center or psychiatric care facility. Case supervision occurs among graduate students and supervisors prior to and following a therapy session to ensure continuity and quality of care. Equal Access Behavioral Health Clinic serves six therapy patients and two patients for intakes per month.

Integrated Behavioral Health Clinical Model

The integration of behavioral health service in primary care has been a paradigm shift in

Figure 1. Integrated Behavioral Health Clinic model

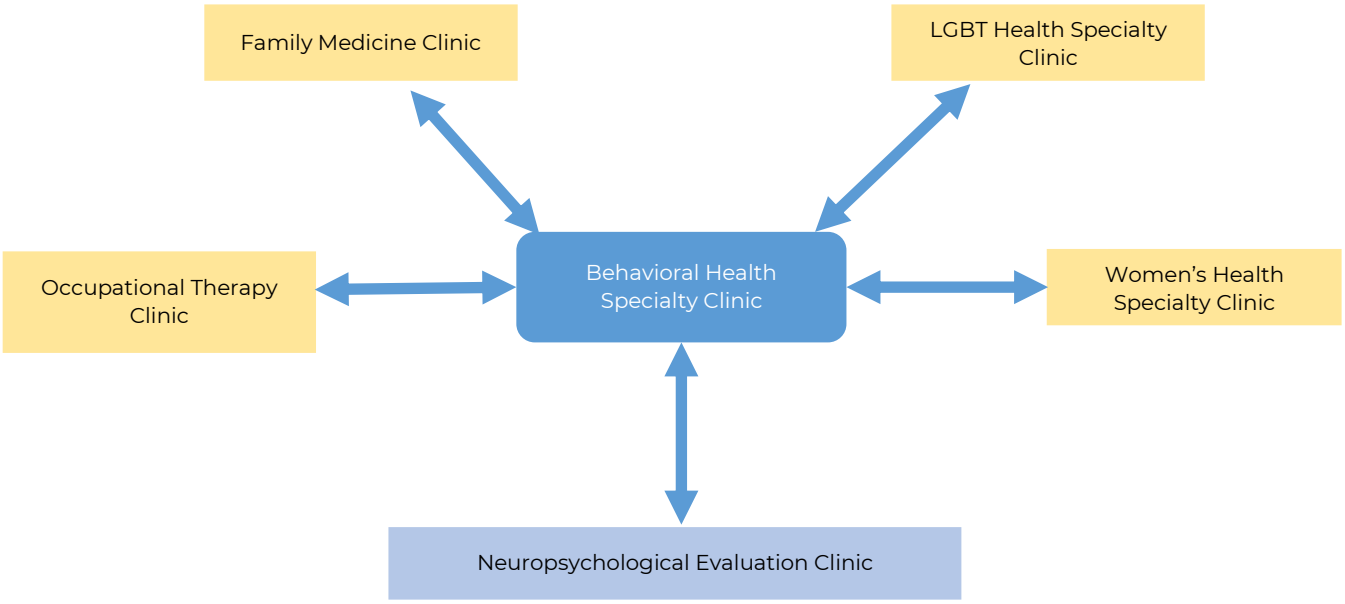

Figure 1 illustrates the current relationships of integration between the Equal Access Behavioral Health Clinic and its student-run primary care counterparts. The independent clinic (featured in the center) is integrated within five specialty clinics, including Family Medicine, Occupational Therapy, Neuropsychology, Women's Health, and Lesbian, Gay, Bisexual, Transgender (LGBT) Health.

Figure 2. Applications of Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration framework levels of integrated care to Integrated Behavioral Health Clinic (IBHC) model

COORDINATED CARE		COLOCATED CARE		INTEGRATED CARE	
LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	LEVEL 6
Behavioral health resources are in separate facilities Referrals are placed between disciplines Minimal, specific patient information is shared	Behavioral health resources are in separate facilities Providers are viewed as resources Requests for behavioral health assessment materials may be placed	Behavioral health is in the same facility, but not the same practice space Interdisciplinary meetings are held infrequently Continuity of referrals increases due to proximity	Consistent communication between behavioral health and primary care providers occurs Increased understanding of one another's' roles	Frequent team meetings and communication Limited access to medical records Changes in primary practice and structure occur to integrate behavioral health	Single merged practice Holistic treatment plans Team-based care is administered

Figure 2 illustrates the levels of integration achieved by the proposed IBHC clinical model. Currently, our model achieves Level 5 of integrated care, as the IBHC involves frequent communication and meetings and involves psychology's physical presence in primary care. However, psychology's access to medical records remains limited.

healthcare.[18] As exemplified in medical centers, 'integrated primary care' or 'integrated behavioral health' represents the service of behavioral health professionals in primary care settings.[19] Benefits of integrated behavioral health include direct access to behavioral health services during primary care visits, improved continuity of patient care, and a holistic approach to health.[20] Clinical frameworks of primary care integration include co-located care, coordinated care, and integrated care.[21] Co-located care describes a referral-based process in which behavioral health resources are located in the same facility as an individual's primary care service. Coordinated care describes a process where patients in a primary care setting are screened and referred to behavioral health provider. The major difference between coordinated and co-located care is the direct exchange of information between physicians and behavioral health providers concerning an individual's screening outcomes and needs. Integrated care describes a process where behavioral health providers work in the same primary care facility as physicians and are a part of team-based assessment and treatment.

Integrated care is associated with better clinical outcomes, and primary care research supports the need for care integration.[22] Studies suggest depression and other mental health disorders (e.g. generalized anxiety disorder, posttraumatic stress disorder) are prevalent in primary care settings.[23] Substance use is more common among primary care patients than the general population, yet substance use screening is not always implemented by general practitioners.[24] Additionally, contact with primary care providers prior to suicide completion is common, as 45% of individuals dying by suicide visited their primary care doctor in the month before their death.[25] Such evidence underscores the importance of integrated primary care as a strategy to comprehensively address patient health concerns and deliver behavioral health interventions in an accessible setting.

A gap of the Equal Access Behavioral Health Main Clinic has been continuity between a patient's healthcare providers. Given this gap and the documented benefits of integrated care, the authors sought to develop an integrated behavioral health clinic in partnership with local student-run medical services. The process of integration was guided by the 6 Levels of Collaboration/Integration framework by the Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration Center for Integrated Health Solutions (SAMHSA-HRSA CIHS)[26] and the Consolidated Framework for Implementation Research model. Additionally, evidence-based literature of best clinical practices for behavioral health in primary care was considered.[27] The resulting clinical model involves a partnership with Equal Access Clinic Network specialty primary care clinics (e.g. sexual/gender minority health, women's health) (Figure 1).

Concordant with the SAMHSA-HRSA model, Integrated Behavioral Health Clinic operates in coordinated care. The Equal Access Behavioral Health Main Clinic provides screening and intervention at an independent site. Clinicians provide referrals to primary care specialties when necessary, but they do not have significant communication with medical providers. Regarding levels of integration, our independent clinic is situated within Level 2 coordinated care, as illustrated in Figure 2. By contrast, our Integrated Behavioral Health Clinic currently reaches Level 5 of clinical integration, whereby graduate psychology students are part of a medical team providing comprehensive, collaborative care.

Each Equal Access Clinical Network primary care clinic operates monthly for three hours. These clinics are held in community health centers that provide resources to low-income community members. As illustrated in the Consolidated Framework for Implementation Research model[28] (Figure 3), graduate psychology students join these specialty services to provide brief behavioral assessment and interventions. In the waiting room, patients complete the Generalized Anxiety Disorder-7 and Patient Health Questionnaire-9 to assess symptoms of depression and anxiety. The patient is approached by the medical student and attending physician for consultation, and psychoeducation concerning mental health and wellbeing is provided. The medical student, attending physician, psychology student, and attending psychologist discuss the patient's presentation, physical symptoms, meas-

Figure 3. Consolidated Framework for Implementation Research (CFIR) model for the Integrated Behavioral Health Clinic (IBHC)

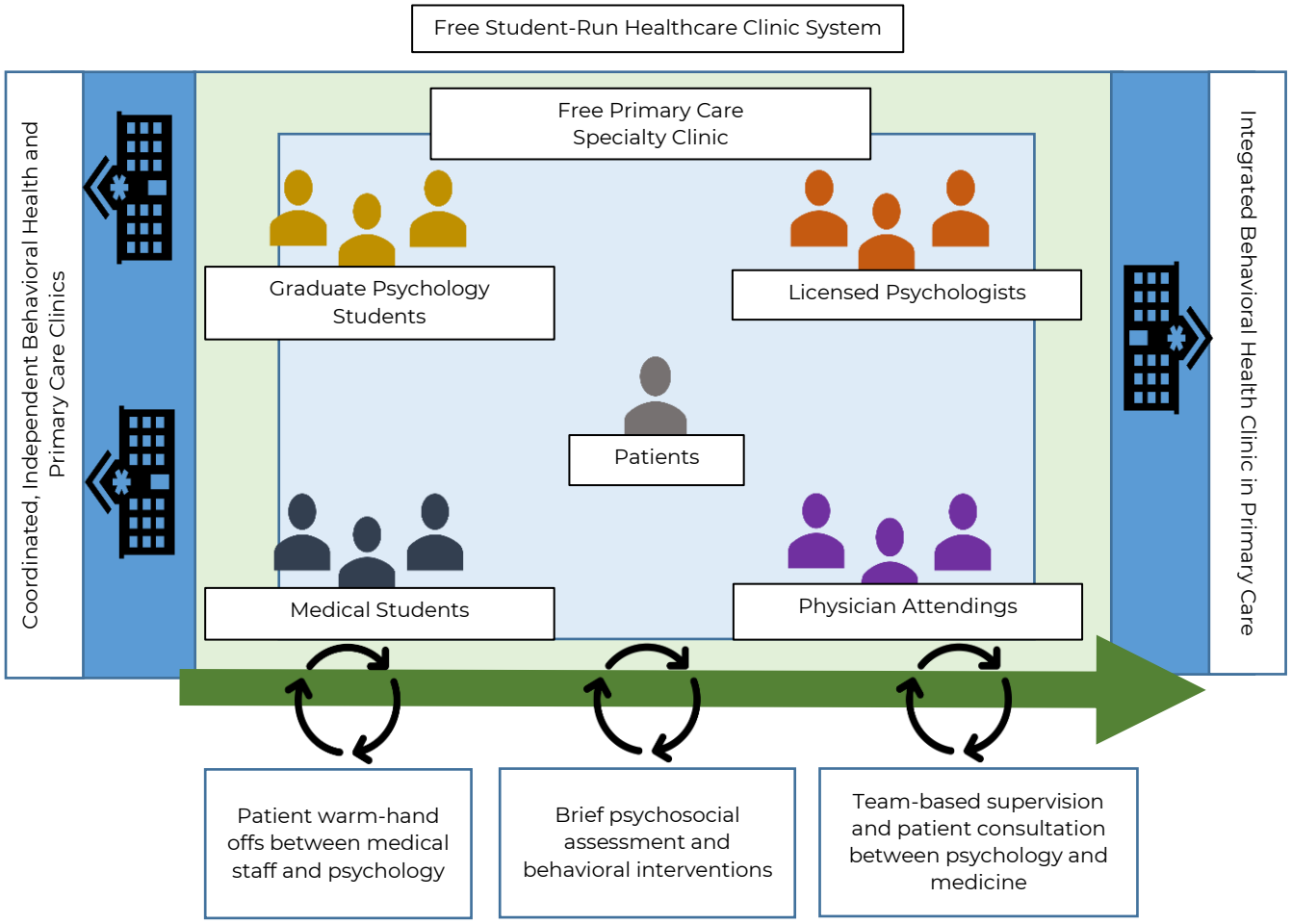

Figure 3 illustrates the implementation framework of the IBHC, drawn from the CFIR model. The diagram describes the process by which the once separate student-run Equal Access Clinic Network and Equal Access Behavioral Health Main Clinic became integrated through the partnership of graduate psychology students, medical students, physicians, and psychologists through team-based interaction in Equal Access Clinic Network primary care settings. Together, the team engaged in warm handoffs, brief psychosocial assessments and behavioral interventions, and team-based patient supervision to discuss holistic approaches to treatment and follow-up.

ure outcomes, history, insight, and cultural context. The team then seeks consent from the patient for behavioral health intervention. If the patient consents, the psychology student provides an in-clinic health behavior assessment and behavioral intervention. If the patient does not consent, they are provided with contact information for the Equal Access Behavioral Health Main Clinic should they wish to seek care. Brief, targeted behavioral health interventions are dependent on the patient's context and the overall treatment plan proposed by the team. This may look like, for instance, brief culturally adapted Cognitive Behavioral Therapy for Insomnia for a mother receiving follow-up medical services for her chronic illnesses. Continuity of care is provided through the integrated clinic, with patient intervention sessions occurring monthly. When this is unfeasible due to other factors (e.g. patient no-shows), single-session behavioral health interventions such as those described are provided. There is substantial evidence to suggest that single-session behavioral health interventions may be beneficial for addressing general mental health concerns,[29-30] acute insomnia,[31] substance use,[32-33] sexual risk-taking,[34] and nutrition and exercise.[35]

Following intervention, patients are provided

with the option to receive further treatment at the Equal Access Behavioral Health Main Clinic, as well as psychoeducational materials to take with them. Clinical supervision occurs among the entire team, with a discussion of future considerations for care in preparation for their return scheduled in the following month. In this way, free, student-run behavioral health services are integrated into the primary care experience to extend the reach of mental health services for underserved community members.

Noted in Table 3, three barriers to implementation were identified within the Consolidated Framework for Implementation Research model. First, primary care providers had limited appreciation of the integration of mental health services, resulting in a reduced flow of patients receiving interventions. Second, mental health volunteers initially had minimal access to patient medical records, limiting knowledge of patient concerns to information provided by the medical team. Third, no assessment of feasibility or outcomes has been conducted, as integration is in its infancy. The authors used several strategies to manage these barriers. First, the mental health and primary care teams have developed a system of patient hand-offs and open dialogue to improve clinical culture. Second, Equal Access Behavioral Health Clinic is currently onboarding patient information into a single electronic system, facilitating the overview of patient information in real-time. Finally, the dissemination of evidence-based measures in the future will be helpful in assessing long-term clinical outcomes.

Discussion

The present report describes the development of a psychology student-run behavioral health clinic model and efforts to integrate this model within a free clinic network. To date, implementation of these models has been successful in providing free clinical services to the community and training opportunities for graduate students. Through Equal Access Behavioral Health Clinic, graduate psychology students have gained experience in brief intervention for high-risk community members. Overall, this report extends current findings regarding mental health services in medical student-run clinics[36] and supports the utility of psychologists and behavioral health professionals in a student-run clinical model. Given that current data supports integrated care, it is recommended that psychology students and professionals be involved in student-run medical clinic practices when possible to meet patient needs and enhance quality of care.

Using the Consolidated Framework for Implementation Research model, facilitators (e.g. networks and communication) and barriers (e.g. culture) of integration were identified among complex, interacting constructs. Strategies were developed to address barriers , and communication among the healthcare team (Equal Access Behavioral Health Clinic and specialty primary care clinics) has been critical in facilitating successful implementation of the integrated clinic. Continued work will be important for formally evaluating the effectiveness of this implementation strategy in the context of student-run mental health clinics.

Several limitations are notable. First, disadvantaged groups who are motivated to seek mental health care may have difficulties accessing transportation, thereby limiting access to care. Second, clinical care is contingent on volunteer support, and attrition of volunteer staff clinic's ability to provide behavioral health support for the community. Finally, data on patient outcomes remains limited. The development of the proposed clinical models introduces standardization of procedures and measures that differ from previous practices. As the clinics grow, reporting longitudinal outcomes data is crucial to understand their efficacy. In spite of the aforementioned limitations, the present article provides an evidence-based, consolidated framework through which practitioners and students in similar communities may implement mental health clinics to meet community needs. Further, the present article provides a foundation for future outcomes research to be collected to continue clinical quality improvement and optimize health outcomes for the community.

Moving forward, several solutions have been identified. To address accessibility challenges and COVID-19, telehealth services have been developed to provide community members with audio and video options for care. To address volunteer attrition, the authors have significantly in-

Table 3. Integrated Behavioral Health Clinic Consolidated Framework for Implementation Research Integration (CFIR) Process

CFIR Domain	Construct	Effect	Strategy Implemented
Intervention Characteristics	Evidence of Strength and Quality – addresses gap documented in scientific literature regarding integrated primary care clinics free to community	Facilitator	
	Adaptability – partnerships among clinics not thoroughly established	Barrier	Developed partnerships with stakeholders at each respective primary care clinic
	Cost – clinics were open to implementation at no cost	Facilitator	
Outer Setting	Patient Needs and Resources – high rates of suicidality and mental health burden in North Central Florida	Barrier	Developed partnerships with stakeholders at local mental health resources
Inner Setting	Networks and Communication – leadership of 8 free primary care clinics communicate with Equal Access Behavioral Health to support and facilitate implementation	Facilitator	
	Readiness for Implementation – leadership engagement in resource allocation	Facilitator	
	Culture – Culture of primary care clinics initially focused on medical treatment	Barriers	Equal Access Behavioral Health Clinic staff provided psychoeducation and open discussions regarding the literature supporting integration and the biopsychosocial model
Characteristics of Individuals	Knowledge and Beliefs – community members perceive value in healthcare, regularly attending respective clinics	Facilitator	
	Self-efficacy – community members enthusiastic to have in-house mental health resources	Facilitator	
Process of Implementation	Planning – initially limited access to patient medical records, reducing patient flow and warm hand-offs between clinicians	Barrier	On-boarding of patient information into a comprehensive electronic system accessible to all clinicians
	Engaging – involving all volunteers in coordination and problem-solving	Facilitator	
	Executing – provide brief evidence-based behavioral interventions, resources	Facilitator	
	Reflection – evaluation of patient outcomes, feasibility	Barrier	Administration of Outcome Questionnaire-45 and other evidence-based measures to assess outcomes

Table 4 provides a detailed explanation of the implementation process across multiple domains of the CFIR guidelines. The table also identifies the different aspects of the implementation process that acted as facilitators and barriers and how these were addressed by the clinical team. Barriers toward implementation included clinical adaptability, high patient need, clinical culture, and planning and reflection of clinical outcomes.

creased recruitment efforts and developed community partnerships with social work and psychiatry to increase the number of volunteers and supervisors at both clinical sites. To improve the encapsulation of clinical outcomes our clinics are receiving grant funding to acquire the Outcome Questionnaire 45, a widely-used measure of behavioral health intervention quality and changes in patient distress over time.

This measure provides a broad assessment of clinical outcomes.[37] These data may inform future decisions regarding which outcome measures may be the most important for Equal Access Behavioral Health Clinic. Overall, the proposed clinical models delineate preliminary efforts by graduate student volunteers to address the mental health needs of the underserved in a framework that others may adopt and implement to serve their communities. In the future, the authors hope to continue fostering community partnerships, analyzing outcome data, and refining our integration process to best serve those in need.

Disclosures

The authors have no conflicts of interest to disclose.

References

1. Cook BL, Hou SS, Lee-Tauler SY, et al. A review of mental health and mental health care disparities research: 2011-2014. Med Care Res Rev. 2019 Dec;76(6):683-710. LINK
2. Jimenez DE, Cook B, Bartels SJ, et al. Disparities in mental health service use of racial and ethnic minority elderly adults. J Am Geriatr Soc. 2013 Jan;61(1):18-25. LINK
3. Mental Health in Florida [Internet]. Florida Behavioral Health Association; 2015. [cited 2020 July 14]. Available from: https://cdn.ymaws.com/www.fadaa.org/resource/resmgr/files/mental_health/MentalHealthInFlorida_Brochu.pdf. LINK
4. Drapeau, CW, McIntosh, JL. U.S.A. Suicide 2017: Official Final Data [Internet]. Washington (DC): American Association of Suicidology; 2018 [cited 2020 Jul 14]. Available from: https://suicidology.org/wp-content/uploads/2019/04/2017datapgsv1-FINAL.pdf. LINK
5. Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Florida, 2014. HHS Publication No. SMA–15–4895FL. Rockville (MD): Substance Abuse and Mental Health Services Administration, 2015. Available from: https://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-FL.pdf. LINK
6. Alachua County Data [Internet]. WellFlorida Council; 2014 [cited 2020 Jul 14]. Available from: https://wellflorida.org/data-reports/alachua-county-data/. LINK
7. Percent of Population Below the Poverty Level in Alachua County, FL [Internet]. United States Census Bureau; 2020 [cited 2020 Jul 14]. Available from: https://fred.stlouisfed.org/series/S1701ACS012001. LINK
8. Simpson SA, Long JA. Medical student-run health clinics: important contributors to patient care and medical education. J Gen Intern Med. 2007;22(3):352–6. LINK
9. Posada J, Potvin H, Kumar A. How a student run clinic can address gaps in access to mental health services. Tex Public Health J. 2015;67. LINK
10. Foster C, Polychroniou P, Ward M, et al. A student-run free mental health clinic for the immigrant and refugee population in Clarkston, Georgia. J Stud Run Clin. 2019;5(1). LINK
11. United States Census Bureau QuickFacts: Gainesville City, Florida [Internet]. Census Bureau QuickFacts; 2014 Jun 19 [cited 2020 Oct 1]. Available from: https://census.gov/quickfacts/gainesvillecityflorida. LINK
12. University of Florida College of Medicine Equal Access Clinic Network [Internet]. UF Health; 2014 [cited 2020 Jul 21]. Available from: https://equalaccess.med.ufl.edu. LINK
13. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-13. LINK
14. Löwe B, Decker O, Müller S, et al. Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. Med Care. 2008 Mar;46(3):266-74. LINK
15. Hofmann SG, Asnaani A, Vonk IJ, et al. The efficacy of Cognitive Behavioral Therapy: a review of meta-analyses. Cognit Ther Res. 2012 Oct 1;36(5):427-40. LINK
16. Cully JA, Dawson DB, Hamer J, et al. A Provider's Guide to Brief Cognitive Behavioral Therapy. Department of Veterans Affairs South Central MIRECC, Houston, TX; 2020. Available from: https://www.mirecc. va.gov/visn16/docs/therapists_guide_to_brief_cbtmanual.pdf. LINK
17. McGinn LK, Sanderson WC. What allows cognitive behavioral therapy to be brief: overview, efficacy, and crucial factors facilitating brief treatment. Clin Psychol (New York). 2001;8(1):23-37. LINK
18. Thielke S, Vannoy S, Unützer J. Integrating mental health and primary care. Prim Care. 2007 Sep;34(3):571-92. LINK
19. Zeiss AM, Karlin BE. Integrating mental health and primary care services in the Department of Veterans Affairs Health Care System. J Clin Psychol Med Settings. 2008; 15(1):73-8. LINK
20. Miller-Matero LR, Dykuis KE, Albujoq K, et al. Benefits of integrated behavioral health services: the physician perspective. Fam Syst Health. 2016 Mar;34(1):51-5. LINK
21. Collins C, Hewson DL, Munger R, et al. Evolving models of behavioral health integration in primary care [Internet]. New York: Milbank Memorial Fund; 2010. Available from: https://www.milbank.org/wp-content/uploads/2016/04/EvolvingCare.pdf. LINK
22. Kwan BM, Nease DE. Integrated behavioral health in primary care: evaluating the evidence, identifying the essentials. Springer Science + Business Media; 2013. Chapter 5, The state of the evidence for integrated behavioral health in primary care; p.65-98.
23. Sadock E, Perrin PB, Grinnell RM, et al. Initial and follow-Up evaluations of integrated psychological services for anxiety and depression in a safety net primary care clinic. J Clin Psychol. 2017 Oct;73(10):1462-81. LINK
24. Kroenke K, Spitzer RL, Williams JB, et al. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007 Mar 6;146(5):317-25. LINK
25. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002 Jun;159(6):909-16. LINK
26. Heath B, Wise Romero P, Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C: SAMHSA-HRSA Center for Integrated Health Solutions; 2013 Mar. 13 p. Available from: https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf. LINK
27. Hunter CL, Goodie JL, Oordt MS, et al. Integrated behavioral health in primary care: step-by-step guidance for assessment and intervention. American Psychological Association; 2009. 291 p.
28. Consolidated Framework for Implementation Research. CFIR Research Team-Center for Clinical Management Research; 2020 Aug. Available from: https://cfirguide.org. LINK
29. Ewen V, Mushquash AR, Mushquash CJ, et al. Single-session therapy in outpatient mental health services: Examining the effect on mental health symptoms and functioning. Soc Work Ment Health. 2018 Sep 3;16(5):573-89. LINK
30. Schleider JL, Dobias ML, Sung JY, et al. Future directions in single-session youth mental health interventions. J Clin Child Adolesc Psychol. 2020 Mar-Apr;49(2):264-78. LINK
31. Ellis JG, Cushing T, Germain A. Treating acute insomnia: a randomized controlled trial of a "single-shot" of Cognitive Behavioral Therapy for insomnia. Sleep. 2015 Jun 1;38(6):971-8. LINK
32. Barreto M, Gaynor ST. A single-session of acceptance and

commitment therapy for health-related behavior change: protocol description and initial case examples. Behavior Analysis Res Prac. 2019 Feb;19(1):47. LINK
33. Forman DP, Moyers TB. With odds of a single session, motivational interviewing is a good bet. Psychotherapy (Chic). 2019;56(1):62. LINK
34. Sagherian MJ, Huedo-Medina TB, Pellowski JA, et al. Single-session behavioral interventions for sexual risk reduction: a meta-analysis. Ann Behav Med. 2016 Dec;50(6):920-934. LINK
35. da Silva SM, Alves ICB, Peixoto EM, et al. Outcome Questionnaire (OQ-45.2): Assessment of the psychometric properties using bifactor model and IRT. PSICO. 2016;47(4):a1-a11. LINK
36. Fischbein R, Gardner-Buckshaw S, Loucek A, et al. Pandemic productivity: student-run free clinic integrates behavioral health in the wake of COVID-19. Acad Psychiatry. 2020 Nov 17:1-5. LINK
37. Doerfler LA, Addis ME, Moran PW. Evaluating mental health outcomes in an inpatient setting: convergent and divergent validity of the OQ-45 and BASIS-32. J Behav Health Serv Res. 2002 Nov;29(4):394-403. LINK