

PRIMARY CARE BEHAVIORAL HEALTH MODEL: PERSPECTIVES OF OUTCOME, CLIENT SATISFACTION, AND GENDER

KARIN ANGANTYR, ANNA RIMNER, AND TOMMY NORDÉN
Evidens University College
TORSTEN NORLANDER
Evidens University College and Karolinska Institute

We examined clients' satisfaction and gender differences in relation to the outcome parameters of the Primary Care Behavioral Health model of integrated care. The model has been shown to be effective in minimizing symptoms and increasing levels of functioning with regard to different mental health concerns. Participants were 54 clients (22 men and 32 women) who received a psychology consultation in accordance with the model, at 1 of 3 primary care centers located in southwest Sweden. Results indicated minimized symptoms and increased levels of functioning and clients felt a high degree of satisfaction with the consultations with the psychologists. There were no gender differences found regarding treatment results or satisfaction with the treatment.

Keywords: cognitive behavioral therapy, psychology consultation, mental health, symptoms, functioning, Primary Care Behavioral Health model, primary care providers.

In today's industrialized world, one third of the visits made to primary care providers are related to psychosocial and behavioral factors, for example, depression, anxiety, sleep disturbances, and alcohol-related problems (Robinson & Reiter, 2007). Approximately 70% of the primary care medical appointments stem from psychosocial issues (Bryan, Morrow, & Kanzler-Appolonio, 2009) and

Karin Angantyr, Anna Rimner, and Tommy Nordén, Center for Research and Development, Evidens University College; Torsten Norlander, Center for Research and Development, Evidens University College, and Department of Clinical Neuroscience, Karolinska Institute.

Correspondence concerning this article should be addressed to: Torsten Norlander, Center for Research and Development, Evidens University College, Packhusplatsen 2, SE-411 13 Göteborg, Sweden. Email: at.norlander@mailbox.swipnet.se or torsten.norlander@ki.se

70% of psychopharmacological prescriptions are signed by general practitioners (Hunter, Goodie, Oordt, & Dobmeyer, 2009). Many common medical disorders diagnosed by primary care providers are attributable to behaviors and poor health habits that cause, maintain, and jeopardize the symptoms of the clients and contribute to suboptimal functioning, for example, obesity, diabetes, coronary disease, and chronic pain (Hunter et al., 2009; Robinson, Gould, & Strosahl, 2010; Robinson & Reiter, 2007). The need for evidence-based psychosocial interventions is significant in primary care; however, this need is not being met. Possible reasons include a lack of competent staff, and the fact that the traditional model of psychological treatment is primarily focused on individual therapy, which currently dominates large parts of primary care (Kazdin & Blase, 2011).

In the USA and England, different types of integrative models have been recommended and tried in order to create a closer collaboration between psychologists and general practitioners as a way of meeting the significant psychosocial demands of primary care provision (Collins, Hewson, Munger, & Wade, 2010; Funderburk et al., 2011). One such model, developed in the USA in the 1990s, is the Primary Care Behavioral Health (PCBH) model of integrated care (Robinson et al., 2010; Robinson & Reiter, 2007). The PCBH model has recently been implemented in some Swedish primary care locations, and is aimed at increasing (a) the accessibility of psychosocial help for a greater proportion of the population, and (b) knowledge of the psychosocial domain among staff members involved in primary care (Robinson & Reiter, 2007). Within the PCBH model the psychologist functions as a consultant working for the general practitioner or primary care provider, and sees clients for brief sessions. A close collaboration between the psychologist and the physician benefits treatment of the needs of the client (Hunter et al., 2009).

The psychology consultant is accessible and the client is often offered an appointment for a first meeting even as soon as the same day as the need is identified. All clients with different types of needs or concerns of a mental, physical, or medical nature are given an appointment with the psychology consultant (Robinson & Reiter, 2007). The appointments are brief, approximately 30 minutes in duration, and the psychology consultant may see 10 to 15 clients per day. The purpose of the first appointment is to conduct a functional analysis of the situation and the current concerns of the client. On the basis of this initial meeting, a plan is formulated with a focus on improved functioning. Feedback on this plan is then given to the referring physician, who, together with the psychologist, is responsible for monitoring the plan. Between one and three follow-up sessions are then offered, with the aim of motivating the client to comply with the suggested plan. When the client exhibits progress, the responsibility for following up the plan is given back to the physician. The psychologist remains an important part of the primary care team, and also works

to disseminate psychological knowledge to the primary care staff, in the form of lectures, newsletters, and supervision, for example. Group activities, designed to be appropriate to each unit of primary care, are arranged to address significant problems or groups of clients (Robinson & Reiter, 2007). Researchers have shown that the PCBH model has positive effects on the level of organization (e.g., a reduced workload for primary care physicians), and results in increased knowledge among staff about mental disorders, as well as increased collaboration among different professionals regarding their clients (James, 2006; Robinson et al., 2010).

Researchers have shown that most clients prefer brief therapy interventions to address their mental health concerns (Brown & Jones, 2005), and that brief therapy is perceived as less stigmatizing for the client (Strosahl, Robinson, & Gustavsson, 2012). In previous studies it has been shown that the effects of psychological interventions are not associated with the duration of the intervention (e.g., Knekt et al., 2008; Molenaar et al., 2011), that the greatest changes take place during the first few sessions (e.g., Barkham et al., 2006; Cigrang, Dobmeyer, Becknell, Roa-Navarrete, & Yerian, 2006), and that the process of change is nonlinear (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009). Researchers have found that there are rapid, radical changes in clients with different types of psychiatric diagnoses in the first few sessions, and raised the possibility that a rapid response predicts long-term improvement in functioning as well as reduced recidivism (Bryan, Morrow, et al., 2009; Strosahl et al., 2012). In line with these results, the PCBH model has been shown to be effective in increasing the client's level of functioning in the case of various problems, including depression, stress, anxiety, and lifestyle concerns (e.g., Bryan, Corso, Neal-Walden, & Rudd, 2009; Roy-Byrne, Katon, Cowley, & Russo, 2001; Stein et al., 2011).

Even clients with severe mental health disturbances have been found to exhibit significant improvements when the PCBH model is applied (Bryan et al., 2012), and in follow-up studies researchers have noted the long-lasting effects of the consultation session up to two years after treatment ceased (e.g., Davis, Corrin-Pendry, & Savill, 2008; Ray-Sannerud et al., 2012). Davis and associates demonstrated an overall reduction in the number of primary care appointments required for clients who participated in the PCBH initial consultation. In the above studies the researchers have described the effects of the PCBH model; however, the satisfaction of the clients with the interventions offered has not yet been examined. Thus, there is a need for studies regarding client satisfaction within the PCBH model framework.

We did not locate any previous studies in which the PCBH model has been examined with regard to gender differences. Other research focused on different interventions has yielded disparate results regarding gender differences. In some studies on psychiatric treatment researchers have shown differences between

men and women with regard to client satisfaction and functioning (e.g., Nordén, Ivarsson, Malm, & Norlander, 2011; Tay, Willcocks, Chen, Jastrzab, & Kohr, 2014), whereas in other studies focused on assessing brief consulting cognitive behavioral therapy interventions, no gender differences have been found in terms of effects and satisfaction (e.g., Hess, 2000; Holland, 1995; Taloyan, Alinaghizadeh, & Löfvander, 2013; Watson & Nathan, 2008). The lack of studies on gender differences in relation to PCBH interventions warrants further research with such a focus.

Our purpose in the current study was to examine experiences with the PCBH model at three primary care centers in southwest Sweden, by studying (a) the effects of symptoms (anxiety and depression) and functioning; (b) the degree to which the participants were satisfied with the intervention, and which factors affected the degree of satisfaction, and (c) if there were gender differences regarding effects and satisfaction with the psychology consultation.

Method

Participants

We based our study on decoded data from 54 clients (22 men and 32 women) who, in accordance with the PCBH model, had attended a session with a psychology consultant at one of three primary care centers located in three small regions in southwest Sweden: Tjörn, Stenungsund, and Stora Höga. The mean age of the participants was 48.96 years ($SD = 17.71$). At the first session 15% were on full-time sick leave from their workplace, 7% were on part-time sick leave, and 78% were not on sick leave. A majority of the participants (50.9%) requested an appointment to address multiple problems. Hence, the perceived problems of the participant group were anxiety (43.4%), stress (62.3%), depressed mood (56.6%), sleep problems (43.4%), pain (11.3%), and other (15.1%). Background data also showed that 30% of the participants were on medication for mental health concerns at the time of the first assessment, and that 34% had previously been in contact with primary care providers to address mental health concerns. The waiting time before the first consultation was less than three days for 26 of the clients and less than one month for 28 of the clients. An independent samples t test showed no significant differences regarding gender in relation to age ($p = .851$). There were also no significant differences between genders in relation to duration of sick leave at the initial PCBH meeting, as assessed by the Mann-Whitney U test ($p = .416$). A chi-square contingency table showed no significant relationships between gender and reasons for seeking help ($p = .520$). Fisher's exact test yielded no significant associations in terms of gender as related to anxiety, stress, depressed mood, sleep problems, pain, other mental health concerns, use of psychotropic drugs, or previous contact with the

primary care provider or medical contacts resulting from mental health concerns ($ps > .05$).

Instruments

The Hospital Anxiety and Depression Scale (HAD). The HAD has been shown to be a reliable and valid instrument for the detection of anxiety and depression in individuals between 16 and 65 years of age (Zigmond & Snaith, 1983). The instrument consists of 14 statements (seven regarding anxiety and seven regarding depression) with four response alternatives (0 to 3), ranging from *positive* to *negative* or vice versa. Examples of symptoms described on the subscale of anxiety include tension, nervousness, restlessness, and sudden feelings of panic, whereas on the depression subscale symptoms include mood swings, power of initiative, confidence regarding the future, and loss of interest. The maximum score on each subscale is 21, and 11 points is the cutoff level for a diagnosis of anxiety or depression (Zigmond & Snaith, 1983). In the current study, we administered the HAD on three occasions: at the first session, immediately following the last session, and at a follow-up session arranged for three months after the last treatment session.

The Duke Health Profile (DUKE). The DUKE is a reliable and valid instrument developed to assess health-related quality of life in relation to primary care (Parkerson, 2002). It consists of 17 questions, rated on a scale from 0 = *none* to 2 = *a lot*, and items may be used individually or as a cluster. Seven questions deal with self-perception in different areas, for example, "I like who I am" and "I feel good in the company of others." The remaining questions deal with patterns of symptoms and level of functioning, for example, "Would climbing a flight of stairs entail physical problems or difficulties for you today?". There are six clusters in the *functioning* subscale: physical health, mental health, social health, general health, perceived health, and self-confidence, and a higher score indicates a better quality of health. The *dysfunctioning* subscale comprises five clusters: anxiety, depression, anxiety/depression, pain, and reduced functioning, and a higher score indicates a higher level of dysfunctioning (Parkerson, 2002). The DUKE total is then inverted so that the dysfunctioning subscale is reversed, that is, the higher the score, the better the level of functioning. In the current study, the DUKE was administered on three occasions: at the first session, immediately following the end of treatment, and three months after the end of treatment.

The Client Satisfaction Questionnaire (CSQ). The CSQ was developed in order to assess general client satisfaction within primary care and nursing (Attkisson & Zwick, 1983; Larsen, Attkisson, Hargreaves, & Nguyen, 1979). The questionnaire has been tested in multiple studies and found to have good psychometric qualities regarding reliability and validity (Attkisson, 2012). Clients respond to eight questions using four response alternatives (1–4 points)

where a greater number of points indicates a greater degree of satisfaction. Anchor points differ across items and include the following variants: *poor–excellent*; *no, definitely not–yes, definitely*; *none of my needs have been met–almost all of my needs have been met*; *quite dissatisfied–very satisfied*; *no, they seem to make things worse–yes, they help a great deal*. The maximum total is 32 points. Examples of questions are, “Did you obtain the help you wanted?” and “If you had a friend in need of similar help would you recommend our program to him/her?”. The CSQ was administered on one occasion in connection with the follow-up session that was arranged three months after the last treatment session.

Clients’ perceptions of psychology consultation (CPPC). In order to examine the clients’ perceptions of the psychology consultation we administered six questions on the topic, each one with four response alternatives, from *not at all significant* (1 point) to *very significant* (4 points). A higher score indicates a more positive perception of the experience to which that particular question referred, for example, “To what extent did you feel confidence in the psychology consultant?”. The questions were put to the clients immediately following the end of the consultation. At the three-month follow up, one of the questions was repeated, namely “How much did you gain from the psychology consultation?”.

Background data. Background data were collected with regard to the participants’ age, gender, duration of sick leave, reason for seeking help, and medication that had been prescribed. Participants were also asked to advise (a) if they had previously had contact with the primary care provider in regard to treatment of mental health concerns, and (b) how long the waiting period had been before they saw a psychology consultant.

Design

As the model is being put into practice at the locations in Sweden where we conducted our study, the psychology consultation is divided into a first contact meeting, and possible follow-up sessions. The first visit is 30 minutes long and consists of a brief introduction where the plan for the session is described. Thereafter, a screening interview takes place, focusing on the client’s current mental health concerns. Based on this interview, the psychology consultant undertakes a functional analysis, providing feedback to the client with the goal of increasing the client’s understanding of the origin of his/her problems and functioning in various situations. Psychoeducational interventions are then provided, adjusted to suit the client’s current concerns, as well as a plan of action for behavioral change to be followed after the consultation. If deemed necessary, additional 15–20 minute follow-up sessions are scheduled, with the purpose of examining how well the client is complying with the plan of action, as well as determining possible adjustments to the plan of action. Following each

session, the psychology consultant writes journal notes, including the functional analysis and plan of action. Oral or written feedback is provided to the referring physician or nurse, along with recommendations for how the plan of action may be supported following the consultation.

Procedure

The data collection took place in three steps: (a) preassessment, (b) postassessment, and (c) at a follow up three months after the last treatment session. The participants were informed in writing that the data would be anonymized and used in a scientific study. All participants gave their informed consent. The criteria for inclusion in the study were that the participants were listed as belonging to the primary care unit at hand, and that they were scheduled for a psychology consultation. The service of a psychology consultation is aimed at individuals with a recent onset of poor mental health, where an improvement in functioning can be expected from brief psychology consultation. Clients are scheduled for a psychology consultation through a visit to the physician. At the preassessment the clients received an envelope containing the informed consent form, information regarding the psychology consultation, the HAD and DUKE measures, and background questions. The envelope was handed to the client in the reception area, and they were asked to complete the questionnaires prior to the first consultation and leave the materials with the psychology consultant. The postassessments (comprising the HAD, DUKE, and CPPC measures) were handed out by the psychology consultant at the time of the last consultation, and were to be completed immediately following the meeting. The completed forms were placed in sealed envelopes and left at the reception desk. The after-three-months follow ups (comprising the HAD, DUKE, and CSQ measures, and one item from the CPPC) were sent out by mail along with a letter of information, a thank you note, and a stamped response envelope.

Ethical Considerations

The management at each primary care unit was informed of the study purposes and gave us their permission, and the study was conducted as part of the ongoing evaluation of the work at the primary care unit. The data were collected by two students in the psychotherapy program at Evidens University College, constituting the basis of their degree thesis. In addition, each client was informed of his or her right to discontinue participation in the project at any time without having to give a reason. A contract was drawn up and signed by both the client and the trainee psychotherapists. Given these conditions, in accordance with the Swedish rules on ethics, those responsible for a training program can make use of the material contained in student reports to compile an article.

Results

Clients' Perceptions of Psychology Consultation

Results of a Mann-Whitney U-test (5% level) with gender (man, woman) as the independent variable and the six ordinal scales (from 1 to 4) regarding the participants' experiences of the psychology consultation, completed immediately following the end of the consultation, as the dependent variables. The tests yielded a significant effect for "How well informed were you about the contents of the consultation prior to the first session?" ($U = 86, p = .002$) and descriptive statistics showed that the women felt better informed ($M = 2.67, SD = 0.91$) compared to the men ($M = 1.72, SD = 0.89$). There were no other significant effects ($ps > .05$). For means and standard deviations, see Table 1.

Table 1. *Clients' Perceptions of the Psychology Consultation*

Item	<i>M</i>	<i>SD</i>
How soon after you contacted your primary care unit, did you establish contact with a psychology consultant?	2.55	0.91
How many times did you see the psychology consultant?	1.31	0.61
How well informed were you of the content of the psychology consultation prior to your first session?	2.23	1.01
To what extent did you feel confident with your psychology consultant?	3.54	0.60
To what degree did you gain an increased understanding of the problems for which you sought help?	3.23	0.71
How much did you gain from the psychology consultation?	3.14	0.75

In the CPPC instrument there was also a question repeated at the three month follow up, namely "How much did you gain from the psychology consultation?" ($M = 2.85, SD = 0.98$). The Mann-Whitney U test (5% level) yielded no significant effects with regard to gender ($p = .726$) in connection with the follow up, and a Wilcoxon signed ranks test (5% level) showed no significant difference between the rating at the end of the consultation and the rating at the follow up after three months ($p = .265$).

The Hospital Anxiety and Depression Scale

A two-way mixed Pillai's multivariate analysis of variance (MANOVA) with the between-groups variable of gender (man, woman) and the within-groups variable of time (before consultation, after consultation, and at follow up after three months) as the independent variables, and with the HAD test scales of anxiety and depression as dependent variables, yielded a significant effect for

time ($p = .002$, $\eta^2 = 0.52$, power = 0.96) but neither for gender ($p = .072$, $\eta^2 = 0.19$, power = 0.52) nor for the time \times gender interaction ($p = .194$, $\eta^2 = 0.22$, power = 0.43). Table 2 contains the mean and standard deviation results of the univariate F tests for time.

Table 2. *A Comparison of Anxiety and Depression Levels Before the Treatment, Immediately After Treatment, and at the Follow Up After Three Months*

	Anxiety		Depression	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Before	10.41	5.12	7.04	4.63
After	9.08	4.82	6.57	4.98
At follow up	6.51	4.78	4.87	4.70

Univariate F tests yielded significant effects for both anxiety, $F(2, 52) = 14.21$, $p < .001$, and depression, $F(2, 52) = 6.32$, $p = .003$. A post hoc paired-samples t test (5% level) showed that for anxiety there were significant differences in terms of reduced anxiety between the three assessments (before–after–follow up). An additional paired-samples t test (5% level) showed that, as regards depression, no significant change took place between the before and after assessments; however, between the before and follow-up assessments the participants obtained lower scores for depression.

The Duke Health Profile (DUKE)

Owing to multicollinearity it was not possible to collate the subscales of the DUKE test into one single, two-way mixed MANOVA and for this reason the analyses were conducted using a two-way mixed analysis of variance (ANOVA) for each subscale.

Functioning. The two-way mixed ANOVA with the between-groups variable of gender (man, woman) and within-groups variable of time (before consultation, after consultation, and at follow up) as the independent variables, and with functioning as the dependent variable, yielded a significant effect for time, $F(2, 50) = 4.18$, $p = .021$, but not for either for gender ($p = .269$) or for the time \times gender interaction ($p = .468$). The follow up paired-samples t test (5% level) showed that there was a significant change between the preassessment and postassessment, whereby the participants' functioning improved on the HAD. There was no significant difference between the postassessment and the follow up; however, there was no significant change between the postassessment and the follow up. For means and standard deviations, see Table 3.

Dysfunctioning. A two-way mixed ANOVA with the between-groups variable of gender (man, woman) and the within-groups variable of time (before consultation, after consultation, and at follow up) as the independent variables,

and dysfunctioning as the dependent variable, yielded no significant effects for either time ($p = .103$), gender ($p = .199$) or for the time \times gender interaction ($p = .272$). For means and standard deviations, see Table 3.

DUKE total score. A two-way mixed ANOVA with the between-groups variable of gender (man, woman) and the within-groups variable of time (before consultation, after consultation, at follow up) as the independent variables, and the DUKE total score as the dependent variable, yielded a significant effect for time, $F(2, 50) = 3.35$, $p = .043$, but not for either for gender ($p = .205$) or for the time \times gender interaction ($p = .292$). A follow-up paired-samples t test (5% level) showed that there was a significant change between the assessments before and after consultation, whereby the health profile of the participants improved. However, there was no significant change between the postassessment and the follow up. For means and standard deviations, see Table 3.

Table 3. *A Comparison of Functioning Subscale, Dysfunctioning Subscale, and DUKE Total Scores Before Treatment, Immediately After Treatment, and at the Follow Up After Three Months*

	Functioning		Dysfunctioning		DUKE total	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Before	65.90	15.32	38.45	17.67	63.72	15.36
After	70.18	14.63	33.41	18.60	68.38	15.64
Follow up	72.93	16.05	30.85	18.50	71.04	16.39

Number of Sessions and Waiting Time Prior to the First Session

A two-way mixed ANOVA with the between-groups variable of number of sessions (one, two, or three sessions) and with the within-groups variable of time (before, after, or at follow up) as the independent variables, and with HAD scales of anxiety and depression, DUKE scales of functioning and dysfunctioning, and the DUKE total score as the dependent variables, yielded no significant effects ($ps > .05$). The waiting time prior to the first consultation, as measured with the CPPC, was within 3 days for 26 of the clients and between 7 and 30 days for 28 of the clients. A further mixed two-way ANOVA with waiting time (within 3 days, within 1 month) as the between-groups variable, yielded no significant effects ($ps > .05$).

Client Satisfaction Questionnaire

The CSQ is used to assess the degree to which clients experience satisfaction with the consultation in which they have taken part. An independent samples t test showed no significant effect for gender on the CSQ ($p = .859$). The mean for the CSQ in the current study was $M = 22.62$ ($SD = 6.08$, range = 10–32). In order to examine which of the variables affected clients' degree of satisfaction,

a stepwise linear regression analysis was conducted with the CSQ as the criterion variable. Predictor variables were gender, age, the six scales referring to experiences of the consultation (CPPC), sick leave status as reported at the three measurement occasions, data from the HAD scales on the three occasions, the DUKE scales, and the 17 items upon which the DUKE scales are based. The analysis generated two models, Step 1: Adj. $R^2 = .57$, $F(1, 20) = 28.45$, $p < .001$; Step 2: Adj. $R^2 = .66$, $F(2, 19) = 221.39$, $p < .001$.

In the first step, the variable "How much did you gain from the psychology consultation?" as assessed immediately following the consultation, emerged with a beta weight of .77. The variable accounted for 57% of the variance in the criterion variable and correlated strongly with the criterion variable ($r = .82$, $p < .001$). In the next step, the variable of depression (from the HAD at follow up) was found to have a beta weight of -.33. Higher levels of depression at follow up, tended to affect the variance of the criterion variable, but at the same time there was no correlation with the criterion variable ($r = -.15$, $p = .311$). Further, depression, as assessed by the HAD, at follow up only contributed 9% to the explanation of the variance.

Discussion

Three main results emerged from the current study: (a) psychology consultation in accordance with the PCBH model had an effect on symptoms and level of functioning, (b) the satisfaction of the participants was largely explained by one single variable, and (c) there were no significant gender differences regarding the effects of the interventions or the satisfaction of the clients with regard to the treatment.

In terms of the effect of the PCBH model on the symptoms of the participants, as assessed with the HAD, or functioning, as assessed with the DUKE, the current results are in line with those gained in international studies (e.g., Bryan, Corso et al., 2009; Stein et al., 2011; Strosahl et al., 2012). We found that ratings of anxiety and depression were low even prior to the preassessment, a fact that may be explained by the PCBH model being focused on prevention. Nevertheless, the results show that psychology consultation has a positive effect on both anxiety and depression, but given that the effect is greater for anxiety than for depression, we may conclude that the method is more suitable for clients experiencing anxiety. Because fear is an important component of anxiety reactions it is quite possible that the PCBH action plan, which includes exposure to what you are afraid of, rapidly generates positive effects in the early stages of development of the health concerns. The results also show that psychology consultation has a positive effect on the level of functioning of the participants. Scores on the DUKE total and the functioning subscale, in particular, were

significantly different at pre- and postassessment. The postassessment level of functioning remained at a similar level at the follow up indicating there was no additional improvement. Therefore, the dysfunctioning subscale results did not show any significant effects.

The above results confirm earlier research in which it has been shown that brief interventions have a positive effect (Knekt et al., 2008; Molenaar et al., 2011). The question is: How brief can the total amount of contact be while still retaining its effectiveness? While this work was in progress, we hypothesized that more sessions would have a stronger effect than a single session. However, there was no significant support for this hypothesis. Thus, brief is good enough given the assumptions of the current study, namely, that clients are given a psychology consultation when there is a recent onset of mild mental health concerns, and that an improvement in functioning is expected to be accomplished through a brief, psychological consultation. The rapid accessibility to the first visit with the psychology consultant is likely to be part of the explanation of the effect of the method on clients' symptoms and level of functioning. The PCBH model provides the possibility of turning around recently developed mental health concerns by giving the clients rapid access to strategies for dealing with these concerns. Clients can be responsible for these strategies and integrate them into their daily life on their own.

This is the first study in which clients' satisfaction with the PCBH model has been assessed. It was evident that the participants generally felt a high degree of satisfaction, a result that is in line with previous researchers' findings that most clients tend to prefer brief psychological interventions to treat their mental health concerns (Brown & Jones, 2005), and that brief interventions are perceived as less stigmatizing (Strosahl et al., 2012). The variable that best predicted satisfaction among the clients, and that accounted for most of the variance, correlating strongly with the CSQ was "How helpful did you find the psychology consultation?", as assessed immediately following the end of the consultation. This result shows that what the psychologist does and the content of the consultation play an important role in client satisfaction with the session. From the data we gathered for this study it is not possible to say what characteristics of the psychologist play a role or which interventions in the consultations are decisive. In the current study, four psychology consultants worked in parallel, suggesting that gender, age, and personality of the individual psychologist were not decisive, and it was, rather, the characteristics they had in common that affected the outcome. The degree of depression (assessed using the HAD at follow up) also seemed to affect the variance, albeit to a significantly lesser degree. Given that there was no correlation with the criterion variable (CSQ), it is impossible to say why.

This is also the first study in which gender differences were analyzed with regard to treatment results, along with client satisfaction with the PCBH model. Our results did not show gender differences regarding either treatment results or satisfaction with the treatment. The only difference found across the study was that men felt slightly less well-informed than did women at the time of the first meeting with the psychology consultant. No significant gender difference has been found in previous studies of brief consulting cognitive behavioral therapy interventions (Hess, 2000; Holland, 1995; Taloyan et al., 2013; Watson & Nathan, 2008). However, studies of psychiatric treatment in a broader perspective have yielded inconsistent results with regard to aspects of gender in connection with treatment results (Nordén et al., 2011; Tay et al., 2014). The difference between preventative brief interventions in primary care versus the vaster field of psychiatric treatment could explain some of the inconsistency, but this field would be worth exploring further.

One limitation in the present study was that we did not use a control group. The PCBH model yielded few possibilities for finding natural control groups within the current primary care units, given that there was no waiting list of similar client groups. Perhaps we might have utilized additional primary care units where the PCBH model is not being implemented and gained access in this way to reference groups. Nevertheless, our findings confirm the results of other studies on the usefulness of the PCBH model and its appropriateness within primary care. In addition, in the current study we showed for the first time that the clients appear satisfied with the PCBH method, and we found no gender differences with regard to treatment results or satisfaction with the treatment.

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