



Broad and Adaptive Integrated Health Psychology Services: Engaging BIPOC Veterans in VA Healthcare

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Abstract

Clinical health psychologists provide adaptive, evidenced-based interventions that incorporate behavioral medicine and behavioral health strategies, with the potential to integrate broadly across the medical system. Veterans Affairs (VA) healthcare strives to meet the needs of an increasingly diverse patient population with complex behavioral health needs. This conceptual paper describes an example of health psychology at one VA healthcare system, with a focus on adaptive and culturally responsive services reaching Black, Indigenous and People of Color/Veterans of Color (BIPOC). The clinical health psychology services and cases described aim to reach Veterans who may not participate in, or benefit as fully from, traditional disease self-management or mental health services. The authors offer recommendations, to secure the value and sustainability of these integrated health psychology services, and hopefully contribute to addressing healthcare inequities.

Keywords Health psychology · Integrated behavioral health · Veterans of color · BIPOC

Background

While the size of the Veteran population is decreasing over time, the use of VA healthcare is growing, and non-White, racial/ethnic minority Veterans represent a steadily increasing proportion of those accessing healthcare services (Frayne et al., 2018). Moreover, women are the fastest growing sub-group of Veterans, and are more racially and ethnically diverse compared to male Veterans. There are also data indicating that non-White Veterans are more likely to use VA for at least some of their healthcare as compared to non-Hispanic White Veterans (Dursa et al., 2016). It is critical that VA healthcare clinicians adapt to this increasingly diverse patient population.

Veterans have higher levels of chronic conditions for which health behaviors may influence etiology and outcomes. For example, Veterans cope with twice the prevalence of diabetes, and three times the prevalence of diagnosed cancer and ischemic heart disease compared to civilian counterparts (Washington et al., 2017). Furthermore, there are self-reported health status and behavioral

indicators revealing discrepancies between Veterans and non-Veterans. For both male and female Veterans, compared to non-Veterans, reports suggest greater limitations with daily activities and physical and/or emotional distress (Hoerster et al., 2012; Lehavot et al., 2012). Veterans are also more likely to report higher rates of tobacco and heavy alcohol use compared to civilian counterparts (Hoerster et al., 2012). Compounding this health status picture, non-white Black, Indigenous and People of Color (BIPOC) communities may cope with a higher prevalence of some major chronic conditions compared to white counterparts. For example, 13.2% of Hispanics and 13.0% of non-Hispanic Blacks cope with diabetes versus 8.0% of whites (U.S. Department of Health and Human Services Office of Minority Health, 2018 data).

Moreover, this diverse Veteran population with complex behavioral health needs faces documented discrimination. From a broad, sociocultural perspective, experiences of discrimination have been linked reliably to poorer physical and mental health (Lewis et al., 2015; Leger et al., 2022). A recent meta-analysis further documented a stable association between interpersonal discrimination and health-related behaviors including tobacco use, alcohol misuse and poor eating behaviors (Pascoe et al., 2022). Within the healthcare sector, reporting suggests BIPOC communities have been impacted disproportionately by access to healthcare (e.g., insurance, transportation) as well as lack of culturally

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responsive care (U.S. News, February 4, 2022). Such lack of understanding or responding to one's culture may contribute to under- or misdiagnosis of mental illness for BIPOC populations (Centers for Disease Control, May 7, 2022; Suite et al., 2007). These conditions may only intensify the stigma surrounding mental health. As an example, greater than 80% of Black Americans report stigma concerns, and therefore are less likely to seek mental healthcare (Ward et al., 2013).

VA healthcare strives to meet the needs of an increasingly diverse and medically vulnerable patient population deserving of culturally responsive healthcare. VA initiatives such as the Patient-Centered Medical Home (PCMH) establish interdisciplinary team-based care which aims to improve population health and meet the specific needs of Veterans. However, inequities and areas of improvement for inclusiveness continue to be documented. For example, Veterans with a substance use disorder receiving primary care services reported poorer perceptions of care including access, provider communication, and information received (Hoggatt, et al, 2019). More broadly, health outcome disparities for chronic conditions, in particular diabetes and hypertension, were found to vary but persist during the first 5 years of implementation of the PCMH (Washington et al, 2017).

A Role for Integrated Health Psychology

Health psychologists can integrate into PCMH and other interdisciplinary teams across medical settings; however, psychology is not a required interdisciplinary team member. The authors outline here how integrated health psychologists can be well-positioned to help interdisciplinary medical teams optimize prevention and chronic disease management, as well as identify and reduce healthcare disparities. First, health psychology services integrate collaboratively into existing medical care. When part of the clinic flow or PCMH, the stigma of mental or behavioral health is reduced. Similarly, health psychologists may be a part of interdisciplinary self-management programs such as Diabetes Education, Weight Management, or Cardiac/Pulmonary Rehabilitation. In these programs, health psychologists serve as an introduction to behavioral health and psychological care that may contribute to physical health. Having such an introduction likely enhances engagement from more Veterans.

Second, integrated health psychologists can utilize case conceptualization with the biopsychosocial model (BSM) (Borrell-Carrio et al., 2004). The holistic BSM honors cultural considerations and responds to the context of each Veteran. Using such case conceptualization can influence outreach and scheduling, tailoring the effort beyond scheduling procedures. In addition, communication and intervention plans can be individualized beyond protocols for behavioral medicine. Adapting approaches to care on these various

levels, the authors believe, has potential to enhance not only engagement but also benefit from the team-based healthcare.

Third, aligned with VA efforts to address access and transportation challenges, integrated health psychologists offer flexible service formats, namely telephone, VA Video Connect and in-person. Perhaps most importantly, integrated clinicians aim to offer appointments that are conjoint, collaborating with other clinicians and/or in conjunction with other appointments. This aims to meet the Veteran *where they are at* in the behavior change process, and further enhance engagement in their healthcare.

This conceptual paper aims to exhibit how health psychologists can function uniquely as part of the PCMH and other interdisciplinary teams, supporting population health and engaging more diverse Veterans. The authors detail one broad, adaptive approach and de-identified case examples of BIPOC Veterans, highlighting more equitable care. The paper concludes with offering recommendations to support the sustainment of these integrated health psychology services.

How Health Psychology Functions in Interdisciplinary Teams

Integrated health psychologists are trained in evidence-based psychotherapies and cognitive and behavioral theories which can be adapted and incorporated into behavioral health approaches (e.g., self-management of obesity, Type II diabetes and heart disease or cardiac rehabilitation (Harvey, 2015; Henshaw and Freedman-Doan, 2009; Larsen and Gibson, 2020)). By offering stress management and behavior change interventions in interdisciplinary programs, health psychologists represent the field of psychotherapy to a broader population. These group and individual interventions are behavioral health in nature, and do not require a mental health diagnosis specifically. Yet, they may function as a psychotherapeutic intervention enhancing readiness for behavior change. Many healthcare disciplines receive introductory workshops in healthcare communication, including motivational interviewing (MI) (McKenzie et al., 2015). With more extensive foundations in communication, clinical health psychologists often conduct these trainings, and can employ MI principles and skills with greater fidelity. To exemplify this, health psychologists develop competencies for identifying MI's "change talk" or a client's statements about desire or need for behavior change as distinct from "sustain talk" or statements about the difficulty or lack of desire to change (Rollnick et al., 2007). Utilizing these competencies enable health psychologists to empower Veterans to move in the direction of change. Health psychologists can acknowledge

and address barriers, while striving to reflect more commitment language and desire for health behavior change (Rollnick et al., 2007).

Integrated health psychologist's curriculum also draws on broader social and cognitive models such as the health belief model (HBM) (Shumaker et al., 2009). This model encompasses beliefs about risk for disease, and whether-or-not health behavior change will indeed reduce risk. Aligned with the biopsychosocial model, the HBM allows for Veterans' beliefs which may not be congruent with disease self-management approaches. This allowance has the potential to address stigma and cultivate trust. Importantly, the HBM has been utilized to understand racial-ethnic and other cultural differences in participation and outcomes for both healthcare and psychotherapy (Martinez et al., 2016). Patient-centered care approaches commonly speak of "keeping the door open" so Veterans will return to future classes or appointments and continue the discussion. Working with the HBM, a trained psychotherapist can explore beliefs non-judgmentally, and potentially keep participants engaged and willing to consider other thoughts and beliefs. Clinically, this can mean first supporting a Veteran-centered or culturally responsive goal that may not relate directly to the traditional health goal (e.g., a first goal may be to re-engage with a local church or grieve for a family loss, before they set a diabetes self-management goal). Building rapport while working on such a personalized goal can increase a Veteran's investment and opportunity to discuss how additional goals may improve their physical health and well-being.

This Veteran or patient-centered approach is also very evident in MI mentioned earlier. MI views the Veteran as expert in their own care, which may enhance readiness for behavior change, and in turn, health-related outcomes (Rollnick et al., 2007). Given some moderating effects of race with use of MI, there is a need to adapt clinical approaches so that all patients can engage (Grobe et al., 2019). With their specialized training, health psychologists may be more skilled to observe when a Veteran is engaging or disengaging in an interaction. When indicated, the health psychologist can adjust their own communication style along the continuum of directive, guiding, and following so that they may interact more effectively with individuals of diverse backgrounds. For example, Grobe et al (2019) found that MI for tobacco cessation was less effective for African American than other participants. The authors discuss the literature's mixed findings suggesting a flexible style, shifting from one approach to another, may be more culturally responsive. The authors believe a health psychologist's skill and adaptive use of HBM, MI and other models (Shumaker et al., 2009) contribute significantly to how integrative services are more inclusive and reach more diverse populations.

Broad, Adaptive Health Psychology Services

The authors deliver a broad set of services, beyond the role in interdisciplinary chronic disease management, at a VA where few specialized health psychology positions are funded. The services provide consultative, time-delimited, or longer-term behavioral health and psychotherapeutic services to support Veteran's adjustment to chronic health conditions.. Veterans referred may or may not meet criteria for a mental health diagnosis. As introduced above, appointments with health psychology often coordinate with the Veteran's medical care. Across a wide range of referral sources, the services provide a link between the referral source and options for an episode of care for individual behavioral health or psychotherapy.

A central tenet in this approach is to keep in mind some foundational challenges that remain for the field of psychotherapy. It has been reported that 18% of the U.S. population meets criteria for a mental health diagnosis; yet, less than half will engage with specialty mental health services (Kessler & Wang, 2008; The State of Mental Health in America, 2015). Mental health stigma and misdiagnosis for BIPOC (Center for Disease Control, May 7, 2022; Ward et al., 2013) magnify these challenges. Some health psychologists approach a first session as a standardized "intake", using a framework based on healthcare metrics (e.g., mental health symptoms, PHQ9 and GAD7 in primary care, pre-diabetes, diabetes status and adherence). In an individual or conjoint first session with these broad, adaptive health psychology services, the authors "*meet the Veteran where they are at*" drawing from MI. It follows, then, that we are steadfastly person-centered, exploring mood and functioning broadly, to optimize investment in the first and subsequent interactions with a Veteran. The authors utilize measurement-based care approaches to communicate and demonstrate value when indicated. However, case conceptualization and team-based adaptive planning for consultation and clinical care are foremost.

One example of this referral and adaptive intake process is with Veterans coping with a chronic condition such as diabetes and/or heart disease. A diabetes educator or other clinician from the specialty clinic (e.g., Endocrine, Cardiology or a diabetes self-management program) contacts the authors by medical record referral or informal correspondence (call, email, etc.). In these communications, concerns about a Veteran's adherence and readiness to set diabetes-related or other behavior goals are discussed. Some referring clinicians convey concerns about co-occurring mental health; others may inquire about cognitive concerns. In these initial consultations, the writers query about the psychosocial context, conflicted social support and communication; distinctions between pre-existing

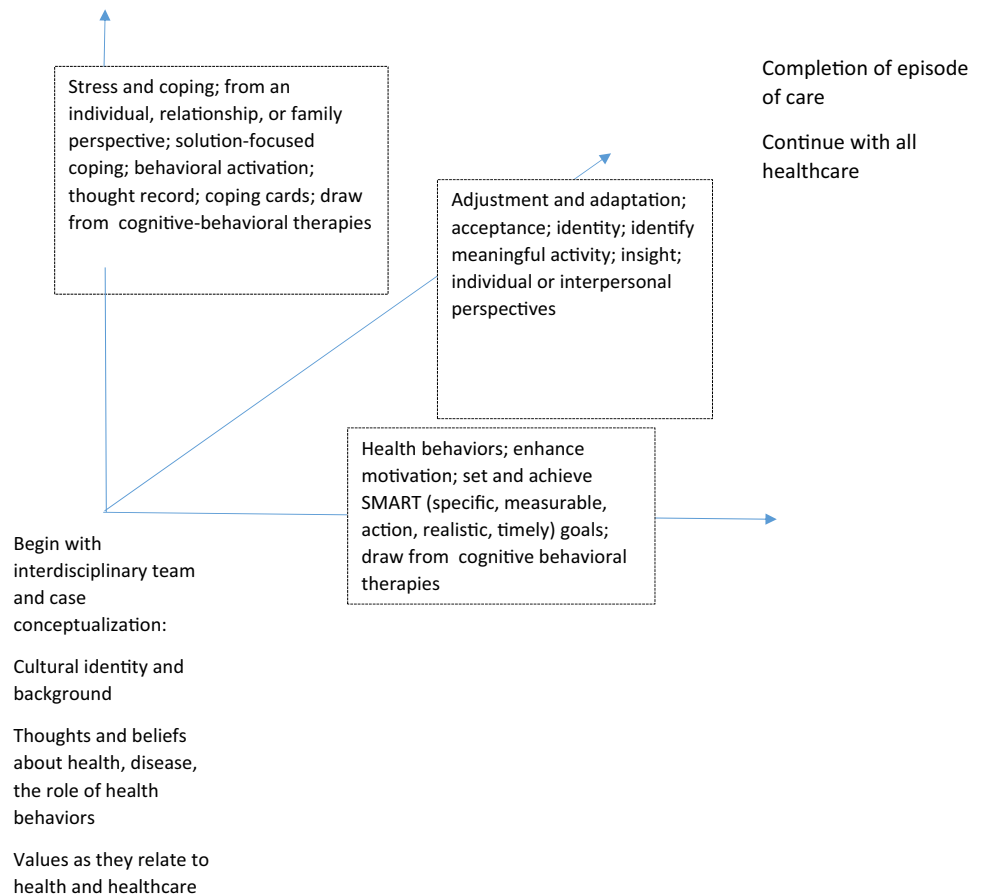
mood disorders and adjustment disorders related to the medical context may be explored. The authors review the medical record for most recent and upcoming appointments, planning for an initial session or brief introduction. Depending on the Veteran's degree of ambivalence or readiness for an adjunctive service, the authors may make a brief telephone call, or in-person introduction coordinated with the referral source. The services are described as a supportive resource tailored to Veteran's individual needs; expressions of ambivalence are normalized. Per Veteran's preferences, a second session is set, which similarly varies in setting, format and length. From this flexible orientation, the services transition to an agreed upon frequency and approximate number of sessions that draw on the evidence-based behavioral medicine and psychotherapies. The authors often hear from referral sources and Veterans later in an episode of care, that they would not have engaged without such flexibility.

A Framework for Broad, Adaptive Health Psychology Cases

For those Veterans that a more comprehensive behavioral medicine or psychotherapy episode of care is indicated, the

authors engage with collaborative decision-making for the therapeutic approach. The services complement the Veteran's healthcare overall, with goals ranging from symptom reduction to enhancing functioning and quality-of-life. Figure 1 below offers a framework as to how these episodes of clinical care take shape and the types of evidence-based therapeutic services considered and rendered. For one recent psychotherapy case that followed this model, one author followed cognitive-behavioral therapy (CBT) for depression. After two brief, initial sessions following an Endocrine Clinic appointment, the episode of care explored undiagnosed major depression with which the Veteran from the BIPOC community copes. The Veteran declined specialty and primary care mental health integrated care that were offered. The integrated health psychologist collaborated further with prescribers from primary care, while introducing a range of cognitive and behavioral strategies. In exploring his BIPOC identity, it became important not to label any health behaviors as non-adherent, or that the Veteran had low motivation for self-management. Rather, the Veteran described health and other beliefs that aligned with his cultural identity, such as desire to be a strong father figure. The services focused initially on behavioral activation. This included physical activity which was more consistent with

Fig. 1 Framework for broad, adaptive health psychology services across a healthcare system



the Veteran's values. One goal of bike riding with his family served simultaneously as solution-focused coping with family interactions as well as a diabetes self-management goal. In subsequent sessions, rigid thoughts about parenting and self-care were challenged. Using a thought record, the Veteran identified alternative thoughts that served as motivating, guiding ideas and images.

As another anecdotal example, one Veteran of color referred for diabetes self-management did not respond to the VA consult or referral procedures (i.e., three different outreach attempts on different dates). The consult could have been completed. However, this individual previously had COVID-19 and a history with co-occurring medical and mental health conditions. Therefore, one author consulted with clinicians who previously provided care to the Veteran, conducted additional outreach, and left a HIPPA-compliant message with a family member. The family member replied, explaining the Veteran had inadvertently blocked some numbers on his cell phone. With exploration, the family member readily connected everyone on a conference call (clinician, Veteran and Veteran's family member). With discussion, the Veteran accepted a health psychology intervention offering. Since this start, the Veteran has engaged in an episode of care via telephone. The author coordinates the timing of the telephone sessions with the Veteran's primary and other health care appointments, supporting re-engagement in all of his care. The sessions have employed acceptance-based strategies to address grief and loss that the Veteran disclosed, as well as behavioral activation for a range of meaningful activity, some which includes diabetes self-management action.

Case Examples of Health Psychology Services Reaching BIPOC Veterans

Integrated health psychologists, with their specific training in behavioral medicine and behavioral health strategies, have an opportunity to be strategic and support greater inclusion and engagement of more diverse Veteran populations. The interventions provided by integrated health psychologists can align behavioral strategies and goal setting with Veterans' cultures, and thereby may help address healthcare inequities. Anecdotally, one author has witnessed greater participation of Veterans of color in integrated behavioral health services, compared to specialty mental health services within the VA system. While BIPOC Veterans comprise 18.1% of the author's healthcare system population, two small pilot studies conducted in the integrated services (a female Veteran weight management program and a diabetes with co-occurring conditions study; Bloor et al., 2015; Kane, et al., 2021) reported a higher percentage of BIPOC Veteran participants (33% and 30.8%, respectively).

Table 1 below outlines case examples of integrated health psychology services which have spanned interdisciplinary disease management program participation and transitioned into episodes of individual psychotherapy and/or behavioral health interventions. All examples are health psychology cases for Veterans who are Black, Indigenous and other People of Color (BIPOC). In order to protect private health information and confidentiality of the individual BIPOC Veterans, the authors describe "elements" or aspects of the integrated health psychology services, namely referral sources, types of measures/outcomes, case conceptualizations, and types of interventions (behavioral and psychotherapy).

Recommendations for Sustaining Broad Health Psychology Services

Evaluating engagement, processes and outcomes for integrated health psychology exemplified in Table 1 is paramount. BIPOC Veterans use VA healthcare increasingly, yet there are concerning issues of discrimination and health disparities to address. This paper has aimed to describe how integrated health psychologists can contribute to improvements with chronic disease management and equitable healthcare by offering adaptive behavioral and mental health interventions across the healthcare system. In order to secure the value and sustainability of such integrated health psychology services, the authors suggest the following policy and programming recommendations as well as research propositions.

Policy and Programming Recommendations

First, specify health psychology as a required discipline in interdisciplinary disease management teams. While health psychologists are not required members, the authors have detailed how the discipline brings a unique set of skills and viewpoint to interdisciplinary teams that potentially engage more fully and retain a broader range of Veterans.

Second, programming elements or criteria for a health psychology referral and intake session can allow for cultural responsiveness. That is, rules can be applied adaptively for individual case needs. The siloed care the authors have observed is often guided by services that are diagnostically and requirement-driven. For example, if a Veteran carries the diagnoses of diabetes and posttraumatic stress disorder, they likely receive separate referrals for diabetes self-management and specialized mental health services. These services can require completing several self-report forms and appointments at inflexible or separate times. In addition to mental health stigma, the authors have observed Veterans who decline specialty mental healthcare and/or report that engaging in such care interferes with their medical

Table 1 Black Indigenous and other People of Color (BIPOC) Veteran case stories of engagement with integrated health psychology services

Measurement-based processes and outcomes	
Referral sources	<ul style="list-style-type: none"> -Primary care provider -Diabetes educator, cardiologist or other medical specialist -Mental health specialty clinician -Self- or clinician referral from chronic disease management program
Case conceptualizations	<ul style="list-style-type: none"> -After years of adherence and meeting blood sugar goals, male with co-occurring depression no longer finds motivation or willingness to engage in self-management -Male with strong family history of heart disease and prior open-heart surgery, insomnia associated with thoughts of dying while asleep, focuses on raising children as a single parent -Male untreated depression, anxiety and self-management of diabetes describes rigid thoughts about self-management as selfish, unnecessary -Males with diabetes with fear of injection / use of needles for insulin delivery, co-occurring posttraumatic stress; needles and injection associated with drug use and/or putting something foreign into one's body -Male with heart disease, diabetes and depression, also providing caregiving role to family members with dementia, relies on prayer for coping -Female disconnected from family ties, significant other adjusting to head and neck cancer; previously, social connections most important aspect of adaptive coping
Interventions: Behavioral health focus	<ul style="list-style-type: none"> -Explore ambivalence about identifying and setting personal health goals related to adherence -Explored synergy between life roles and health goals, such as culturally respectful eating wisely goals for the family, to align with his parenting goals -Identify additional health behavior goals such as eating wisely, or moving the body/exercise based on Veteran's health beliefs as well as healthcare information Increase understanding, validate and normalize fear of needles Solution-focused coping to access affordable healthy foods Portion size and mindful, intuitive eating goals (versus food choices) -Focus on being involved in healthcare, adjusting activities to what is feasible
Interventions: Psychotherapy focus	<ul style="list-style-type: none"> -Clarify family and independent values, in order to identify more personalized, holistic goals in which Veteran invests -Implement thought record, identifying alternative thoughts, associated with sleep, eating, movement or exercise -Develop the discrepancy in ambivalence between the health-care system's goals and that of the Veteran's health beliefs, family level, or systemic racism related goals -Practice mindful awareness within the psychosocial context of the Veteran and observe with curiosity responses—thoughts, behaviors, sensations—during and following insulin injections -Cognitive restructuring around health beliefs, while respecting the protective role of religious-focused coping -Behavioral activation in Veteran's identified meaningful actions, serving as role model for family or community -Acceptance, exploring and finding meaning with grief and loss; explore and increase awareness of multiple losses and grief; explore association between loss and trauma
Process measures include: (a) qualitative descriptions of consult management; (b) number of sessions; (c) flexibility of format (in-person in coordination with other appointments, telephone, virtual/video); (d) individual and/or with family member(s), and (e) Veteran's comments/testimonials	<ul style="list-style-type: none"> -Outcomes include mood symptom measures (PHQ9, GAD7), setting and/or achieving one or more health goals, medical condition specific measures (Diabetes Related Distress), and objective measures such as A1c for diabetes, blood pressure, or weight

appointments. The availability of clinical health psychologists to collaborate with primary and specialty care is paramount to enhancing Veteran participation, behavior change and outcomes.

Third, clinic schedules and productivity for interdisciplinary team members need to allow for indirect, non-patient care time and coordination of the team's care. Every case example described in this paper required significant indirect care time and coordination. Clinicians who work in siloes or separate teams are without mechanisms and support for such team communication. Some coordination and planning for such services may happen in primary care, but remain challenging (see Watkins et al., 2011 discussion on challenges for engagement that remains for primary care mental health integration). The complexity of team “huddles” in primary care continues to be studied and deserves consideration in disease self-management programs.

Research and Quality Improvement Suggestions

Healthcare necessarily measures access to care, objective medical outcomes, clinician productivity and revenue. Also, diagnostically derived symptoms are likely the most common psychotherapy outcome measure. However, the adaptations to services described in this paper may warrant adjustments to evaluation measures. *One adjustment is to measure perceptions of integrated health psychology and satisfaction with health care.* This effort could garner support and help sustain integrated psychological services. Perceptions of utility and trust can be assessed from the viewpoint of Veterans or patients as well as referring providers and interdisciplinary team members. Such evaluation could, in part, address experiences of misunderstanding, mistrust and/or discrimination among BIPOC communities that have been documented in healthcare (e.g., Centers for Disease Control, May 7, 2022; Lewis et al, 2015; Zickmund et al., 2018). One example is a “referring providers’ perceptions of health psychology services” survey conducted by the authors previously. The authors initial paper documented broad satisfaction with integrated health psychology services, adding quantitative data to support perceptions such as:

- (1) “I don’t think the Veteran would have come in and been admitted for the surgery without you calling and talking with him”—Oncology Surgeon
- (2) “After you met with the Veteran, he started to trust me and the healthcare system again. I feel like we now have rapport and can work on health behaviors proactively.”—Primary Care Physician (Bloor et al., 2017)

Moreover, measuring perceptions and satisfaction can identify elements of the services that need improvement as well as new areas of need.

Another adaptation for evaluations could be to measure more nuanced and longer-term outcomes. In the diabetes pilot referenced earlier, the authors found that diabetes-related distress lessened in our small sample (Kane et al., 2021). Still, important clinical details were not captured in the report. One meaningful clinical anecdote to the diabetes pilot is a BIPOC Veteran who did not complete the post measures due to psychosocial stressors and canceled appointments during the time of the study. Approximately one year after the study concluded, this Veteran returned for primary care appointments and re-engaged with health psychology. He manages his own chronic conditions including depression, as well as caregiving for a family member with dementia. The life events he experienced during the study included caretaking for an additional family member diagnosed with dementia. The family counted on the Veteran to help even more. When the Veteran re-engaged with health psychology, his self-report was “extremely satisfied with care”, improvement with mood, and increased confidence in his ability to balance self-care and care for others. Moreover, the Veteran had met his A1c, blood sugar goal for managing diabetes for the first time since his diagnosis.

To capture relevant aspects of this case example, *integrated health psychologists can report:* (1) cultural representation by reporting study sample demographics and comparing these to the demographics of the population served; (2) measures of engagement in services over longer, more inclusive time frames, such as 6-, 12- and 18-month follow-up, not only standardized disease self-management or psychotherapy time-delimited time frames; and, (3) qualitative assessment of culturally relevant goals (e.g., initiation of and progress towards a culturally relevant goal) in addition to general and disease-specific distress, health status, depression and anxiety measures.

Integrated health psychologists need to garner both mental health as well as primary care and medical care leadership support. In turn, integrated health psychology may attain greater healthcare system recognition. The authors hope the kinds of policy, programming, and research recommendations made here could be instrumental in garnering this needed support and recognition. With successful implementation of such recommendations and hospital-wide support, broad and adaptive health psychology services can continue to benefit more diverse, complex and deserving Veteran populations.

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Data Availability This paper does not report on additional/original data collection.

Code Availability Per above, not applicable.

Declarations

Conflict of Interest Lindsey E. Bloor, Alexander A. Jendrusina, Kyle Rexer have no commercial relationships relevant to the content of this manuscript. Authors report no conflicts of interest.

Ethical Approval Examples are clinical cases described in the manuscript use “elements” or aspects of the integrated health psychology services, in order to protect private health information and confidentiality of individual BIPOC Veterans.

Consent to Participate Two pilot studies referenced in the manuscript had full approval by the VA Ann Arbor Healthcare System Institutional Review Board (IRB) and Research & Development Committees. Full references are provided.

Consent for Publication This manuscript has not been submitted elsewhere for publication and will not be submitted elsewhere while under your consideration.

Human and Animal Rights This paper is a portrayal of clinical services and integrated approach. The case examples are de-identified and presented in terms of elements or themes of the cases in order to further protect any identifiable information.

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