
   a. **Summary:** As obstetrics and gynecology (ob/gyn) practices move toward becoming patient-centered medical homes for their patients, the need for providing integrated behavioral health care has increased. Themes common in ob/gyn settings—such as menstruation concerns, initiation of contraception, pregnancy, childbirth, and menopause—serve as occasions for health promotion and as life transitions where behavioral health concerns may arise. When these transitions are complicated by issues such as trauma, infertiltiy, and pregnancy loss, the need for sensitive, collaborative care between psychology and obstetrics/gynecology becomes particularly critical. Women’s health psychologists can serve a key role for ob/gyn practices by co-managing patients’ care, offering consultation to providers, providing brief behavioral health consultations to patients, facilitating psychotherapy engagement, and providing treatment for women and their families.


   a. **Summary:** Special patient populations can present unique opportunities and challenges to integrating primary care and behavioral health services. This article focuses on four special populations: children with special needs, persons with severe and persistent mental illness, refugees, and deaf people who communicate via sign language. The current state of primary care and behavioral health collaboration regarding each of these four populations is examined via Doherty, McDaniel, and Baird’s (1996) five-level collaboration model. The section on children with special needs offers contrasting case studies that highlight the consequences of effective versus ineffective service integration. The challenges and potential benefits of service integration for the severely mentally ill are examined via description of PRICARe (Promoting Resources for Integrated Care and Recovery), a model program in Colorado. The discussion regarding a refugee population focuses on service integration needs and emerging collaborative models as well as ways in which refugee mental health research can be improved. The section on deaf individuals examines how sign language users are typically marginalized in health care settings and offers suggestions for improving the
health care experiences and outcomes of deaf persons. A well-integrated model program for deaf persons in Austria is described. All four of these special populations will benefit from further integration of primary care and mental health services.


   a. **Summary:** Despite an early interest in pediatrics among psychologists and a natural partnership between psychology and pediatrics, psychologists’ impact on services for children in primary care settings could be much greater than it is. The purpose of this article is to describe the special contributions of pediatric psychologists and pediatricians in the development of comprehensive, integrated systems of health care for children; the importance of health behavior change as a preventive measure in the lives of children and adolescents; and how psychologists, through their leadership in clinical, research, and advocacy efforts, can harness the important resources of family relationships to promote the health of children.


   a. **Summary:** The purpose of this study was to assess the effect of integrating behavioral health services into well-child visits in underserved, remote, and/or fringe areas. Specifically, the following were examined: the structure of the well-child visit for standard care in comparison to when a behavioral health provider was integrated into the visit and the effect of integrating a behavioral health provider on behavioral health topics covered and parent satisfaction. Participants were 94 caregivers of children attending well-child visits. Group differences were examined for participants in well-child visits with a behavioral health provider and participants in a standard well-child visit. Findings suggest a statistically significant increase in caregiver-rated perception for the number of topics covered with the integration of a behavioral health provider in the well-child visits. No significant effects of caregiver-rated helpfulness or satisfaction were observed. Implications for the findings and future research directions are discussed.

a. **Summary:** Quality improvement programs for depressed youths in primary care settings have been shown to improve 6-month clinical outcomes, but longer-term outcomes are unknown. The authors examined 6-, 12-, and 18-month outcomes of a primary care quality improvement intervention. **METHOD:** Primary care patients 13-21 years of age with current depressive symptoms were randomly assigned to a 6-month quality improvement intervention (N=211) or to treatment as usual enhanced with provider training (N=207). The quality improvement intervention featured expert leader teams to oversee implementation of the intervention; clinical care managers trained in cognitive-behavioral therapy for depression to support patient evaluation and treatment; and support for patient and provider choice of treatments. **RESULTS:** The quality improvement intervention, relative to enhanced treatment as usual, lowered the likelihood of severe depression (Center for Epidemiological Studies Depression Scale score \( \geq 24 \)) at 6 months; a similar trend at 18 months was not statistically significant. Path analyses revealed a significant indirect intervention effect on long-term depression due to the initial intervention improvement at 6 months. **CONCLUSIONS:** In this randomized effectiveness trial of a primary care quality improvement intervention for depressed youths, the main effect of the intervention on outcomes was to decrease the likelihood of severe depression at the 6-month outcome assessment. These early intervention-related improvements conferred additional long-term protection through a favorable shift in illness course through 12 and 18 months.


a. **Summary:** Health care access issues present significant challenges for rural populations and health providers. Psychology can support improved access and quality of rural health services through the development of integrated behavior health programs within primary care settings. This article reviews a clinical training and service delivery program, the Rural Hawai‘i Behavioral Health Program, which has evolved in response to the pressing health needs of Native Hawaiians in rural communities. Native Hawaiian cultural factors and components of the primary care model that have supported the development of this program will be reviewed. Program expansion, sustainability, and treatment efficacy research will be discussed.