Culture, in terms relevant to mental health clinicians, can be defined as “a set of meanings, norms, beliefs, and values shared by a group of people; it is dynamic and evolves over time and with each generation...culture shapes how individuals make sense of the social and natural world...and culture shapes how and what symptoms are expressed” (p 4-5). Our culture and our patients’ culture shape our interactions, and help define and determine how we treat our patients. Knowledge of various cultures and cultural psychiatry is becoming more important and essential, especially in a multicultural society such as the United States, but, in fact, around the world, as it is becoming more and more interconnected. Learning how to practice, what I would call, culturally informed psychiatry (or, if you wish, cultural psychiatry) is crucial, not only for psychiatrists-in-training but also for practicing clinicians. “Culture exists in a constant state of change” (p 5) and our society also is constantly changing. Thus guides on how to practice culturally informed psychiatry are important. They help us not only to catch up but also to refresh and adjust to cultural changes.

Russell F. Lim, MD, has revised his popular Clinical Manual of Cultural Psychiatry and with a group of clinician-experts in this area published its second DSM-5 updated edition. In addition to using DSM-5 concepts and definitions, the book includes several new topics (with their own chapters) and an online access to clinical vignettes/interviews of patients from various cultural backgrounds. (The fictional cases are available at www.appi.org/Lim.)

The first 2 chapters deal with general concepts: 1. “Assessment of culturally diverse individuals: Introduction and foundation” and 2. “Applying the DSM-5 outline for cultural formulation and the cultural formulation interview: A resident’s/early career psychiatrist’s perspective.” The chapter on assessment provides a historic perspective; it discusses culture vs ethnicity vs race, reviews the concept of cultural conceptualization of distress, psychosocial stressors, and cultural features of vulnerability and resilience. Among several recommendations, the authors note that “Cultural myopia occurs when the clinician frames the therapy in cultural terms to the exclusion of other clinical perspectives” (p 27). A useful part of this chapter discusses the use of interpreters and their competency criteria. (The second chapter also mentions that if no interpreter is available, one can use national telephone translation services, such as Certified Languages International [www.certifiedlanguages.com], 1-800-Translate [www.1-800-translate.com].) I would welcome, however, a better discussion of “Euro-American Culture,” which is mentioned in passing as placing “a high value on independence, autonomy, and self-sufficiency, perhaps best reflected in the pioneer image of self-reliance and ‘rugged individualism’” (p12). The second chapter emphasizes that “everyone brings his or her own personal and professional culture to an interaction; culture influences many aspects of psychiatric illness, including illness manifestation, coping, and help-seeking behavior” (p 43). The chapter also includes a detailed outline of cultural identity of the individual (language, place of origin, socioeconomic status, relationship and sexual orientation, ethnicity, race, age, religion/spirituality, education, immigration history, and level of acculturation), with good examples of how to ask about all aspects of one’s cultural identity. Similar to other chapters, it is well-illustrated with video examples.

The following 4 chapters review in great detail issues in the assessment and treatment of African American
patients, Asian American patients, Latino patients, American Indian, and Alaska Native patients. The chapters are informative and detailed, with a lot of interesting reading. However, why just these 4 groups were selected is not clear to me. The selection seems to be the usual “menu” of many cultural manuals and other cultural psychiatry texts. The chapter on Asian American patients, compared with other previous texts, includes a brief section about the population of the Indian subcontinent, which is a significant progress—Albert Gaw’s seminal book on cultural psychiatry⁠1 did not mentioned this area of the world at all! I think that the book would be better served by shorter chapters addressing more specific Asian cultures (including discussing their religions) than to lump population of this vast and diverse continent together. Plus, there are significant omissions of important parts and cultures of the world (eg, the Middle East and Islamic culture, and Judaism [also in relation to the Jewish culture in diaspora] and sub-Saharan Africa). Both omissions are hard to understand, but have happened in other cultural psychiatry texts.

The next 3 chapters review cultural issues in women’s mental health; cultural issues in gay men, lesbians, and transsexuals; and cultural issues of transgender and gender nonconforming patients. Again, the chapters are informative, interesting, and loaded with facts (eg, a table where same-sex relationships are legal in the United States and other countries). The following chapter focuses on religious and spiritual assessment. Although the topic is interesting, I believe that a review of world religions, their basic tenets, and attitudes toward mental health issues would be useful, too. The last chapter of this part addresses the, in my opinion, overrated area of ethnopsychopharmacology. It includes informative tables on various topics that one is not sure what to do with. An example is the table on ethnicity and atypical antipsychotics, such as risperidone: faster response in Puerto Rican and Dominican patients (faster than what?), or clozapine: Argentina and Chile: lower dosages increased diabetes mellitus and death from cardiovascular disease.

The book concludes with a chapter on applying the updated DSM-5 outline for cultural formulation and formulation interview and 3 appendices. Appendix 1 is a reprint of the DSM-5 Outline for Cultural Formulation, Cultural Formulation Interview, and Supplementary Modules. Appendix 2 is a reprint of the DSM-5 Glossary of Cultural Concepts of Distress (the old culture-bound syndromes). Again, such as in many other instances, it is not clear how these cultural concepts were selected. A much more complete list of cultural concepts or syndromes likely would be more useful. Appendix 3 lists the cultural formulations of case examples seen in the videos.

Do not get me wrong, this is a useful book, a product of a lot of hard labor, and the videos are a great addition. I agree with the editor’s stated hope that it will be useful to medical students, residents, psychiatrists, psychologists, and all mental health practitioners when they begin their evaluation of and work with culturally diverse patients. My main issue with this clinical manual is not with what is in the book but with mostly what is missing, and that is a bit long for a “clinical manual.” Both of those issues could be fixed…in the third edition!

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As pointed out in the book’s Introduction, “…there has been a steady decline in the availability of psychiatric services, both inpatient and outpatient, for children and adults. As a result, more and more children in behavioral crisis are referred to emergency departments, where processes and facilities may be limited, creating a suboptimal environment for their care. Although the majority of children will be discharged home, they typically must wait for prolonged periods in disruptive environments that may escalate their symptoms” (p xi).

This statement actually highlights a couple of issues—the need for a good pedopsychiatric emergency room (ER) or setting (within the general ER) available everywhere, and the importance of knowing how to avoid referring a child or adolescent to the ER. The statement also raises a question of possible over-medicalization of various aspects of child and adolescent behavior.

A group of specialists from the Children’s Comprehensive Psychiatric Emergency Program at Bellevue Hospital Center in New York City put together a small volume addressing questions about which children should be referred to the ER, what should be tried before sending them to the ER, and what should be the best course of action. The first chapter, “Kids in crisis,” starts by stating that the ER often is a bad place to start psychiatric treatment and outlines the main goal of this volume: “to assist those who work with children—teachers, guidance counselors, pediatricians, social workers, community mental health providers, and others—to recognize the early warning signs of impending mental health crisis and help kids get help so that the crisis (and the trip to the ER) can be averted…making the most of an ER visit if it is truly needed and preventing future incidents to help kids stay safe and stay on track” (p 2). The chapter then describes what a psychiatric crisis is, how it can come on gradually or suddenly, or be evident only at home or at school. It discusses when a psychiatric crisis is an emergency (most psychiatric crises are not true emergencies and could be managed outside the ER); what to expect from the ER (most kids are discharged the same day); how to understand the ER evaluation; and how to work with ER staff. The last part of this chapter points out specific ways to avoid the ER: (1) by being familiar with the resources available in your community and in your program to manage a crisis; (2) by working with your team to plan for managing a crisis; (3) when treating a child in a mental health crisis, by approaching the child in a caring, inquisitive way rather than in a disciplinary way; (4) by knowing the child and the environment he (she) is coming from; (5) by knowing that children in general do not want to be “in trouble” and, if they are in crisis, it generally is because they do not know how to help themselves with whatever is going on; and (6) whenever staff (and others) feel they are stuck and there is no way around the problem, they should put themselves in the child’s shoes (p 9-10).

The following 8 chapters review common crisis situations: aggression; suicide and self-injurious behavior; tantrums and behavioral outbursts; the “odd” child; child abuse and trauma; risky behaviors; clinical and forensic psychological issues with at-risk youths and juvenile delinquents; and substance use.
The chapters follow a similar structure, starting with a brief overview of the topic and case presentation, then discussing the understanding of the specific crisis, identifying kids at risk for the specific issue discussed (aggression, suicide, etc.), differential diagnosis, identification of immediate triggers, risk assessment, on-site stabilization (before going to the ER), and deciding when to get help. Each of these chapters (after references) is accompanied by a diagram of the process of managing the specific crisis, from catching the warning signs to referral to the ER if specific behaviors occur or continue. The text emphasizes various management issues, e.g., that even if one has decided to call 911 or the police, “de-escalating the crisis onsite as much as possible is important. De-escalation can prevent injury and assault and minimize the negative impact on both the child in crisis and any adults and children witnessing the event” (p 26). The chapter on tantrums emphasizes that tantrums that persist past kindergarten are reasons for concern and that tantrums occurring daily, even in young children, or regularly lasting longer than 10 minutes should be a red flag that the behavior is outside of the norm (p 55). The chapter on child abuse and trauma includes online resources for working with traumatized children. The behaviors discussed in the chapter on risky behaviors include truancy, runaway behavior, substance abuse, and risky sexual behavior.

The chapter on clinical and forensic psychological issues emphasizes the need for collaboration among various institutions and workers to find solutions, from forensic case workers to law guardians and guardians ad litem, parole officers, diversionary programs, juvenile detention centers, and secure residential programs. The chapter also points out the importance of knowing the child’s guardian status and having legal documentation upon arrival to the ER (Who has the physical custody of the child? What if a parent is incarcerated and is unable to provide consent? What if the child is ward of the state?). Finally, the chapter on substance use raises many important issues, such as the rapid development of the adolescent brain, which can be seriously disrupted by substance abuse (there may be persistent cognitive impairment in those who started to smoke marijuana as adolescents), or the risk and protective factors for substance use and substance use disorders (individual, family, and school and community ones), and some telltale signs of intoxication for commonly used substances. (The Partnership for Drug-Free Kids Web site has a more comprehensive list at www.drugfree.org/drug-guide.) The chapter also includes a list of some common drugs and their street names.

The last 2 chapters deal with system issues. Chapter 10, “Finding help—helping families find effective treatment for children with psychiatric illness,” lists, describes, and explains numerous psychiatric services, such as outpatient mental health clinics, walk-in services, school-based clinics, mobile crisis programs, home-based crisis programs, case management, children’s community residences, residential treatment facilities, various educational programs, preventive services (e.g., in-home preservation services, foster care placement), and, finally, services for children with developmental disabilities. The last chapter reviews various models of emergency psychiatric care for children and adolescents, such as community-based models, hospital-based models, and emergency department-based models.

Perhaps the title of this book should have been “How to avoid referral to the psychiatric emergency room,” because that really is the main message. And, actually, it is a good, useful, and well-conveyed message, because ER care is suboptimal and disruptive. I am not completely sure who the audience of this book should be. I agree with Susan Torrey who writes in the introduction that the book “will be useful to practitioners in hospital or community-based settings, including physicians in training, pediatricians who work in office-based or emergency settings, psychologists, social workers, school psychologists, guidance counselors and school nurses” (p xii); I would say that the book will be especially useful for those working with kids in the school setting. However, I am not sure how this book would be helpful to parents, as suggested on the cover. How would they get to it and really read it? Maybe this book also should be available on the Web with an option to download a specific chapter that the “specialist” could offer to parents of a child with a specific problem.

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Integrated care—the integration of primary care and behavioral health—has become a mantra of public or community psychiatry and also of some primary care physicians, and rightfully so for several reasons. The public sector takes care of the seriously mentally ill. Severely mentally ill individuals also often suffer from serious physical illnesses (most of them either partially preventable or treatable). They do not always seek treatment for these illnesses, or do not comply with referrals for treatment. Severely mentally ill people also have a 25-year reduced life expectancy (p xiii), probably for a combination of reasons, with serious physical illnesses playing a major role in the shortened life expectancy. Finally, it has been shown that “mental health disorders (largely depressive, anxiety, and substance abuse disorders) occur in approximately 20%-25% of primary care patients and that quality of mental health care is poor and mental health outcomes are problematic” (p ix). Psychiatrists do not provide good care for their patients’ physical illnesses, and primary care physicians do not take good care of their patients’ mental health issues. Thus integration of their services clearly makes sense.

The literature supporting the notion of integration of primary care and behavioral health is rich; however, there are not many summarizing texts available. Lori E. Rainey, MD, put together a group of behavioral health experts on integrated care who summarized various aspects of this topic in the 10 chapters of this volume. The book is divided into 2 sections: I. Behavioral Health in Primary Care Settings and II. Primary Care in Behavioral Health Settings. The first section includes 6 chapters: 1. “Evidence base and core principles;” 2. “The collaborative care team in action”; 3. “Role of the consulting psychiatrist”; 4. “Child and adolescent psychiatry in integrated settings”; 5. “Risk management and liability issues in integrated care”; and 6. “Training psychiatrists for integrated care.” As noted in the Preface, “The terms integrated care and collaborative care are often used interchangeably and essentially imply a similar delivery system” (p xiv). The way to think about it, according to Dr. Rainey, is that systems are integrated and people collaborate (p xiv).

The first chapter presents discussions of various terminology and issues such as cost-effectiveness of collaborative care, core principles (patient-centered care, evidence-based care, measurement-based treatment to target, population-based care, and accountable care), and collaborative care team. The authors point out that psychiatric consultants on such teams typically provide a range of services that include (1) informal “curbside consultations” to CMs [care managers] and PCPs [primary care providers] in person or by telephone, (2) systematic case review meetings in which psychiatrists meet with a primary care-based CM and/or PCP to systematically review all patients on a clinician’s panel who are presenting diagnostic or therapeutic challenges, and (3) occasional face-to-face consultations where they are requested by a PCP to see a patient in person or by televideo connection” (p 10). Coordinated care enhances primary care by “adding three crucial services: (1) care coordination and care management for patients; (2) proactive monitoring and treatment to target using validated clinical rating scales; and (3) regular systematic caseload review and consultation for patients who do not show clinical improvement” (p 10-11). The chapter is a solid introduction to the

Integrated Care: Working at the Interface of Primary Care and Behavioral Health

topic and to, at times, not-so-easy-to-comprehend language and acronyms of this entire area. (An example of a questionable acronym is “AIMS Center,” which means Advancing Integrated Mental Health Solutions but, for most psychiatrists, “AIMS” means the Abnormal Involuntary Movement Scale.)

The second chapter reviews the differences between primary care and behavioral health cultures (eg, treatment is traditionally physician-driven in primary care, boundaries are flexible in primary care and firm in behavioral health); core tasks and components, such as screening, treatment (“stepped care”), tracking, and program review and feedback; and collaborative care team (behavioral health providers, primary care providers, consultant psychiatrists, and “silent” partners such as receptionists, nurses, or administrators), and the team dynamics at the interface of primary care and behavioral health. It also includes an overview of evidence-based brief interventions, such as motivational interviewing, behavioral activation, problem-solving therapy, and distress tolerance skills. The chapter also includes useful tables on comprehensive vital signs, commonly used screening tools in primary care settings (although I am not sure who uses Brief Psychiatric Rating Scale or Positive and Negative Syndrome Scale in this setting), and a table with Patient Health Questionnaire-9. The authors point out that “Therapists who are used to and enjoy long-term relationships with patients in hour-long sessions may not be suited for the BHP [Behavioral Health Providers] role unless they are excited about making significant changes in the way they practice and are able to adapt to the needs and culture of primary care” (p 27).

The third chapter deals in detail with the roles of the consulting psychiatrist, such as providing informal consultation, direct evaluation of patients, education, population-based care, and leadership (boundary-spanning and shared ones). The chapter also provides some tips for the successful primary care provider-psychiatrist partnership, such as use of humor, flexibility, patience, desire to be part of a team, and willingness to share leadership. The following chapter points out that pediatric primary care has a long history of promoting integrated care and that the term medical home was first used by the American Academy of Pediatrics almost 50 years ago. The chapter expands on the terms and model of integrated care into pediatric primary care and on resident/fellow child and adolescent training in integrated care. The fifth chapter on risk management and liability issues in integrated care “should not be used as a substitute for legal or medical advice...Rather it is intended to provide general risk management information only” (p 91). Nevertheless, the chapter reviews many important issues, such as doctor-patient relationship and legal duty, risk management considerations when providing consultations, the role of the psychiatrist in a split model treatment (eg, supervisory, collaborative and consultative roles), the hybrid role of the psychiatrist in integrated care setting, and its legal implications (eg, contractual issues, policies and procedures, risk management tips, general liability, employment liability, scope of practice, and some new issues such as privacy and security, data breach, and documentation).

The last chapter of this section deals with the issues of training psychiatrists for integrated care and is structured using the 6 general competencies: medical knowledge; patient care; professionalism; interpersonal and communications skills; practice-based learning and improvement; and systems-based practice. The authors emphasize that “Developing an appreciation for the fast-paced, high-volume world of the primary care team is necessary to be able to provide realistic guidance for medical decision making” (p 121).

The second section includes 4 chapters: 7. “The case for primary care in public mental health setting,” 8. “Providing primary care in behavioral health settings,” 9. “Behavioral Health Homes,” and 10. “Management of leading risk factors for cardiovascular disease.” The chapter outlining the case for primary care discusses the mortality and morbidity among seriously mentally ill, modifiable risk factors (health behaviors: tobacco use, substance use, poor diet, lack of physical activity, high-risk sexual activity), social determinants of health (the economic and social conditions that influence health status in individuals and groups), medication effects, and low quality of care provided to severely mentally ill individual. Following discussion emphasizes that psychiatrists are in a unique position to lead the multidisciplinary effort to modify these factors because...
they are trained to treat both physical and psychological illness. The chapter then expands on approaches to adverse health behaviors, such as substance use, tobacco use, diet, exercise, medication side effects, and others. The next chapter on providing primary care in behavioral health setting describes structure of programs providing these services (eg, administrative structures such as the Community Mental Health Centers and Federally Qualified Health Centers and Veterans Affairs programs). The chapter indicates that “Current roles for psychiatrists in the behavioral health setting should already include supporting and motivating attention to health issues, using safer psychotropic medications when possible, and making sure appropriate physical screening (weight, blood pressure, smoking status, lipid profiles, and blood glucose levels) regularly occurs and that abnormal findings are addressed” (p 176). However, the chapter also mentions that, so far, there has not been clear evidence of improvement in behavioral health outcomes from participation in the primary and behavioral health care integration program. The chapter further expands on various administrative issues, such as electronic data gathering or registry development, and provides some practical tips on program design.

The following chapter notes that “the Patient Protection and Affordable Care Act (PPACA) established a ‘health home’ (HH) option under Medicaid to serve enrollees with chronic conditions by building a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for state Medicaid programs” (p 193). The chapter outlines HH requirements, patient eligibility and enrollment, HH service definitions, HH providers, payment methodologies, key principles of the effective HH, and a host of other issues, and includes an example of a Missouri HH program. The last chapter provides excellent guidelines for management of cardiovascular disease risk factors such as obesity, diabetes, dyslipidemia, hypertension, and tobacco use disorders. It includes detailed diet and lifestyle modifications and pharmacotherapy descriptions, and includes clinical pearls for the management of these risk factors. This is clearly the most useful chapter that one can use in her (his) practice whether she (he) practices in integrated care environment or a private office.

This is an interesting and important, yet a bit disappointing book. It includes a lot of information and good case examples (however, the experience examples through the book are not useful), but its writing is uneven and one wishes all chapters were as concrete in their advice as the last 2. It could be a bit shorter. It also is surprising that a book on integration of primary and behavioral health care is written solely by behavioral care specialists (at least based on the authors’ academic appointments), without participation of a single PCP. Nevertheless, it is the first step in the right direction, as the integrated care seems to be the mantra of the future.

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REFERENCE
### BOOKS RECEIVED

The following books have been received or otherwise obtained and will be reviewed by selected individuals, the courtesy of the sender is acknowledged by this listing.

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