

# Integrated Mental Health Care

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This brief overview will summarize the case for providing behavioral health services in primary care, review core components of evidence-based integrated mental health programs and conclude with lessons from regional and national efforts to implement such programs.

## The case for behavioral health services in primary care

Behavioral health problems such as depression, anxiety, alcohol or substance abuse are among the most common and disabling health conditions worldwide. They often co-occur with chronic medical diseases and can substantially worsen associated health outcomes.<sup>1</sup> When behavioral health problems are not effectively treated, they can impair self-care and adherence to medical and mental health treatments, and they are associated with increased mortality and increased overall health care costs.

National surveys have consistently demonstrated that more Americans receive mental health care from primary care providers than from mental health specialists.<sup>2,3</sup> Most patients would prefer an integrated approach in which primary care and mental health providers work together to address medical and behavioral health needs. In reality, however, we have a fragmented system in which medical, mental health, substance abuse and social services are delivered in geographically and organizationally separate “silos” with little to no effective collaboration. In a recent national survey, two-thirds of primary care providers reported they could not get effective mental health services for their patients.<sup>4</sup>

## Improving the treatment of behavioral health problems in primary care

Efforts to improve the treatment of common mental disorders in primary care have focused on screening for common mental disorders, education of primary care providers, development of treatment guidelines and referral to mental health specialty care. Although well intended, these efforts have by and large not

been effective in reducing the substantial burden of mental disorders.<sup>5</sup> Another approach to improve care for patients with behavioral health problems is to co-locate mental health specialists into primary care clinics. Having a mental health professional available to see patients in primary care can improve access to mental health services but there is little evidence that co-location of a behavioral health provider in primary care by itself is sufficient to improve patient outcomes at a population level.<sup>6</sup>

In recent years, a number of conceptual models have been put forth to help guide the integration of medical and mental health services. These include the “Four Quadrant Model” of care<sup>7</sup> and recent work on the patient centered medical home.<sup>8</sup> Other useful summaries of approaches to integrate mental health and primary care have been published by the Milbank Memorial Fund,<sup>9</sup> the Hogg Foundation for Mental Health<sup>10</sup> and the Integrated Behavioral Health Project funded by the California Endowment.<sup>11</sup>

At this point, the most robust research evidence comes from studies of “collaborative care” programs for common mental disorders such as depression<sup>12,13</sup> and anxiety disorders,<sup>14</sup> and from studies of screening and brief intervention programs for at-risk drinking in primary care.<sup>15</sup> In such programs, primary care providers are part of a “collaborative care team” that includes behavioral health staff such as nurses, clinical social workers or psychologists who can support medication management prescribed by PCPs and provide brief, evidence-based psychosocial treatments and a psychiatric consultant who can advise on the care of patients who are not improving as expected.<sup>12</sup>

In the largest trial of collaborative care to date, the IMPACT study, 1,801 primary care patients with depression and chronic medical disorders from 18 primary care clinics in five states were randomly assigned to a collaborative stepped-care program or to care as usual. The program added two new team members to primary care, a depression care manager and a consulting psychiatrist. It also introduced two important clinical processes, systematic tracking of

From Health IT in the Patient Centered Medical Home. Patient Centered Primary Care Collaborative; see <http://www.pccpc.net/files/pep-report.pdf>

clinical outcomes and stepped care in which treatments are systematically adjusted with consultation from a psychiatrist if patients are not improving as expected. IMPACT participants were more than twice as likely as those in usual care to experience a substantial improvement in their depression over 12 months.<sup>16</sup> They also had less physical pain, better social and physical functioning and better overall quality of life than patients in care as usual (<http://impact-uw.org>). This collaborative care approach was preferred by patients and primary care providers<sup>17</sup> and the IMPACT program was found to produce substantial long-term costs savings compared to care as usual.<sup>18</sup> More recent studies have demonstrated the effectiveness of the IMPACT program in depressed adolescents,<sup>19</sup> depressed cancer patients<sup>20</sup> and diabetics<sup>21</sup> including low-income Spanish-speaking patients.<sup>22</sup> The collaborative care approach tested in IMPACT has been recommended as an evidence-based practice by SAMSHA, the President's New Freedom Commission on Mental Health and a number of national organizations including the National Business Group on Health.

### Implementing Effective Integrated Care Programs

Although there is some variation in the components of effective integrated care programs, most of them build on a few core clinical principles. These include the strategies of “measurement-based care,”<sup>23</sup> “stepped care,”<sup>24</sup> and “treating to target.” Systematic measurement of clinical outcomes using brief patient-rating scales, such as the nine-item Patient Health Questionnaire (PHQ-9) for depression,<sup>25</sup> helps clinicians keep track of whether patients are improving as expected or if treatment needs to be adjusted. Psychiatric consultation, a limited resource in most settings, can then be focused on patients who are not improving as expected. Such systematic “treatment to target” can overcome the “clinical inertia” that is often responsible for ineffective treatments of common mental disorders in primary care.<sup>26</sup> Effective programs also include the core components of chronic illness care as proposed by Wagner and colleagues.<sup>27</sup>

In recent years, several national initiatives have supported the implementation of integrated care approaches, including programs supported by the MacArthur Foundation (<http://www.depression-primarycare.org>), HRSA (<http://www.hrsa.gov/mentalhealth>), the Hogg Foundation for Mental Health (<http://hogg.utexas.edu>), the California Endowment (<http://www.ibhp.org/>) and the John A. Hartford Foundation (<http://impact-uw.org>). Large scale implementations of evidence-based programs such

as IMPACT include efforts by national health plans such as Kaiser Permanente<sup>28</sup> or the DIAMOND program in Minnesota, in which the Institute for Clinical Systems Improvement (ICSI) works with eight health plans, 25 medical groups and over 80 primary care clinics to implement collaborative care for depression.<sup>29</sup> In the state of Washington, the Mental Health Integration Program (<http://integratedcare-nw.org>) includes more than 100 community health centers and over 30 community mental health centers that work together to provide integrated care for safety net clients with medical and behavioral health needs.

Below are some of the lessons from such large-scale implementation efforts:

- ▶ Fragmented financing streams are an important barrier to integrating mental health and primary care services,<sup>30</sup> but financial integration does not guarantee clinical integration. Effective financial, operational and clinical integration are needed.
- ▶ Simply co-locating a mental health provider into a primary care setting may improve access to behavioral health care but it does not guarantee improved health outcomes for the large population of primary care patients with mental health needs.
- ▶ Effective treatment requires a move from episodic acute care in which we provide the equivalent of “behavioral health urgent care” to patients presenting for care to a population-based approach in which all patients with behavioral health needs are systematically tracked until the problem is resolved. A “registry” or clinical tracking system can help identify patients who are “falling through the cracks” and support effective stepped care.<sup>31</sup>
- ▶ Initial treatments (be they pharmacologic or psychosocial) are rarely sufficient to achieve desired health outcomes. Systematic outcome tracking, treatment adjustment and consultation for patients who are not improving can help achieve the desired health outcomes.
- ▶ Effective collaboration in primary care requires mental health providers to be flexible. This includes regular communication with patients' PCPs, the willingness to be interrupted during therapy sessions, the use of the telephone to reach patients who cannot make clinic appointments and the use of brief, evidence-based therapies such as motivational interviewing, behavioral activation, problem solving or brief cognitive behavioral

therapy that can be provided in the context of a busy primary care practice.

- ▶ Training providers in integrated care is important but not sufficient. Effective implementation requires ongoing support from clinical champions in primary care and behavioral health, financial support, operational support and a clear set of shared and measurable goals and objectives.
- ▶ There are many ways to implement effective integrated care for behavioral health problems in primary care. Few organizations can take an evidence-based program described in the medical literature “from the shelf” and implement it without adaptations to their local setting. Treatment manuals used in research studies have to be translated into job descriptions and clear operational manuals that help busy clinicians implement the program in their unique settings.
- ▶ Attention to core principles, such as measurement-based care and careful tracking of desired outcomes at the patient and clinic level, can help make sure that integrated care programs live up to their promise as they are implemented in diverse real world settings.

While the full-scale implementation of evidence-based collaborative care programs may be challenging for small- to moderate-sized primary care practices under current health care financing mechanisms,<sup>30</sup> relatively simple changes can help practices improve care and gain important experience on the way to becoming a fully integrated patient-centered health care home. Such changes include:

- ▶ Routine use of brief, structured rating scales for common mental disorders, such as the PHQ-9 for depression,<sup>25</sup> to help with case finding, but more importantly to determine if patients started on treatment are improving as expected.
  - ▶ Incorporation of such behavioral health rating scales into paper or electronic health records, creating a “registry” function that allows PCPs and clinic managers to identify patients who are “falling through the cracks” or not improving as expected.
  - ▶ Stepped care and “treatment to target” in which treatments (medications, psychosocial treatments or referrals to mental health) are actively changed and adjusted until the desired health outcomes are achieved.
- ▶ Incorporation of evidence-based motivational interviewing strategies into patient encounters to help patients engage in and adhere to effective treatment for behavioral health problems.
  - ▶ Training office-based personnel to help perform core support functions of behavioral health care managers such as proactive outreach and tracking of treatment adherence, medication side effects, referrals (if appropriate) and treatment effectiveness.
  - ▶ Development of relationships and shared workflows with behavioral health providers that are not simply referrals but include active dialogue and collaboration between the PCP and the behavioral health provider to ensure patients achieve the desired clinical outcomes.

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