Annals of Internal Medicine

POSITION PAPER

The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper

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Behavioral health care includes care for patients around mental health and substance abuse conditions, health behavior change, life stresses and crises, and stress-related physical symptoms. Mental and substance use disorders alone have been estimated to surpass all physical diseases as a major cause of disability worldwide by 2020. The literature recognizes the importance of the health care system effectively addressing behavioral health conditions. Recently, there has been a call for the use of the primary care delivery platform and the related patient-centered medical home model to effectively address these conditions.

This position paper focuses on the issue of better integration of behavioral health into the primary care setting. It provides an environmental scan of the current state of conditions included in the concept of behavioral health and examines the arguments for and barriers to increased integration into primary care. It also examines various approaches of integrated care delivery and offers a series of policy recommendations that are based on the reviewed information and evidence to inform the actions of the American College of Physicians and its members regarding advocacy, research, and practice.

Ann Intern Med. doi:10.7326/M15-0510 **www.annals.org**

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This article was published online first at www.annals.org on 30 June 2015.

A review of the literature, including the most recent National Survey on Drug Use and Health (1), shows that many persons experience the consequences of behavioral health conditions, including mental health disorders, substance abuse and misuse, and lifestyle issues (such as inappropriate eating behaviors, sedentary lifestyle, and patterns of social isolation). These conditions are linked to increased likelihood of physical illness, higher mortality rates, poorer treatment outcomes, and higher health care costs.

Several stakeholders support the use of the primary care setting as an appropriate platform to address both physical and behavioral health conditions, which recognizes the comprehensive, whole-person focus of primary care and the observation that the primary care setting is currently the point of care for many patients with behavioral health problems (2). The degree of integration of behavioral care into the primary care setting can vary from selective screening, diagnosis, brief treatment, and referral to a truly integrated care approach in which all aspects of primary care recognize both the physical and behavioral perspectives. Available research supports the effectiveness of various approaches to integrated care, but there are several barriers to implementation, including insurance and payment issues, long-standing conflicting treatment cultures, stigma, and workforce issues.

This Executive Summary provides a synopsis of the full position paper, which is available in the **Appendix** (available at www.annals.org).

Methods

This policy paper was drafted by the Health and Public Policy Committee of the American College of Physicians (ACP), which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties. The authors reviewed available studies, reports, and surveys on the integration of behavioral health in primary care from PubMed, Google Scholar, relevant news articles, policy documents, Web sites, and other sources. Recommendations were based on reviewed literature and input from the ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies and nonmember experts in the field. The policy paper and related recommendations were reviewed and approved by the Health and Public Policy Committee in February 2015 and the Board of Regents in April 2015. Financial support for the development of this position paper comes exclusively from the ACP operating budget.

Recommendations

1. The ACP supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources.

* This paper, written by Ryan A. Crowley, BSJ, and Neil Kirschner, PhD, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who served on the Health and Public Policy Committee from initiation of the project until its approval and authored this position paper are Thomas Tape, MD (*Chair*); Douglas DeLong, MD (*Vice Chair*); Micah Beachy, DO; Sue Bornstein, MD; James Bush, MD; Tracey Henry, MD; Gregory Hood, MD; Gregory Kane, MD; Robert Lohr, MD; Ashley Minaei; Kenneth Olive, MD; and Shakaib Rehman, MD. Approved by the ACP Board of Regents on 28 April 2015.

2. The ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care.

3. The ACP recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that are barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws.

4. The ACP supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting.

5. The ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting.

6. The ACP recommends that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health. These programs need to address negative perceptions held by the general population and by many physicians and other health care professionals.

CONCLUSION

Physicians and other health care professionals will have to consider the behavioral and physical health of the patient if they are to be treated as a "whole person." Most patients with behavioral health needs use the primary care office as their main source of care, and given the nation's shortage of behavioral health providers, this may be the only setting in which behavioral health problems can be broadly recognized and treated. Changes to the health care delivery system, payment models, education and training, health insurance coverage, and societal and cultural perceptions are necessary to encourage communication and cooperation between the behavioral and physical health disciplines.

From the American College of Physicians, Washington, DC.

Financial Support: Financial support for the development of this guideline comes exclusively from the ACP operating budget.

Disclosures: Authors have disclosed no conflicts of interest. Authors followed the policy regarding conflicts of interest described at www.annals.org/article.aspx?articleid=745942. Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M15-0510.

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Appendix: The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care

Concept of Behavioral Health

The definition of the term *behavioral health* and the conditions it encompasses have varied. It has referred to mental health behaviors, substance abuse behaviors, a combination of both, and even a more broadly defined range of behaviors linked to an individual's overall health. As a result, the Agency for Healthcare Research and Quality (AHRQ) funded an effort to develop a lexicon to provide common meaning in the use of behavioral health and related terms, with a particular focus on usage in discussions about integrating behavioral health into physical health care (3). This policy paper uses a modification of this lexicon more recently offered by Davis and colleagues (4), in which behavioral health care is defined as a "broad term used to encompass care for patients around mental health, and substance abuse conditions, health behavior change, life stresses and crises, as well as stress-related physical symptoms."

Behavioral Health Conditions: An Environmental Scan

According to the Centers for Disease Control and Prevention, mental health disorders are "medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning" (5). Based on the 2013 National Survey on Drug Use and Health (1), an estimated 43.8 million U.S. adults aged 18 years or older had a mental illness in the past year. This represents 18.5% of all U.S. adults. Mental disorders among adults include (in order of prevalence): anxiety (such as generalized anxiety disorder, panic disorder, and posttraumatic stress disorder), mood disorders (such as major depressive, bipolar, and dysthymic disorder), personality disorder (such as borderline, avoidant, and antisocial), and schizophrenia (6). In 2013, an estimated 9.3 million adults (3.9% of all adults) aged 18 years or older had serious thoughts of suicide in the past year, 2.7 million (1.1%) made suicide plans, and 1.3 million (0.6%) attempted suicide (1). Adult women are more likely to be diagnosed with mental illness than men (7).

The literature reflects the use of a special category of mental illness labeled "serious mental illness" (SMI), operationally defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a "diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in DSM-IV [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition] (APA [American Psychiatric Association], 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" (8). An estimated 10 million adults (4.2% of the adult population) met the criteria for SMI in 2013. Schizophrenia, major depression, and bipolar disorder are diagnostic categories that are often associated with SMI. Persons with SMI are more likely to have shortened life spans, issues with substance abuse, and physical comorbid conditions than the general population. Social issues, such as homelessness and unemployment, are disproportionately found in this population (9, 10). There is a substantial shortage in the availability of psychiatric inpatient beds, which has led to overuse of "boarding" of these patients in the emergency departments of hospital facilities and the prison system and has prevented many of these patients from receiving the care they require (11, 12).

The most recent National Survey on Drug Use and Health (13) shows that substance use disorders remain a serious problem. An estimated 21.6 million persons aged 12 years or older were classified with substance dependence or abuse in 2013 (8.2% of the population aged 12 years or older). Of this total, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million had dependence or abuse of illicit drugs but not alcohol, and 14.7 million had dependence or abuse of alcohol but not illicit drugs. Overall, 17.3 million had alcohol dependence or abuse, and 6.9 million had illicit drug dependence or abuse. The definition for illicit drug use included nonmedical use of prescription drugs. Marijuana remained the most abused substance other than alcohol, followed by pain relievers and cocaine. Many states have legalized or decriminalized marijuana, but at this point, the effects of such policy on use and abuse rates are unknown. Among adults aged 18 years or older in

2013, 3.2%, or 7.7 million persons, had co-occurring substance use and mental health disorders (1).

According to the Centers for Disease Control and Prevention, drug overdose rates are at historic highs, driven largely by the increase in nonmedical use of prescription drugs—specifically prescription opioid painkillers (14). This has led to extensive efforts by medical societies, drug companies, and state and federal government agencies to mitigate the inappropriate use and abuse of these medications. Initiatives that are used toward this goal include drug reformulation to make misuse more difficult (15), increased limitations in use based on changes in the Drug Enforcement Administration control substance category (16), establishment of risk evaluation and mitigation strategies (17), and increases in educational requirements and duties for prescribing physicians regarding the monitoring, documentation, and treatment related to prescription opioids (18). The literature shows some potential adverse effects from the "crackdown" on painkillers, including increased difficulty in legally obtaining opioid medications for prescribed use and increased use of heroin, an illicit opioid that provides abusers with a similar effect with easier availability and lower cost (19–22). The number of persons using heroin for the first time has nearly doubled from 2006 (23).

A national survey showed that, in 2013 (13), an estimated 66.9 million Americans aged 12 years or older were current (that is, within the past month) users of a tobacco product despite well-publicized, evidence-based linkage to serious health issues: 55.8 million persons (21.3% of the population) were current cigarette smokers, 12.4 million (4.7%) smoked cigars, 8.8 million (3.4%) used smokeless tobacco, and 2.3 million (0.9%) smoked pipes. Although this prevalence reflects a significant decrease in tobacco use since the 1960s (24), it still shows that many Americans continue to engage in this unhealthy behavior. Use of electronic nicotine-delivery systems, including electronic cigarettes, has increased in recent years. These devices, which typically deliver nicotine to the user when activated, are largely unregulated, and evidence of safety and efficacy as a smoking cessation device is inconclusive (25). Use of these products among young persons is growing, and a 2014 survey found that use of electronic nicotine-delivery systems among teenagers has surpassed that of cigarettes (26).

The concept of behavioral health conditions often includes many additional behaviors directly related to overall health and mortality, such as inappropriate eating behaviors, sedentary lifestyle, and patterns of social isolation. The Centers for Disease Control and Prevention reports that greater than one third (or 78.6 million) of U.S. adults are classified as obese, with its higher risk for heart disease, stroke, type 2 diabetes, and types of cancer and increased all-cause mortality (27). The related issue of sedentary lifestyle is associated with a similar group of conditions and has prompted the World Health Organization (WHO) to issue a warning that a sedentary lifestyle could be among the 10 leading causes of death and disability in the world (28). A recent survey by the UnitedHealth Foundation found that 22.1% of the adult population had not participated in any physical activity or exercise other than their work in the past month (29). Social isolation is a significant problem in the elderly, with current estimates of the prevalence in community-dwelling older adults ranging from 10% to 43%. It has been linked to many health factors, including increased risk for all-cause mortality, rehospitalization, and falls (30).

Why Is Integration of Behavioral Health and Physical Health Necessary?

The concept that behavioral health is important to overall health has historical roots that date back to many ancient cultures focusing on mind–body interaction. In modern times, the Institute of Medicine has highlighted the importance of health care's recognition of the interaction of general physical, mental, and substance abuse issues in providing health care (31). This message has been echoed by many respected sources, including the WHO (32), AHRQ (33), and SAMHSA (34). It is also reflected by recent federal and state actions. For example, the Mental Health Parity and Addiction Equity Act of 2008 ensures parity in coverage between behavioral and physical conditions, and the Patient Protection and Affordable Care Act (ACA) contains many provisions promoting integrated behavioral and physical care delivery. These include the addition of no-cost (that is, no cost-sharing) benefits under Medicare and most commercial plans for alcohol misuse screening and counseling, depression screening, obesity screening and counseling, and tobacco use cessation counseling. Mental health and substance use disorder services are 1 of the 10 categories of services required for plans included in the new health insurance exchange and Medicaid alternative benefit plans. Finally, many state Medicaid programs require integrated care.

The literature shows that many common physical symptoms seen in the medical setting have no identifiable organic cause (35). Furthermore, mental illness, certain lifestyles, and related behaviors (such as excessive drinking, smoking, illicit drug use, and poor nutrition) have all been linked to physical illnesses and increased morbidity and mortality rates. The number of patients with comorbid behavioral and medical health issues is significant; 1 estimate determined that, over a 12-month period, 34 million U.S. adults reported having mental health and medical conditions (36). Comorbid conditions affect treatment outcomes, health care costs, and mortality rates. Patients with behavioral health issues die at a younger age than others (10), and

persons with SMI have higher mortality rates than those with non-SMI (37). Although the high mortality rates can be attributed to suicide and accidents, physical health issues, including chronic disease, are often the cause of death in persons with mental illness.

Sixty-eight percent of adults with mental illness also have at least 1 chronic physical illness (38). Patients with a mental illness are more likely to have high blood pressure, heart disease, diabetes, obesity, and asthma than those with no mental illness (38). Mental health comorbid conditions can undermine adherence to diabetes treatment, which can lead to future complications, such as blindness and reduced quality of life (39). Despite the evidence of comorbid conditions, not all patients receive the necessary screening and services to identify behavioral health issues. For example, only approximately one third of patients with diabetes as well as mental and physical comorbid conditions receive diagnosis and treatment of their mental condition (39).

Behavioral and physical comorbid conditions also have serious economic consequences. Treatment of chronic physical health issues for patients with behavioral health needs is 2 to 3 times more expensive than that for patients with only physical health needs (40). Diabetes treatment for patients with behavioral health issues can cost up to 50% more than that for persons without them (41). Many studies have concluded that depression increases the cost of health care up to 100%, particularly for patients with multiple chronic illnesses (42). Behavioral health issues are also prevalent among the nation's public insurance program enrollees, potentially driving up federal and state government spending: 49% of Medicaid enrollees with disabilities have a psychiatric illness, and prevalence of mental illness among the Medicaid population is twice that of the general population (43).

Support for Integrating Behavioral Health Care in the Primary Care Setting

Although the literature calls for the addition of primary care in the behavioral health setting (such as treating patients with SMI) (44) and the addition of behavioral health care into the primary care setting, this paper focuses on the latter approach: use of the primary care setting as the springboard for addressing both physical and behavioral health care. The degree of integration can vary from screening, diagnosis, brief treatment, and referral in the primary care setting. Such integration may involve colocation of both behavioral and physical care services in the primary care setting to a truly integrated care approach in which all aspects of care delivered in the primary care setting recognize both the physical and behavioral perspective. Full primary and behavioral integrated health care has been defined as "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population" (3). The levels of integration will be discussed in more detail.

The concept of providing whole-person, comprehensive care is rooted in the definition of primary care (45). The Institute of Medicine specifically included addressing mental and emotional needs in the scope of the definition of primary care in its oft-quoted 1996 report. The concept of increased integration of primary care and behavioral health services has been supported by several sources. WHO emphasizes the importance of a primary health care approach, including addressing behavioral health conditions, in meeting population health care needs (32). The concept of primary care and mental health coordination was promoted in the 2003 report for the President's New Freedom Commission on Mental Health, which noted that "mental health is the key to overall physical health" (46). Many health professional organizations have supported policies to merge behavioral and medical care, including the American Psychiatric Association (47), the American Society of Addiction Medicine, the American Psychological Association (48), and the American Academy of Family Physicians (49). Federal agencies are also involved in encouraging integration: The SAMHSA and the Health Resources and Services Administration (HRSA) jointly operate the Center for Integrated Health Solutions to study existing and emerging models and assist community-based medical and behavioral health providers in integrating the physical and mental health care fields (50). AHRQ has done extensive research on medical–behavioral health care integration through the Academy for Integrating Behavioral Health and Primary Care (33).

More recently, the patient-centered medical home (PCMH) has been proposed as the most appropriate model to address the integration of primary and behavioral care, highlighting its emphasis on primary care, care coordination, and delivery of care by a team of professionals (51, 52). The ACA incentivizes the development of Medicaid health homes, which promote addressing behavioral health issues in the primary care setting. Primary care practices that participate in Maine's PCMH pilot project are expected to integrate behavioral or mental health, and coordination payments have been boosted to help practices offset the cost (53, 54). The National Center for Quality Assurance has included addressing behavioral health needs as a significant element in its 2014 PCMH recognition program standards (55).

For many patients with behavioral health issues, the primary care setting is the point of care, and most mental health care is provided in the general medical setting (56, 57). A 2000 survey determined that "32% of

undiagnosed, asymptomatic adults would likely turn to their primary care physician to help with mental health issues; only 4% would approach a mental health professional" (58). One third of patients with a mental health issue use primary care as their only source of health care (57). More than 40% of antidepressants are prescribed by primary care physicians (49, 59).

The literature also shows opportunities in the primary care setting not only to address current behavioral health conditions but also to serve as a platform to promote prevention in at-risk patients or populations and address behavioral health conditions at the prodromal stage (60, 61).

AHRQ provided its rationale for integrating behavioral health care in the primary care setting in a 2008 evidence review. It stated that patients with mental illnesses often did not receive treatment, were often cared for in the medical rather than behavioral health sector, and were more likely to visit a primary care physician or provider than a mental health provider on an annual basis. This enabled the primary care provider to recognize and manage behavioral care needs. The agency also noted that primary care physicians were more likely to treat patients with chronic medical conditions, which enabled them to address comorbid conditions among patients with complex needs. In addition, AHRQ stated that strong evidence showed that depression and anxiety-related disorders can be treated in the primary care setting (although quality guidelines need to be developed and disseminated to ensure that good care is rendered) (2).

Barriers to Integration and Other Issues About Behavioral Health Care

The barriers to seamless integration of behavioral and primary care are both administrative and financial. The literature addresses many of these barriers, as discussed in the following sections.

Behavioral and physical health care providers have a long history of operating in different care silos. The artificial separation of behavioral and physical health care is reflected in many ways. For example, primary care physicians generally lack extensive clinical training in behavioral health (53), and traditional medical and mental health training models and practice environments are substantially different, which may lead to cultural clashes if they are not thoughtfully integrated (62).

Different administrative and regulatory structures for physical health, mental health, and substance abuse care, particularly at the state level, often lead to substantial complexities for an integrated approach to care; these complexities include meeting an excess of regulatory requirements that often conflict, and problems in developing an effective clinical team as a result of differences in credentialing and licensing requirements among the different agencies.

Different purchasing, payment, and benefit models across various types of care complicate the financial viability of integrated programs. Managed care organizations that "carve-out" behavioral health and are funded and operate separately from medical care providers have networks that often exclude primary care clinicians, lack fee schedule payment for consultations and team meetings among physical and behavioral health providers, and have restrictive same-day billing rules for integrated care are among the barriers to integration (63, 64).

An ingrained bureaucratic infrastructure or culture in many settings with powerful constituencies tends to maintain the status quo (63).

Treatment access. Sixty percent of adults with a diagnosable mental health disorder do not receive services (65). Untreated mental illness can be incredibly harmful to overall health and well-being, especially among patients with other chronic diseases. Adults with severe mental health disorders are more likely to be uninsured than those without such disorders (66). A survey found that 59% of primary care physicians stated that inadequate health insurance coverage was a "very important" reason for not getting outpatient mental health referrals (67). Combined survey results from 2010 to 2013 found that 37.3% of persons who needed and sought treatment for substance use cited "no health coverage/could not afford" as the reason that they did not receive such treatment, 8.2% expressed that they "had health coverage but [it] did not cover treatment or cover costs," and 8% mentioned "no transportation/inconvenient hours" (1). The ACA, which mandates behavioral health coverage for qualified health plans, implements insurance reforms to ensure accessibility, and expands mental health parity protections to most types of health plans, will reduce health coverage–related barriers that impede access to behavioral health care. The SAMHSA estimates that the ACA's behavioral health insurance requirements and mental health parity provisions will provide new or expanded behavioral health benefits to 60 million persons (68).

The mental health care system is often the target of state budget cuts. Many states reduced mental health service budgets during the last economic recession. One report concluded that states cut $4.35 billion in public spending on mental health between 2009 and 2012, the most since the era of deinstitutionalization (69). Although some states have taken action to partially increase funds as the economy improved, mental health service budgets remain a popular target for budget offsets, which reduces access to hospital, community-based, and supportive care (70).

Information exchange. Confidentiality laws that pertain to sharing behavioral health information are generally more restrictive than those that pertain to physical health. This is not due to the privacy rules of

the Health Insurance Portability and Accountability Act because sharing information for the purposes of treatment, payment, and health care is permitted by "covered entities" without formal patient consent. The one exception is "psychotherapy notes," and only if they are clearly separated from the rest of the medical record. However, many states have mental health laws that are more restrictive and need to be reassessed. There are also federal alcohol and drug abuse treatment confidentiality rules (called "Part 2 regulations") that require formal patient consent in sharing records from specifically licensed alcohol and drug abuse treatment facilities that receive federal funding (71).

Behavioral health providers have adopted electronic medical records later than their physical health colleagues. Only 5% of behavioral health providers were anticipated to meet federal "meaningful use" standards by 2012, compared with 50% of office-based physicians (63, 72).

The stigma of behavioral health treatment. A persistent and pernicious stigma continues to surround obtaining care for behavioral health issues. Among adults reporting an unmet need for mental health services, 8.2% did not seek mental health treatment because they did not want others to find out, 9.5% reported that it "might cause neighbors/community to have negative opinion," and 9.6% had concerns about confidentiality (7). Twenty-eight percent believed that they could handle the problem without treatment, and 22.8% did not know where to go to receive treatment (7). The perception problem is particularly embedded in certain age groups (that is, older persons), racial and ethnic minority populations, and residents of rural areas (57, 73).

Workforce issues. Behavioral health faces a significant workforce shortage in many parts of the United States. The definition of mental health provider varies, but the HRSA defines "core mental health professionals" as clinical social workers, clinical psychologists, marriage and family therapists, psychiatrists, and advanced practice psychiatric nurses (74). According to a report from the U.S. Department of Health and Human Services, 91 million persons lived in areas with a shortage of mental health professionals. To meet the mental health needs of this population, more than 1800 psychiatrists and nearly 6000 other practitioners would be needed to fill vacant slots. Fifty-five percent of U.S. counties (all rural) have no practicing psychologists, psychiatrists, or social workers (75). According to Dr. Jeffrey A. Lieberman, president of the American Psychiatric Association, the millions of newly insured patients under the ACA will "overwhelm, if not inundate" the mental health field (76). SAMHSA has identified many reasons for the workforce shortage, including high turnover rates, low compensation, an aging workforce, unequal distribution of the workforce, and negative stigma associated with behavioral health issues and the mental health profession (75).

Levels of Integration

Blount (77) has defined the following levels of behavioral health care integration in the primary care setting.

Coordinated care. Behavioral and physical health clinicians practice separately in their respective systems. The primary care clinician may deliver diagnostic and brief behavioral interventions. A referral relationship is established with behavioral health clinicians and related resources in the community. Information about mutual patients is exchanged as needed, and collaboration is typically limited outside of the initial referral. An example of the coordinated care model with minimal collaboration would be a small primary care practice that screens for behavioral health disorders, provides limited interventions when appropriate (such as a brief intervention [78]), and makes referrals to community behavioral health practitioners when warranted.

Colocated care. Behavioral and physical health clinicians deliver care in the same practice. Colocation is more of a description of where services are provided than a specific service. Patient care is still often siloed to each clinician's area of expertise, but colocation enhances the likelihood of informal and formal communication and can reduce the number of "no-shows" for behavioral health referrals. This model has been established in many community health centers, which may have a licensed clinical social worker, mental health counselor, or other clinician with primary care clinicians in the same clinic. In 2010, 70% of community health centers provided mental health services and 55% provided substance use disorder treatment services (79).

Integrated care. Behavioral and physical health clinicians act together to design and implement a unified patient care plan. This model often connotes close organizational integration as well, perhaps involving social and other services.

An example of a more fully integrated approach is Tennessee's Cherokee Health System, which integrates a behavioral health provider in the primary care setting to address patient needs related to traditional mental health issues, such as depression, and health psychological issues, such as self-management of chronic illness. This health system also provides specialty mental health services, such as psychiatric consults and therapy through face-to-face visits and telemedicine venues (80). Behavioral health providers are considered "core members" of the primary care team and perform behavioral health assessment, triage, and intervention services at the time of the patient's primary care visit. Integration of behavioral health consultants has led to substantial reductions in care use. Cherokee reports that medical use has decreased by 28% for Medicaid

patients and 20% for patients with commercial insurance, psychiatry visits have been reduced by 27%, and crisis visits have decreased by 48% (81).

Another promising integration approach is the collaborative care model, which includes "care coordination and care management; regular/proactive monitoring and treatment to target using validated clinical rating scales; and regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement" (42). The collaborative care approach is discussed further in the next section.

Evidence for Effectiveness of Integration

The conceptual rationale for integrating behavioral health into primary care is strong, and a growing body of evidence supports its effectiveness.

A 2008 AHRQ-funded review of randomized, controlled trials and high-quality quasi-experimental design studies in the literature reflected the effectiveness of care programs with some degree of integrated care for depression, anxiety, at-risk alcohol use, and attention deficit–hyperactivity disorder in primary care settings. The data on depression were cited as particularly strong. The evidence review could not parse out the discernable effects of the degree of provider integration or the processes used (82). A 2012 Cochrane Collaborative review demonstrated significantly greater improvement in anxiety and depression outcomes for adults treated under a collaborative model of care than those treated by traditional means (83). The studies included in the AHRQ and Cochrane evidence reviews seem to have overlapped. A recent randomized trial of collaborative primary care intervention with adolescents resulted in greater improvement in depressive symptoms than usual care at 12 months (84). Comparative effectiveness reviews conducted under the auspices of the U.S. Preventive Services Task Force supported the effectiveness of the following services in the primary care setting: screening and counseling for alcohol misuse; screening when staff-assisted depression care supports were in place to ensure accurate diagnosis, effective treatment, and follow-up for depression in adults; counseling and interventions for tobacco cessation; and screening and counseling for obesity in adults (85).

Several approaches to more integrated behavioral health care in the primary care setting have received substantial validation in the literature, including the following.

The Improving Mood–Promoting Access to Collaborative Treatment model for depression has been effective in multiple health care systems with several populations and various comorbid conditions (86). The approach uses an evidence-based diagnostic instrument (such as the Patient Health Questionnaire–9 [87]) and adds a depression care manager (a nurse, social worker, or psychologist who educates, supports, coaches, provides brief evidence-based treatment, and monitors progress) to the primary care team and designates a consulting psychiatrist to assist when patients do not respond to treatment as expected. Treatment is adjusted throughout the process according to an evidence-based algorithm. The Depression Improvement Across Minnesota, Offering a New Direction program is based on a similar collaborative model and has strong evidence for effectiveness (88).

The Screening, Brief Interventions, Referral to Treatment approach has been effective for the treatment of drug and alcohol abuse in the primary care setting as well as others. The approach typically uses evidence-based screening techniques (such as the Alcohol, Smoking and Substance Involvement Screening Test [89]; Alcohol Use Disorders Identification Test [90]; and Drug Abuse Screening Test [91]). Patients with low-risk patterns of alcohol use and no drug use receive screening only, those with moderate- to high-risk alcohol use patterns or illicit drug use receive brief interventions, and patients that fulfill defined criteria for addictive patterns of behavior are referred to specialty care. Brief interventions generally follow a scripted program, which varies by site. Brief therapy techniques include motivational enhancement therapy and brief behavioral therapy approaches (92, 93).

Addressing behavioral health issues has decreased overall health care costs. A 1999 meta-analysis of studies that addressed evidence of cost offset for the inclusion of behavioral health treatment with physical health care found that medical use decreased an average of 15.7% for patients receiving behavioral health treatment, whereas medical use increased by more than 12% for related control participants. However, the reviewed studies included a heterogeneous group of interventions and conditions, and the rigor of many of the included studies can be questioned (94). Katon and colleagues (95, 96) found that depression treatment in primary care for patients with diabetes or coronary heart disease resulted in lower total health care costs in a series of randomized studies that used a collaborative care model. These results are particularly meaningful given the frequency of these conditions in primary care and because as many as 20% of patients with these conditions also have depression (96).

AHRQ funded a project to review the available research on integrating behavioral health (specifically mental health) into primary care and to identify research gaps. The stakeholder involved concluded that "the efficacy of integrated care has been established; however, its ability to be sustained in everyday practice remains to be proved, and will in part depend on the level of incentives and support provided through payment system reform, as well as the ability of the practices to provide the care efficiently" (97).

Recommendations

1. The ACP supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources.

The basis for this recommendation is derived from several sources. It is consistent with the concept of "whole-person" care, which is a foundational element of primary care delivery. It recognizes that physical and behavioral health conditions are intermingled: Many physical health conditions have behavioral health consequences, and many behavioral health conditions are linked to increased risk for physical illnesses. Primary care practice is currently the entry point and the most common source of care for most persons with behavioral health issues—it is already the de facto center for this care. Available research evidence, although limited, also supports the efficacy of this approach.

The PCMH model, with its emphasis on "whole-person" primary care, care coordination, and delivery of care by a team of professionals, is an excellent foundation for this integration of care. Its bundled monthly pay components also provide a means to financially support the required infrastructure and clinical resources necessary for effective integration.

2. The ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work to remove payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care.

The evidence shows that integrating behavioral health and primary care leads to improved mental health outcomes, improved physical health, improved quality of life, and lower costs. Primary care physicians also support integrated care and report that the integrated care model encourages better communication and coordination among behavioral health and primary care physicians and reduces mental health stigma, when compared with an enhanced referral model (98). However, significant payment barriers impede integrated care.

The effect of disparate payment systems is evident in the Medicaid program, in which behavioral health care funding is often separate (that is, carved out) from medical care even in managed care organizations, leading to disconnected care delivery. To help merge behavioral health and medical care funding streams and better coordinate care, the ACA authorized the Medicaid health homes demonstration program, which builds off of the PCMH concept.

Missouri's primary care health home project for patients with chronic conditions seeks to encourage primary care providers to focus on treating the whole person and addressing each patient's physical and behavioral health needs (99). The state receives a temporary 90% Medicaid match from the federal government to provide a per-member, per-month payment to federally qualified health centers, rural health centers, and physician practices to retain a behavioral health consultant, nurse care managers, and care coordinators (99). Behavioral health providers are charged with screening and evaluating patients for behavioral health conditions and managing these needs of the population in the primary care setting (100). Health homes in all states are required to report on quality measures, and states must gather and report use, spending, and quality data for independent review.

Accountable care organizations allow health care providers to share savings from patient safety and quality care improvements. Essentia Health, a health system based in the upper Midwest, has sought to better integrate behavioral health in the primary care setting within an accountable care organization framework (101). In Essentia's model, behavioral health providers are embedded in the primary care team. Psychiatric nurses work with primary care providers to manage medications, plan treatments, and diagnose illness. On-site behavioral health providers assist with behavioral health screenings and conduct motivational interviewing, psychoeducation, and other therapeutic services. Consulting psychiatrists are available off site to address complex cases. To facilitate communication, provider offices are situated in proximity to each other and schedules allow for behavioral health and primary care providers to discuss patient needs. The duties of the behavioral health providers may shift on the basis of the primary care clinic's needs, which increases primary care provider buy-in and support.

Additional payment models that can potentially facilitate integrated care include bundled payments, partial and full capitation, and even fee-for-service. For example, additional fee-for-service payment codes could be aligned to incentivize integration by establishing payment for behavioral health–primary care consultations, multidiscipline care plan development, and related activities.

Other care settings have integrated behavioral health considerations into quality assessment and improvement efforts. In recognition of the prevalence of major depression among nursing home residents, the Minimum Data Set 3.0 assessment and care management tool evaluates nursing home residents for depression using the Patient Health Questionnaire–9, in addition to physical health indicators. Results from this data set factor into the skilled-nursing facility reimbursement method used by Medicare. The latest version was updated with increased attention to addressing "second-generation issues" related to behavioral health treatment, such as physical injuries that may arise due to

antidepressant use (102). Public and private payers should initiate demonstration projects that test and evaluate other payment models that integrate behavioral health in the primary care setting. In regard to the PCMH with onsite behavioral health services, it has been suggested that resources be focused on patients with chronic medical conditions and those with high health costs rather than behavioral health screening for all patients (103). Targeted screening efforts may better enable practices with limited resources to extend behavioral health services to patients with the greatest needs.

Payment models should account for practice characteristics (such as practice size and available resources) and characteristics of the target population (such as those with SMI and elderly persons).

3. The ACP recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that are barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws.

The ACA and mental health parity laws address many enduring behavioral health coverage problems. Premium tax credits and Medicaid expansion provisions have increased coverage to millions of Americans, including nearly 4 million persons with severe mental health disorders (66). Insurance industry reforms, including prohibitions on preexisting condition limits and curbs on cost-sharing and annual and lifetime dollar limits, have helped make the system more equitable to patients with behavioral health needs. Nongrandfathered individual and small-group marketplace-based qualified health plans and Medicaid expansion plans are required to provide mental health, behavioral health, and substance use care benefits as part of the essential health benefit package. The employer and individual responsibility requirements will further increase insurance access.

Although these reforms will undoubtedly benefit many patients with behavioral health needs, gaps in coverage may persist. For example, many patients with severe mental health needs require supportive services, such as vocational training and housing supports. Federal regulations give states the option to provide these services to the Medicaid expansion population (104). Benefit packages for marketplace-based private insurance plans may also have gaps in coverage of ancillary care (105). Self-insured plans are not obligated to cover the essential health benefits package. Mental health essential benefits may vary in type of covered services within the essential health benefits category, treatment limits, definition of medical necessity, and provider availability (106). The Medicaid institution for mental diseases exclusion, which prohibits the federal government from paying its share of the cost of services provided in an institution for mental diseases, also applies to Medicaid expansion alternative benefit plans; Sara Rosenbaum argues that this exclusion contradicts mental health parity requirements (107, 108). The National Alliance for Mental Illness has expressed concern about the process for applying mental health parity laws to individual and small-group qualified health plans, particularly about ensuring equal coverage for benefits; time, duration, and scope of mental health and substance use services; and treatment limitations (including previous authorization and step therapies) (109). Federal and state regulators should work to ensure that the Mental Health Parity and Addiction Equity Act is fully implemented as intended so that patients with behavioral health needs do not enroll in plans with discriminatory benefit packages.

Comprehensive coverage of evidence-based interventions varies widely and may not be offered in even the more generous health insurance plans. In 2007, evidence-based services for adults, such as assertive community treatment (a team-based treatment model to support persons in an outpatient setting [110]), were available in only 34 states, integrated mental health or substance abuse treatment was offered in 19 states, and illness or disability self-management was covered in 19 states (10). Because coverage does not equal access, patients in some states and geographic areas may have difficulty finding the appropriate providers to deliver evidence-based services.

Medicaid is the single largest source of health coverage in the United States and plays a major part in providing behavioral health coverage to millions of persons. A study of Oregon Medicaid enrollees found that gaining Medicaid coverage decreased the probability of having positive results on depression screening tests and increased the likelihood of higher self-reported mental health (111). With the eligibility expansion initiated by the ACA, millions of low-income persons and families, including previously excluded childless adults, will be able to enroll in coverage. However, only 29 states and the District of Columbia have elected to expand their programs (112). The ACP strongly supports full expansion of the Medicaid program to broaden access to coverage and to incentivize states to test new models of integrating behavioral health into primary care, such as Medicaid health homes.

Provider network adequacy has also been a major concern after the rollout of the coverage provisions in the ACA in January 2014. Many exchange-based health plans have been classified as "narrow" network plans—lower-cost plans with a tight, limited networks of provider (113). These plans exist despite federal regulations that require qualified health plans to maintain a network that is "sufficient in number and types of providers, including providers that specialize in mental

health and substance abuse services, to assure that all services will be accessible without unreasonable delay" (114). It is imperative that federal and state regulators enact laws that require health plans to ensure accessible behavioral health providers and primary care physicians, accurate provider directories, and transparent processes for provider selection.

4. The ACP supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting.

Although a review of the current literature supports the efficacy of the integration of behavioral health care in the primary care setting, it is quite limited and filled with many gaps. Substantial research is needed to focus on the efficacy of various models of integration, as well as the diagnostic and treatment interventions most appropriate for use in these models. The following additional factors should be considered within this research effort: specific conditions addressed, populations involved (such as child vs. adult), funding structures, personnel employed, and resources available to the participating practices.

The ACP particularly encourages studies that examine whether the PCMH care delivery model provides effective and efficient behavioral health care in the primary care setting. Its emphasis on team-based care and care coordination seems particularly suited to provide this integration.

5. The ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting.

Cross-discipline training is needed to prepare behavioral health and primary care physicians to effectively integrate their respective specialties. Primary care physicians need to be trained to screen, manage, and treat common behavioral health conditions, and behavioral health providers need to be trained to understand care for common medical needs (115). Both sectors need to overcome the operational and cultural barriers that prevent seamless integration. A report from the SAMHSA–HRSA Center for Integrated Health Solutions cited inadequate skills for integrated practices and reluctance to change practice patterns as workforce challenges related to integration (116).

Before the 1960s, most care for patients with serious mental health issues was provided in state- and county-based inpatient psychiatric hospital settings. Patients with mental illness and their advocates began pushing states to transition more care into community-based outpatient centers. Further, state and county efforts to shift costly inpatient psychiatric care responsibilities and spending to other payers, availability of medications to treat psychotic disorders, and managed care use restrictions facilitated a movement to community-based outpatient care (117). The number of inpatient psychiatric beds sharply declined from 525 000 in 1970 to 212 000 in 2002, and the increase in community-based services has not been sufficient to replace the number of psychiatric beds lost over the past few decades (117, 118). Although many patients are well-served in the community, some with serious mental health needs, such as schizophrenia, require a level and duration of care not provided in the outpatient setting. As a result, general hospital emergency departments, prisons, and jails have become the de facto care setting for patients with serious mental health needs, and these facilities often lack the resources and clinicians with the appropriate training to provide sufficient care (119, 120). New evidence-based care models, including assertive community treatment and mobile crisis teams (121), have emerged to address these needs, and policies should encourage their use. For patients with needs that can only be met in an inpatient psychiatric hospital setting, policy changes, such as the reevaluation of strict medical necessity rules to permit longer stays and broadening federal payment for high-quality inpatient psychiatric care, may be necessary to increase capacity (117).

Physicians have also cited educational needs related to integrated care. The Integrated Behavioral Health Project under the California Mental Health Services Authority identified training gaps that need to be addressed to facilitate integration. The top 3 training needs cited by physicians were "[better understanding of the] impact of physical disorders on mental health, addressing behavioral health components of physical disorders, and understanding and addressing the psychiatric effects of medications for physical conditions" (122).

To tackle these training concerns, the SAMHSA–HRSA Center for Integrated Health Solutions developed training and education strategies that include "portable curricula on a few high priority competencies, which would include data and interventions that hold promise for highly affected communities with disparate mental health outcomes and access" (116). Physician training should also develop teamwork competencies and communication skills so information can be delivered to patients in an empathetic and understandable manner (123).

Some medical schools have developed programs to teach existing and future health care professionals to work effectively in an integrated practice. The University of Massachusetts Medical School Center for Integrated Primary Care offers a certificate program to prepare behavioral health providers to work in the primary care setting. A care management certificate program is offered to nurses and mental health professionals to provide training in such activities as assessment, care

planning, and quality evaluation in the PCMH setting (124).

Policymakers and other stakeholders must address the nation's serious shortage of behavioral health care professionals. Proposed solutions to the mental health workforce shortage include increasing training and use of paraprofessionals or primary care physicians and other health care professionals to administer some mental health services, adjusting licensure and scope of practice laws to include more midlevel mental health professionals, establishing special federal programs to train mental health providers, and offering more attractive compensation packages to mental health providers willing to work in underserved areas (74).

The ACA includes many training and workforce-oriented programs that seek to address the nation's medical and behavioral health personnel shortages and increase knowledge and implementation of behavioral–medical health integration. The Mental and Behavioral Health Education and Training Grants program is authorized through Title VII of the Public Health Service Act to recruit and provide financial assistance to students entering the behavioral health fields. This program may help reverse the behavioral health workforce shortage and increase the number of behavioral health providers able to work in the primary care setting.

Another initiative established in the ACA, the Primary Care Extension Program, is authorized to provide support and assistance for training primary care providers about mental and behavioral health services, among others. The program will train extension agencies to work with primary care providers to disseminate information about best practices, assess implementation, and assist with PCMH implementation. This program, when adequately funded, may provide an avenue to accelerate implementation of integrated, colocated, or coordinated care behavioral–medical health models. To ensure positive results, this program and other similar initiatives must train both behavioral health and primary care professionals on effective work practices in a team-based care setting to avoid isolated, siloed care found in noncollaborative settings.

The ACA also authorized the National Health Care Workforce Commission, a group of nongovernmental experts with a mission to provide analysis and recommendations to address our nation's most pressing health care workforce concerns. Given the urgency for expanded integration of behavioral health in primary care, the Commission should recommend policies to address related workforce gaps. However, Congress has not funded the Commission, although members were appointed in 2010.

Several general sources for tools and resources to facilitate the introduction of behavioral health into the primary care setting are already available, such as the SAMHSA–HRSA Center for Integrated Health Solutions (50), the Academy developed and maintained by AHRQ (33), and the Services and Tools for Behavioral Health Integration section of the Patient-Centered Primary Care Collaborative Web site (125). In addition to the need to expand current tools and resources, development of effective delivery mechanisms to disseminate this information into the primary care practice setting is needed.

6. The ACP recommends that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health problems. These programs need to address negative perceptions held by the general population and by many physicians and other health care professionals.

Research shows that negative stigma of mentally ill persons exacerbates feelings of hopelessness, loneliness, and distress among patients and their families and leads to discrimination in housing, education, and employment, making it difficult for patients to lead normal lives (126). Fear of judgment, isolation, and prejudice also discourages patients with mental health needs to seek treatment and adhere to care regimens.

Physicians and other health professionals are not immune to negative attitudes toward patients with behavioral health needs. Evidence shows that mental health professionals tend to hold pessimistic views about treatment outcomes. An Australian study found that psychiatrists were less optimistic about patient outcomes than psychiatric nurses (127). Other findings showed that family physicians or general practitioners were "even more often stigmatizing" than psychiatrists toward patients with mental illness, and a survey of English patients concluded that family physicians were most often identified as a group that needed to be targeted for educational sessions to reduce discrimination (127). Research indicates that primary care providers and psychiatrists are less likely to provide evidence-based care to patients with schizophrenia than patients without it due to the unsupported perception that patients with schizophrenia are less likely to adhere to recommended treatment (128). Stigma of mental illness may also negatively affect recruitment into the psychiatric field and related research (129) and is a barrier to effective behavioral–medical care integration: The SAMHSA Center for Integrated Health Solutions has identified "negative attitudes about persons with mental health and substance use problems" as an impediment to building a workforce dedicated to integration of the 2 fields (116).

Public education efforts, fighting mental health discrimination, recovery-focused interventions, and messaging are among the recommended solutions to combat the stigma associated with behavioral health (57, 130). WHO has called on member states to establish behavioral health–related antidiscrimination laws and

public education campaigns to promote mental health across the lifespan (131).

Conclusion

This policy paper focuses specifically on the issue of increased integration of behavioral health into the primary care setting. Its recommendations establish an initial foundation to guide ACP efforts regarding advocacy, research, and practice to achieve this important goal. Nonetheless, many areas related to behavioral health were not addressed, and they are no less important to our members, the patients they treat, and society in general, such as ensuring the delivery of good primary care in specialized behavioral health treatment settings—the home for care for many patients with SMI or substance abuse issues. Other related areas that have already been addressed in ACP policy statements include efforts to decrease prescription drug abuse (18), acceptance of substance abuse as a public health issue rather than a criminal issue (132), and the relationship between behavioral health issues and ensuring firearm safety (133).

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